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API Privatization Feasibility Study

Prepared for the
Alaska Department of Health and Social Services

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WICHE
Western Interstate Commission for Higher Education
Behavioral Health Program

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Executive Summary

In November 2019, the Alaska Department of Health and Social Services (DHSS) contracted with the Western Interstate Commission for Higher Education Behavioral Health Program (WICHE) to conduct a study to examine various scenarios for the operation of the Alaska Psychiatric Institute (API). The primary objective of this study is to identify potential operational scenarios for API, and to examine each scenario based on qualitative and quantitative metrics in an effort to determine the impact on the State of Alaska. WICHE collaborated with the National Association of State Mental Health Program Directors Research Institute (NRI) and Stoel Rives, LLP to complete this study (collectively, "the WICHE Team").

The WICHE Team considered status quo operations of API and determined, based on leadership and quality of care concerns that this is not a viable option for reasons identified in this report. The team then conducted a comprehensive analysis of performance indicators and Medicaid cost data to determine how API compares to other state hospitals, both publicly and privately operated. The WICHE Team also held interviews with stakeholders of Alaska's behavioral health system, and representatives from other state mental health authorities (SMHAs) who have pursued privatization to understand the challenges and opportunities DHSS faces in making decisions about the future of API.

Based on this research, this report provides a comparative analysis of the legal considerations, staffing scenarios, cost considerations, Olmstead Risks, and quality of care implications for each of the following four operational scenarios for review and consideration:

- **Scenario 1:** Contracting with a for-profit, third party to assume responsibility for hospital management and operations (while the state retains all API capital assets).
- **Scenario 2:** Maintaining the facility under state ownership and operation with an analysis of whether, and how, it is possible for the State to **effectively** operate API if it remains exclusively state-run.
- **Scenario 3:** Forming a public corporation under state supervision to operate the facility.
- **Scenario 4:** Maintaining the facility under state ownership and operations but contracting for specific components of hospital services to improve care and reduce costs.

The first scenario the WICHE Team examines in this report is full privatization, considering both for-profit and not-for-profit structures. This scenario assumes that the State of Alaska would retain ownership of the physical plant and land associated with API, but that the contractor would be responsible for all incurred capital costs and would manage the operation and maintenance of the physical plant. Should DHSS decide to pursue full privatization to a for-profit entity, the state can expect a decrease in state general fund expenditures of $1.2 million. If a not-for-profit organization is selected, the state can expect a decrease in state general fund expenditures of $2.6 million in year one. We anticipate quality of care to improve over API's current situation, as it is assumed that salaries will increase, vacancies will be filled with greater flexibility for

recruitment and compensation, and treatment will be enhanced. Assuming the state retains the authority to determine admissions, access to care should also improve as API increases its workforce and quickly restores and maintains its occupancy rate, which will also help reduce forensic and civil waitlists. Administrative accountability should also increase under this scenario as the new CEO would have new performance targets to meet, and repeated failure to meet the targets would result in loss of employment and endanger the contract.

The second scenario is continued state management of API implementing strategies to increase the effectiveness of operations. Should DHSS continue to manage API, several changes are offered that would help increase the hospital's performance. Specifically, changes in the areas of leadership, performance improvement, and investment in workforce, along with improving staff and patient culture would greatly benefit API. Choosing this option will require changes to the current status quo operations of API and the approach of the Executive Branch management and oversight to support effective operations. The major changes proposed in this scenario include the designation of a staff development office to improve staff competency, skills, confidence, and therefore staff and patient safety; and the creation of an enhanced performance improvement and management function to transform the API's implementation of performance improvement, including rapid cycle processes across the hospital to improve overall performance and outcomes. The success of this performance improvement initiative is contingent on the engagement of hospital and DHSS leadership and must be recognized as a key responsibility of all staff.

The third scenario the WICHE Team explored is the creation of a not-for-profit, public corporation or public authority, to operate API with state supervision. To create an organizational structure that is more flexible and nimbler, yet still ensures accountability to the public, stakeholders, patients and families; some behavioral health experts have suggested that API become a not-for-profit, public-benefit authority/corporation. A public authority could oversee changes in the areas of leadership, performance improvement, and investment in workforce development, along with improving staff and patient culture. The authority could also implement the specific changes recommended in Scenario 2 by enhancing staff-development and performance improvement and management functions. Operation under a public corporation could provide API with the dedicated management resources, including a governing board, public authority, and CEO. As the authority would be a newly formed entity, creating a culture and management approach within the public corporation, and the CEO described in Scenario 2 may be more pragmatic than relying on a significant transformation within API to successfully implement significant, long-standing changes. Multiple public entities of this nature operate in Alaska; however, the entity that most closely resembles the model the State of Alaska might emulate is the Alaska Mental Health Trust Authority.

The fourth scenario the WICHE Team explored is the privatization of select hospital components. Currently, API contracts for food service, campus security, and patient transport services. For this study, the WICHE Team reviewed API's organizational structure and staffing levels of various

departments in an effort to identify potential areas that could potentially be privatized and determined that the Communication Center and Housekeeping ("Environmental Services" within Facilities Management) are reasonable candidates for privatization. The state could reasonably expect to save $20,137 per year for privatizing the Communication Center, and $57,504 per year for privatizing Environmental Services.

The pros and cons of each scenario are described in Table 1 on the following page.

Table 1: Comparison of the Pros and Cons, and Cost Savings of Each Scenario

Scenario	Pros	Cons	Budget Change Year 1 Cost/(Savings) From Base Year
1. a) Full Privatization *For-Profit*	• The State and DHSS would be able to cease operating the hospital and DHSS could focus on working with the API contract operator to "fit in" to the state's behavioral health continuum and DHSS could advocate for using API in its appropriate role and mission. • Full privatization is estimated to result in a decrease in state general fund expenditures. • A private contractor would have more flexibility in recruitment and hiring practices and might be able to experience more success than API at filling vacant positions. • A private contractor would not be limited by the State of Alaska's state employee salary structure. Challenges also exist with the classification of clinical positions in the State system.	• It may be challenging to find a qualified not-for-profit contract operator given the workforce issues and API's current challenges. • The state will continue to be responsible to ensure an adequate safety net exists for persons with serious and persistent behavioral health disorders in need of inpatient services, through contract performance management activities. • Responsibility for patient and staff safety and outcomes will be transferred to a contractor, yet negative outcomes will be perceived to be, at least to some degree, the partial responsibility of the State and DHSS. • API's supervisors would no longer be eligible to be covered by the supervisory bargaining unit. Employees would not be covered by the State's malpractice and workman's compensation programs. • Should the contract with a private entity need to be terminated, transition to another private contractor or returning to State management and operations, could be disruptive to API operations.	($1,202,766)
1. b) Full Privatization *Not-for-Profit*			($2,582,994)

Scenario	Pros	Cons	Budget Change
2. State Operation [Enhanced]	• With significant commitment of leadership and the reallocation of some staff resources in addition to four (4) additional FTE to support performance management transformation, API could become an effective public psychiatric hospital. • As API's performance improves and a positive work culture develops, it is expected that more employment candidates would accept employment offers from API. • The state and DHSS would avoid the disruption and delays (e.g., litigation) that might occur from a decision to privatize API. • While this scenario suggests an increase in funding, this investment will gain efficiencies and improvements to API's operation, which may result in reductions in expenditures, given time, while improving patient treatment outcomes.	• Improving API would require investing more sustained DHSS leadership engagement and oversight. • It may be difficult for existing DHSS leadership to give API the time and attention required to implement this scenario, given other demands. • Given the long-standing concerns about API expressed by many stakeholders, it may be challenging to get support for giving API a 'fresh start' to begin changing public perceptions.	$342,289 4 FTE
3. Creation of a Public Corporation	• With significant commitment of leadership and more resources, API could become a "success story" by applying "private sector" management techniques, including process improvement transformation. • As API's performance improves and a positive work culture develops, it is expected that more prospective employment candidates would accept employment offers from API. • The state and DHSS would avoid the disruption and delays (e.g., litigation) that might occur from a decision to privatize API. • While increased funding is required, efficiencies and improvements to API's operation might result in reductions in expenditures, given time; and will support more effective operations and improved patient outcomes. This cost is less than the management and oversight expenses during FY19 and FY20.	• There are unknown costs associated with the formation and initial operation of a Public Corporation. • Improving API would require spending even more money. • It may be difficult for existing DHSS leadership to give API the time and attention required to implement this scenario, given other demands.	$342,289 4 FTE

Scenario	Pros	Cons	Budget Change
4. a) Partial Privatization *Communication Center*	• A private contractor would have more flexibility in recruitment and hiring practices and might be able to experience more success than API at filling vacant positions. • A private contractor would not be limited by the State of Alaska's state employee salary structure. • Ensuring 24/7 Communication Center staffing coverage will no longer be the responsibility of the State and API staff would not be pulled from other areas of the hospital to cover gaps. • No contract administration costs as management would be absorbed by API Administration staff.	• Quality of services could decline, requiring intervention with contractor. • Increased staff turnover may be more likely to occur jeopardizing the continuity and consistency of operations. • Employees would not be covered by the State's malpractice and workman's compensation programs. • Should the contract with a private entity need to be terminated, transition to another private contractor or returning to State management and operations, could be disruptive to API operations.	($20,137)
4. b) Partial Privatization *Environmental Services*			($57,504)

To provide context to the operational scenarios, in-person and telephonic stakeholder interviews were held to gain a better understanding of API, its role in Alaska's behavioral health system, and the challenges and opportunities the state faces in making decisions about API and its future[1]. Issues around leadership, labor relations, and concerns about the state government's ability to lead API were identified as the main challenges inhibiting progress at API. API suffers from a lack of leadership, both at the State and hospital levels. Frequent turnover among individuals in leadership positions has led to a lack of institutional knowledge, leading to inefficient and ineffective hiring, dismissal, and procurement processes. In addition to consistent leadership, improving relationships between the State, API, and the labor unions will help API overcome some of the issues associated with the hiring and termination of staff, non-competitive salaries, and restrictive scheduling practices. Stakeholders also acknowledged that API is part of Alaska's behavioral health continuum of care but is often the "catchall" for individuals in crisis, straining API's limited resources. The stakeholders recommended that other system partners contribute more resources to ensuring that citizens of Alaska can be better served in their communities. To address this, API needs to reevaluate its referral and admission process and practices. Should API move forward with privatizing API, there is significant stakeholder doubt that the state can effectively manage a private contract to focus on high-quality care and outcomes. Having dedicated staff at DHSS to oversee the contract will help alleviate these concerns.

The WICHE Team evaluated the historical performance of API in comparison to other state hospitals in the west, and privatized state psychiatric hospitals in the U.S. to understand the

[1]The WICHE Team met with representatives from DHSS, the Alaska Mental Health Trust Authority, Denali Family Services, Alaska Native Tribal Health Consortium, API Leadership, Wellpath, NAMI Alaska, API Governing Body, Alaska State Hospital and Nursing Home Association, Anchorage Community Mental Health Services, Mat-Su Health Foundation, University of Alaska Anchorage College of Health, Providence Behavioral Health, Public Defenders Office, the American Federation of State and County Municipal Employees, and the Alaska Public Employees Association.

specific challenges API faces moving forward. We also identified how some of these challenges may be remedied under a new management structure. A review of the data shows trends consistent with a hospital that relies on its beds to provide short-term acute care services, which differs from the role most public state psychiatric hospitals play in the U.S. Most state hospitals receive complex cases that require longer, higher-intensity interventions, whereas private psychiatric hospitals often act in a gatekeeper/triage role for managing acute crises and returning patients to the community. API's high utilization rates, adult admission rates, and short median lengths of stay when compared to national averages support the idea that Alaska uses its state hospital to provide short-term acute care services. These indicators may also reflect a limited availability of community behavioral health services, including crisis stabilization services in Alaska. API's readmission rates have also been significantly above the national average for many years, supporting the notion that additional services in the community are needed. API's rates of seclusion and restraint exceed the national average by significant margins. Various reasons may exist for these high rates. As previously discussed, API provides short-term acute crisis services at a greater rate than other state hospitals in the U.S. and may admit significantly more patients who are actively psychotic and aggressive than their peers. In addition, the workplace culture and workforce challenges confronting API may contribute to a lack of training and skill possessed by API staff to deescalate patients with aggressive behavior. Cost data, comparing API to other hospitals, identified general services as the largest percentage of API's budget and a relatively low percent of the budget covers patient care (inpatient adult and pediatrics and direct care). This distribution is not aligned with other hospitals. Reviewing the staffing of API in relationship to patient care could help API to operate more efficiently.

Six states shared their experiences and lessons learned related to their pursuit of privatization with the WICHE Team to help guide Alaska as it considers privatizing operations at API. Several common themes emerged during these conversations.

- One of the most important strategies Alaska can implement when beginning the reorganization process is to ensure a transparent procurement process, being candid about the problems the state hopes to solve with a new management structure. Creating an advisory board of stakeholders to be involved in all phases of the process, from the RFP to contract oversight, will help Alaska achieve transparency, will set up a process for ensuring the needs of all stakeholders are addressed, and therefore enable any issues that arise after privatization be quickly mitigated.
- Should the state decide to privatize API and a vendor is selected, it is important that the contract be specific and detailed enough to protect the interests of the state. For instance, the state should ensure the vendor does not require employees to sign non-compete clauses, allowing the state to retain API staff should the vendor's contract be terminated.
- The state should retain the authority to approve admissions so that the vendor does not deny services to individuals who are appropriate admissions and likely to benefit from treatment.
- The state must also be prepared to hold the vendor/leadership accountable for the

quality of care provided at API. DHSS must have at least one full-time employee at the state level dedicated to contract oversight and outcomes monitoring. Assigning two or three additional DHSS staff members with clinical backgrounds to assist in contract monitoring will also be instrumental so the state can effectively conduct quality reviews at the facility.

- The state should also take measures to ensure the vendor forms good relationships with other behavioral health providers in Alaska's continuum of care. This will ensure continuity of care for individuals leaving the hospital, and that appropriate services are available to prevent inappropriate or unnecessary hospitalization.

It is notable that items identified above are good practices for the effective operation of a state hospital regardless or the structure, public, private, or authority/corporation. Several states indicated that by engaging in public consideration of potential privatization, that hospital staff and community providers came together with suggestions to improve hospital operations and labor relations, and the state determined it did not need to pursue privatization. Therefore, exploration of potential privatization of API opens the window for Alaska to introduce potential system changes short of full privatization.

Stakeholders voice significant concerns about API's future. The hospital, while out of regulatory peril as of the date of this report, remains at risk until conditions are improved and sustained. Outside of API, insufficient community resources significantly impact the hospital's operations. Individuals wait for admission when many could perhaps be served at a lower, and less expensive level of care. Each of the operational scenarios presented in this report is feasible. What is not feasible is continuing the status quo operations at API, given the costs associated with litigation risks, the human cost of patient and staff safety, as well as the effective treatment of patients.

The cost estimates of potential litigation are difficult to estimate. However, delays created from litigation could result in negative patient outcomes at API unless improvements are made under the current, status quo, operating situation. It is reassuring that API is not currently out of compliance with state licensing, CMS certification or Joint Commission accreditation. However, structural problems exist, including numerous direct care vacancies, delays in hiring, and an inappropriate and sometimes toxic "institutional culture" impacting the quality of treatment, and patient and staff safety. The continued uncertainty and operational flux impede API from operating effectively.

Contracting with a private entity offers an opportunity for DHSS to construct an agreement containing the critical components and expectations for the operation of API. This scenario holds DHSS responsible for contract management and oversight without being responsible for the day-to-day operations.

If the hospital remains under state operation and leadership, the current challenges require focused and comprehensive attention and sustained efforts. The time for incremental change is long past. Scenario #2 State Operations Scenario offers a hopeful and exciting future for API but demands significant dedication of DHSS time and API leadership staff time and commitment, to champion the changes required.

For the Governing Body to take on a true oversight role and monitor the performance of API legislative action is required as the group currently has no authority and is only serving in an advisory capacity. The Governing Body currently exists as a representative board, and not a policy-making and fiduciary board. The Department will also need to ensure that the Governing Body meets the Centers for Medicare and Medicaid Services (CMS) conditions of participation requirements.

A focus on key performance indicators (KPI) should be articulated, measured, and delivered with incentives or penalties for performance attached. KPIs should be manageable and attainable to be effective. Given that API is part of a larger behavioral health system, any KPIs implemented at API should apply to similar psychiatric hospitals/units in Juneau, Fairbanks, and now in Mat-Su, reflecting system-wide goals. As CMS transitions to a pay-for-performance model in the future, API's reimbursement may be in jeopardy if these data are not accurately reported going forward.

Creating a not-for-profit public corporation could perhaps provide an alternative and focused leadership solution – recognizing and embracing the unique needs and requirements of API (and of operating a psychiatric hospital). It could also elevate and create interest and discussion about API's exposure, transparency, accountability, and role in the state's behavioral health system. At the same time, DHSS would be placing API's operation in the hands of "subject matter experts with a distinct role" and could focus on initiatives more in common with DHSS's broader role and mission. However, this option would require the development of a new administrative infrastructure, which requires an investment and could take some time to implement but may help to improve operational efficacy and offer API a 'fresh start' while allowing it to remain a public operation.

Regardless of the operational structure of API, it will be important for the State and API leadership to establish a clear mission for API, and to focus on admitting patients who are consistent with this mission. Respondents noted that while the mission of API is to treat people with serious mental illness, the pragmatic reality is that API risks remaining a "catch-all" for the most complex patient presentations requiring a non-jail/prison facility. Additionally, it is suggested that the State consider the following:

- ✓ Establishing clearly articulated admission criteria and alternative treatment options for people who do not meet admission criteria for API.
    - The State could investigate implementing a policy similar to other State Psychiatric Hospitals, including Arizona, that more clearly articulate admission criteria.
- ✓ Conducting a staffing analysis of the Administration and General, Direct Care and Direct Care Support costs/staffing based on the data provided in Table 8.
- ✓ Assessing the role of API within the behavioral health service continuum in Alaska, to best align its mission to serve the needs of adolescents with serious emotional disorders and adults with serious mental illness.
- ✓ Restoring API to full capacity as soon as possible given the number of individuals on waitlists, while at the same time ensuring the development of a therapeutic and welcoming environment with a focus on trauma focused care, active treatment and recovery.
- ✓ Increasing transparency of API operations, including the reporting of key performance measures to stakeholders with a focus on quality improvement that supports staff engagement and patient outcomes.
- ✓ Reporting administrative and clinical measures to the Executive and Legislative Branches in an annual report.
- ✓ Engaging the judicial system to educate them about appropriate API referrals to most likely to benefit from treatment.
- ✓ Investing in increased programs and services in Alaska for individuals with intellectual/developmental disabilities, traumatic brain injury including those with complex behaviors and dementia.
- ✓ Working closely with CMS to ensure that all billing opportunities are pursued for reimbursement.
- ✓ Developing a focused and enduring effort to improve stakeholder confidence in the State's ability to assure high quality psychiatric facility that provides safe and effective treatment.
- ✓ Establishing a mechanism for a 5-year status review of the operational scenario and resulting outcomes of API within the behavioral health continuum of care in Alaska.

Introduction and Approach

Introduction

In November 2019, the Alaska Department of Health and Social Services (DHSS) contracted with the Western Interstate Commission for Higher Education Behavioral Health Program (WICHE) to conduct a study to review the current Alaska Psychiatric Institute (API) operations to inform the four (4) identified scenarios for the operation of the API, located in Anchorage, Alaska. These scenarios identified by DHSS include:

- **Scenario 1:** Contracting with a for-profit, third party to assume responsibility for hospital management and operations (while the state retains all API capital assets)
- **Scenario 2:** Maintaining the facility under state ownership and operation with an analysis of whether, and how, it is possible for the State to **effectively** operate API if it remains exclusively state-run.
- **Scenario 3:** Forming a public corporation under state supervision to operate the facility.
- **Scenario 4:** Maintaining the facility under state ownership and operations but contracting for specific components of hospital services to improve care and reduce costs.

WICHE collaborated with the National Association of State Mental Health Program Directors' Research Institute (NRI) and Stoel Rives, LLP to complete the study. The primary objective of this study is to examine the identified operational scenarios for API and analyze each scenario based on qualitative and quantitative metrics, in an effort to determine the potential impact on these scenarios on the State of Alaska and API.

API, Alaska's sole state psychiatric hospital, is challenged with operational issues that have reduced the quality of care and threatened the welfare and safety of staff and the individuals it serves. In 2018, API performed lower than other public psychiatric hospitals of similar size in certain Joint Commission and Centers for Medicare and Medicaid (CMS)-required measures. As a result of these challenges, in 2018 the Joint Commission threatened to revoke API's accreditation and API was also placed on provisional licensure state by DHSS. In addition, the CMS indicated they would terminate certification unless immediate corrective action was taken. In order to improve operations and quality of care, Alaska entered into a contract with Wellpath in February 2019 to provide immediate support for the hospital. DHSS attempted to extend the contract with Wellpath for three years; however, political pressure from the legislature and the state's unions resulted in DHSS entering into a month-to-month contract with Wellpath, while DHSS continued to explore options for improved and sustainable operations.

Progress has been made over the past year in improving the quality of patient care, filling vacant positions, retaining its Joint Commission accreditation and CMS certification, and regaining full state hospital licensure. During the past 12 months, API has operated at about 60 percent average monthly census in February 2020 compared with a low of 44 percent in January 2019. API faces extreme workforce challenges, and doubts linger about the hospital's ability to provide adequate

services. The challenges facing API raised the question of whether changes in the hospital's operational governance and structure would lead to improved patient care, staff recruitment, retention, and financial performance, which prompted this feasibility study.

Approach

The WICHE Team developed an approach to complete the study that blends both qualitative and quantitative information to complete the analysis and develop scenarios of potential operation (as defined by the Request for Proposals). While many tasks performed by the Team occurred simultaneously, we completed the following steps as part of the study:

- Collected and analyzed stakeholder input;
- Reviewed API recent/current performance to inform the various operational scenarios;
- Reviewed and examined the most recent API performance data and inpatient psychiatric hospital cost data from Medicare cost reports;
- Reviewed other states' psychiatric hospitalization privatization efforts;
- Completed an analysis of legal obligations to the operational scenarios presented; and
- Developed operational scenarios based on each of the following scenarios.

Scenario 1: Contracting with a for-profit or not-for-profit third party to assume responsibility for hospital management and operations (while the state retains all API capital assets).
Scenario 2: Maintaining the facility under state ownership and operation with an analysis of whether, and how, it is possible for the State to **effectively** operate API if it remains exclusively state-run.
Scenario 3: Forming a public corporation under state supervision to operate the facility.
Scenario 4: Maintaining the facility under state ownership and operations but contracting for specific components of hospital services/operations to improve care and reduce costs.

This report begins with a summary of the issues that emerged out of conversations with stakeholders, illustrating the range of stakeholder involvement in the process and identifying their concerns around costs and quality of service delivery at API. To further understand how API operates compared to its peers in the west, and those around the country (both public and private), this report provides a review of API's performance measures and costs. It then provides an analysis of each operating scenario proposed; which addresses; 1) Cost Savings Estimates (including the costs related to potential litigation), 2) Quality of Care, 3) Access to Care (including the impact on waitlists), 4) Administrative Quality Measures (including the use of modern technology and data management solutions), and 5) Workforce. This study also includes findings from a review of recent literature on privatization efforts in public hospitals across the U.S. and incorporates summaries of recent privatization efforts in other states, highlighting important lessons learned for Alaska from both successful and failed initiatives across the country. Lastly, the report includes a discussion of legal considerations and lawsuit risks, based on the experiences of several other states.

Interviews with Key Alaska Stakeholders

The WICHE Team conducted in-person and telephonic stakeholder interviews to gain a better understanding of API, its role in Alaska's behavioral health system, and the challenges and opportunities the state faces in making decisions about API and its future. We met with representatives from the following groups:

- Alaska Department of Health and Social Services, including:
  - DHSS Leadership [current and former]
  - DHSS Human Resources
  - DHSS Procurement
- The American Federation of State and County Municipal Employees (AFSCME)
- The Alaska Public Employees Association (APEA)
- Alaska Mental Health Trust Authority
- Denali Family Services
- Alaska Native Tribal Health Consortium
- Alaska Psychiatric Institute Leadership
- Wellpath
- National Alliance on Mental Illness (NAMI) Alaska
- API Governing Body
- Alaska State Hospital and Nursing Home Association
- Anchorage Community Mental Health Services
- Mat-Su Health Foundation
- University of Alaska Anchorage College of Health
- Providence Behavioral Health
- Public Defenders Agency
- Other States:
  - Florida
  - Georgia
  - Kentucky
  - Michigan
  - Missouri
  - Colorado

Throughout these interviews, the WICHE Team identified the following themes related to API: the need for focused and consistent leadership, concerns about labor relations, concerns about state government's ability to "fix" API, and API's role in the state's behavioral health system.

Leadership

During each of the key-informant interviews, leadership was identified as a critical challenge. Contributing to this particular challenge are high rates of staff turnover and frequent transitions of key staff across all areas of hospital leadership (e.g., CEO, chief medical officer, chief of psychiatry, staff psychiatrists, psychology leadership, nursing leadership (including the Department of Nursing and Unit Nurse Managers), quality assurance, and social work). In addition to leadership issues at API, leadership challenges in the larger behavioral health system at DHSS and changing priorities in the state legislature and the Governor's office were cited as contributing factors to the challenges facing API. Filling positions with qualified staff and providing training about the state government operational processes and how best to work within the system, will be significant contributors to the success of API.

> ***"API has always been just okay, but for at least a decade it has been in steady decline."***
>
> ***"API has been treated like an island, without consistent support from the division, department, legislature, or Governor. Prior to the recent "crisis," priority of API was low, and dependent upon how interested a Commissioner was in mental health or psychiatric inpatient care."***

Both internal and external informants point to the lack of specialized administrative focus (e.g., human resources, procurement, electronic health record maintenance, and physical plant) to support the operation of a specialty hospital. The centralization of these functions at the state level creates additional steps in accomplishing tasks necessary for hospital operations. However, with proper training and understanding of the processes for new leadership, some of these challenges may be overcome. In particular, the hiring process was identified as a challenge for API, but state human resources (HR) staff identified issues with the processes at API that lead to hiring delays. Hiring into the state system follows a merit-based process where positions must be posted for competitive hiring to ensure equal opportunity employment. Following human resources processes can be made easier for API staff if they understand how to complete each step. The same competitive hiring and merit-based system is followed at other Alaska 24/7 facilities without the same complications seen at API. Interviewees suggest that this may be the result of more consistent leadership who understand how to work effectively and efficiently within the established state hiring procedures. An important note is that during this study, DHSS assigned two (2) HR FTE to work on campus with API. It is hopeful that these staff dedicated to API will help address many of the long-standing HR issues at API.

Working within the established state system also applies to the procurement process. Interviewees described a time when there was a total absence of spoons at API which was resolved by staff purchasing spoons on their own and bringing them to API. Procurement rules allow for the purchase of items like this, contingent upon available funds in the budget. In this instance, a greater understanding of procurement rules may have helped to remedy the

situation. Providing new leadership with training and guidance on working within the system may improve operational functions at API.

Labor Relations

Key informants indicate a need for greater flexibility in hiring, disciplining and dismissing staff. The current Collective Bargaining Agreements are regarded by many respondents as the biggest challenge to staffing API. No specific Labor-Management agreement has been developed for API, or even the public healthcare field in Alaska; rather, staff at API are subject to the same Labor-Management agreement as other state agencies, including the state Department of Transportation and Public Facilities (DOTPF). The current agreement was recently negotiated for a three-year period. Many respondents believe the contract is not flexible or relevant enough to allow for the safe and appropriate staffing of acute, direct-care health and mental health services. However, others attribute the challenges to historical practices, processes, misinformation and resistance to following protocols and collaborating to achieve desired results.

Unions and other respondents describe the Labor-Management relationship at API as being contentious. No single cause for the adversarial relationship was cited; however, actions on both sides likely contributed to the current situation. The collective bargaining agreement (CBA) exists across many departments within the state system. It is unclear if anyone from API was consulted as the current agreement was crafted. Given the unique nature of the work at API, this may be a positive development, however it should first be determined if in fact the issue is the current CBA agreement or the (mis)interpretation and/or operationalize of it. It may be helpful to utilize mediation services to resolve this and move forward to the benefit of all parties.

Hiring and Salaries

Throughout the key-informant interview process, understaffing at API was described as a significant issue; specifically, the current process of posting and filling positions does not support rapid and effective response to staff shortages. The centralized human resources department requires certain information to post and hire for vacant positions. The turnover in leadership at API appears to have minimized their ability to provide human resources the necessary information for job postings. Additionally, despite the staffing crisis at API, no priority is given to recruiting for and ultimately filling those positions. The state has a job classification system that standardizes pay scales across the state (e.g. nurses at the same employment tier earn the same salary regardless of whether they are a public health nurse or a direct care nurse at API). These standard salaries are reportedly less than can be earned at other places, thereby hampering recruitment. The Division of Personnel and Labor Relation's (DOPLR) Classification Section in the Department of Administration provides professional reviews, analyses, recommendations, and final actions on substantive classification and compensation matters. The State of Alaska's policy is to set pay grades based on internal alignment and to be competitive with the 65th percentile of the market. Classification studies are job based-analysis reviews of the work done by positions within a job classification, whether those responsibilities do or do not fit into an existing job classification. The goal of these studies is to update, revise, or establish job classifications, assign

pay grades according to the State's classification pay plans. Studies are initiated by DOPLR based on their requirement to maintain the classification and pay plans, or by division request. The duration of a classification study varies based the number of departments involved and how much the work being reviewed has changed. It is reported that studies can typically be completed in three to 12 months; depending upon the number of job classes and positions included in the study and the number of changes in the work. Exempt positions are not subject to the State Personnel Act or the classification system. As such, the CEO, CFO of API and all physicians, psychiatrists and pharmacists are exempt. The Classification Section can identify market salaries by request (this was done recently for psychiatrist pay where an analysis was done of the pay at the 65th and 90th percentiles).

Classification studies have recently been completed on behalf of API for the following series: psychiatric nursing assistant (implemented August 1, 2019), psychiatric nurse (implemented August 1, 2019), physician assistant/advanced nurse practitioner (implemented December 16, 2019), assistant nursing administrator, and nursing administrator (all nursing administrator changes implemented January 16, 2020). The following series are in que for classification studies: mental health clinicians, occupational therapists, and recreational therapists. These changes were implemented in FY20 and as such the changes in salaries are not reflected in the calculations of the scenarios.

When exceptionally qualified candidates apply for positions and the unit wants to offer higher salaries to these candidates, API needs to provide information to human resources about the candidates' qualifications and how they compare to other applicants in the pool. Additionally, they need to identify the difference in the cost of salary and benefits from the standard salary positions. The Union then needs to approve these hires as they deviate from the policies set forth in the CBA. The Office of Management and Budget also needs to approve the salaries and ensure they fit within the budget. This process can take as little as a week or as long as several months. This variation may be tied to the expertise of the leadership working on hiring, including the timeliness and accuracy of the required documentation. If the unit works to keep the position moving through the process, it can move more quickly, but if leadership does not fully understand the process and requirements, things may move more slowly. The Unions indicated a willingness to work with the state to change the pay scales for non-exempt employees. Alternatively, there is no salary schedule for exempt employees, requiring the Governor's office approval of salaries for exempt positions. Having the two new HR staff on campus at API should help with these processes and communications.

Scheduling

Staffing and scheduling is an ongoing issue at API. The administration reports being unable to flexibly move staff across units based upon client mix and acuity levels. Staff cannot be shifted to weekends or holidays, or to meet increased demands. The CBA has been blamed for this issue as it was reported that staff are guaranteed in the CBA to work a regular schedule, and not engage in activities such as quality improvement efforts outside of their primary job functions. In other

hospitals, differential pay is offered to incentivize staff to fill shifts (e.g., nights and weekends), and direct care staff are encouraged to achieve competency to work with various patient populations/ages. It was reported that three requests have been submitted to the unions to allow differential pay and each has been denied. However, the following language currently exists in the Collective Bargaining Agreement between the Alaska State Employees Association, American Federation of State, County and Municipal Employees Local 52, AFL-CIO and the State of Alaska covering the General Government Bargaining Unit, July 1, 2019 through June 30, 2022:

21.04 Swing and Graveyard Shift Differentials
A. All bargaining unit members who work a "swing" shift which starts between 12 noon and 7:59 p.m. are entitled to a three and three-quarters percent (3.75%) increase over their basic salary as established by this Article for all hours worked in each such shift.

B. All bargaining unit members who work a "graveyard" shift which starts between 8 p.m. and 5:59 a.m. are entitled to a seven and one-half percent (7.5%) increase over their basic salary as established by this Article for all hours so worked in each such shift.

C. All bargaining unit members who are assigned to work a shift originally assigned to another member shall be paid the appropriate shift differential which the other member would have been paid.

D. Except in emergencies or situations in which the bargaining unit member agrees, shift assignment will not be changed without at least twenty (20) working days' notice prior to the effective date of the change. This does not preclude temporary changes in work hours as provided in Article 27.F (Shift Assignment).

Article 27 - Shift Assignment
B. Shift Assignments.

1. Shift assignments shall be made in accordance with the needs of the Employer.
2. Seniority shall be considered in assigning employees to desired shift assignments. For purposes of this Article, seniority means continuous length of service in the job class.
3. Neither permanent assignments nor temporary reassignments shall be used as a means of disciplining bargaining unit members. The parties acknowledge that changes in assignment may be appropriate as part of a corrective or investigatory action.

F. Nothing in this Article precludes temporary reassignment of a bargaining unit member because of illness, vacation, emergency, training, orientation, or similar causes.

There is contradiction in the information shared about shift assignments and shift differential, however there does appear to be a good basis for discussion and clarity on these issues. In particular, gaining clarity on 21.04 D and Article 27 F, specifically what constitutes an 'emergency', especially given the staffing requirements for the intensity of services needed in a

secure environment such as API for a vulnerable population, and how staffing can be maintained during difficult to cover shifts (especially nights and weekends). Making process and practice changes could help with the recruitment of additional staff as well as the retainment of existing staff. Another concern related to the staffing issues, is that API does not staff 24/7 to deliver on its mission. Effectively, staff do not consistently deliver active treatment during evenings and weekends. Improving scheduling could have dramatic effects on the quality of care patients receive and help to create a safer work environment by having sufficient staff providing direct care during each shift.

Some stakeholders discussed the staffing challenges at API as they pertain to shift assignments. Currently there are not defined schedules for the entry level Psychiatric Nurse Is, like there are for the Psychiatric Nurse IIs, who function at full proficiency.

The premise of having two distinct job class levels is that API has: 1) an entry level position that is basically Psychiatric Nurse I trainee (specific only to either recently-graduated or on-call Registered Nurses with less than twelve months of full-time, prior experience providing direct care as a Registered Nurse) and 2) Psychiatric Nurse IIs who perform at full proficiency, with applied experience and responsibility including the ability to independently perform the full range of professional psychiatric and behavioral health-related nursing care, assessment, and related services. Therefore, given their difference in competency and experience, it is not reasonable to only have Psychiatric Nurse Is only duty at any given time. However, it is important that their competency be regularly evaluated, and they be reclassified as soon as they achieve the Psychiatric Nurse II competencies. Additionally, for shift assignment purposes, seniority as a psychiatric nurse should be considered as continuous length of service in the job class of a psychiatric nurse and not the specific level within this classification, as stated in the GGU Article 27 B Shift assignments.

Disciplinary Processes

API leadership find it difficult to discipline staff and cite the CBA as a significant factor. It was reported that patient care abuses are held as equal to being late for work. This has led to the perception that API is limited regarding the actions it can take when disciplining staff and that they are less able to respond to situations as they arise. Human resources staff indicate that API staff can be immediately put on administrative leave following an allegation of patient abuse or staff can be moved to a non-patient contact position, during the period of investigation. HR staff report that putting someone on administrative leave can be done immediately and they report responding to calls or emails on nights and weekends when a significant event occurs.

The disconnect between human resource policy and perception likely stems, at least in part, from management's difficulty in substantiating claims of misconduct. An investigation must be completed for someone to be removed from employment. In one recent example of staff harming a patient, it was reported, by some stakeholders that it took weeks for someone at API to provide evidence to substantiate the claim of abuse. Staff at API need to do the investigation

and provide detailed outcomes to human resources before someone can be dismissed. The staffing shortage and turnover at API contribute to this problem, as there may not be anyone trained and available to conduct the investigation. The investigation needs to include evidence and a list of violations. This report needs to include a clear description of what happened, which policies were violated, what should have happened and statements from witnesses.

The turnover in leadership also contributes to issues with discipline, as staff may not know that they need to provide information to human resources. Training may be necessary to help leadership and other supervisory staff tasked with this work to ensure compliance with all policies and to help expedite the process. Stakeholders reported that patient abuse is taken seriously by human resources and the Unions and is a dismissible offense; however, the Unions want the employees to have a chance to be heard before dismissal. The process of dismissing staff is compounded by inconsistent supervision and inconsistent documentation in performance reviews. Without proper documentation throughout the performance cycle and proper training of management on the importance of performance reviews, dismissing an employee is more difficult. Lower level misconduct (e.g. yelling at a patient) must be documented over time in order to meet the dismissal criteria of just cause. If the behavior has been allowed to happen over time and has not been addressed, the case will not meet the test of dismissal for just cause. Without evidence staff cannot be dismissed, as it cannot and should not be done based solely on allegations. Again, as previously noted, having HR staff assigned to API should help to resolve these issues.

Lack of Confidence in State Government and Accountability

With very few exceptions, key informants reported a low level of confidence in the State of Alaska to effectively manage API, citing longstanding recruitment and retention issues and difficulty disciplining staff, coupled with quality of care concerns. Equally important, there was a corresponding lack of confidence in the state's ability to effectively procure and manage a contract with a third-party to operate API in a privatized scenario. This lack of confidence does not apply to any specific administration, but cuts across multiple administrations. Concerns include contract monitoring if API is privatized, specifically whether the right person could be identified and hired to monitor the contract, supervision of this position, as well as what will happen if privatization occurs, but performance does not improve or gets worse. There is consensus across stakeholders around needing a strong contract manager to oversee performance should privatization occur.

The hospital needs to be focused on quality care and outcomes. Stakeholders noted the necessity of third-party oversight of any operational scenario. This could be the role of the newly reformed Governing Body. It was noted that no single person can represent the perspectives of everyone, but that a larger group should have some authority on API operations. The re-formation of the Governing Body has increased transparency and accountability, which is largely regarded as progress by the stakeholders interviewed for this study. Respondents reported that the state is trying to be conscientious and mindful about who has voting membership on the Governing Body

to prevent a state-centric or hospital-centric focus. This broader perspective has not existed historically, however is regarded as a necessary and positive step forward.

For the Governing Body to take on a true oversight role and monitor the performance of API legislative action is required as the group currently has limited authority and is only serving in an advisory capacity. The Governing Body currently exists as a representative board, and not a policy-making and fiduciary board. The Department will also need to ensure that the Governing Body meets the Centers for Medicare and Medicaid Services (CMS) conditions of participation requirements.

Making this change may be a positive step forward in broadening the community's role in helping API to run more effectively and efficiently. For the Governing Body to function in a true oversight role, training may need to be conducted by someone with a comprehensive understanding of proper psychiatric hospital board operations. An explanation of the roles and responsibilities of board members, conflicts of interest, and competing priorities needs to be provided as well as an explanation of the oath of a board member. The newly formed board, while still developing, in its current iteration, lacks defined goals and has little oversight. It may be challenging to recruit a strong CEO to enter such an undefined relationship. There is concern that if API were privatized that this accountability and transparency may be reduced.

In addition to oversight by a third party, respondents suggested a focus on key performance indicators (KPI) that should be articulated, measured, and delivered with incentives or penalties for performance attached. KPIs should be manageable and attainable to be effective. Given that API is part of a larger behavioral health system, any KPIs implemented at API should apply to similar psychiatric hospitals/units in Juneau, Fairbanks, and now in Mat-Su, reflecting system-wide goals.

API is Part of the Behavioral Health System

API should function as a key component of the larger behavioral health system in Alaska. As the hospital continues to struggle with limited resources, it will be important for other hospitals and system partners to do more to help people in their communities to stay out of API when feasible and to better engage/transition those who are admitted upon discharge. It may be necessary for API leadership to consider changing the API patient referral process. This should include increasing the availability of designated evaluation and treatment (DET) beds along with legal changes to help people get the best care possible in their communities and to help reduce readmissions. Some respondents believe that a breakdown in the larger Alaska behavioral health system is contributing to the current problems at API, including the readmission rate. Respondents overwhelmingly reported the need for a more robust continuum of care where crisis services are available in the community, such as through the recent efforts to begin planning for identified components of the Crisis Now model from the Alaska Crisis Now consultation report, conducted by RI International (RI) in 2019, in the communities of Anchorage, Mat-Su and Fairbanks. This would allow API to focus on more moderate-to-long-term care; without that, API

appears to fall into the crisis stabilization role by default. Discharges are delayed due to the lack of community-based intermediate options such as intensive case management, residential treatment or partial hospitalization. API sometimes discharges patients to homeless shelters and the length of stay is longer in the winter than summer because there are few safe discharge options; this too is a function of the limited community behavioral health system. There appears to be a lack of API leadership participation in community system engagement. Re-engaging in those conversations may be a positive first step toward helping support the larger system. Additionally, efforts to not bifurcate API and community behavioral health services should be considered to support the full continuum of care.

Alaska has been approved for a Medicaid 1115 Waiver from CMS to enhance the state's community -based continuum of care. This may impact admissions to API if a robust continuum of community-based services become available over time. A significant limiting factor to expansion of the broader behavioral health system is recruitment of a qualified workforce. The State is working to expand the billing capacity of providers with different credentials (e.g., Licensed Marriage and Family Therapists are now allowable providers and there is proposed legislation to include Licensed Professional Counselors as allowable providers). These efforts will help to expand the capacity of professionals with a variety of backgrounds to help reduce the workforce barriers. Another important component to expanding the broader behavioral health system is setting appropriate reimbursement rates for community mental health services. If the new rates are set too low, mental health centers may not be able to afford to provide services, leaving API as the only option. Conversely, if the rate is set "correctly" this could help to facilitate more appropriate discharges from API.

Mission / Appropriate Patients

Respondents cited the admission of patients to API who are unlikely to benefit from psychiatric care as another factor contributing to some of the current problems. In particular, the admission of patients with complex behavioral management issues related to intellectual disability or developmental disabilities, traumatic brain injury, and dementia change the milieu on the units, increasing risk for harm to patients and staff. It was reported that these admissions are due to the lack of appropriate treatment options in the community. It will be important for the State and API leadership to establish a clear mission for API, and to focus on admitting patients who are consistent with this mission. Respondents noted that while the mission of API is to treat people with serious mental illness, the pragmatic current reality is that API will remain a "catch-all" for the most complex patient presentations requiring a non-jail/prison facility. The state should consider establishing a clearly articulated admission criteria and alternative treatment options for people who do not meet admission criteria for API. Respondents agreed that API should be focused on treating adults with acute, serious and persistent mental illness requiring inpatient psychiatric hospitalization, Title 12 (forensic) and Title 47 (involuntary commitment/civil commitment) patients, and adolescents with serious emotional disturbances in need of inpatient hospitalization. Respondents noted that some civil-admission patients are waiting in jail holding cells or are being sent out-of-state for treatment until an API bed becomes

available. Admitting patients who could most benefit from inpatient psychiatric treatment may reduce the waitlist.

Respondents noted that larger hospitals in Alaska should have some limited capacity to manage psychiatric patients in the emergency department or the medical floor, but that hospitals tend to transfer their psychiatric patients to API. Alaska should continue to explore increasing DET and crisis stabilization bed resources throughout the state. While every hospital needs to know their limitations, it was noted that many psychiatric patients could be stabilized in their local community hospital, reducing the transports and admissions to API for brief stays.

Respondents noted that API should be prioritized for patients who have not been successfully treated in their community. Local hospitals should work with patients before transferring them to API, this may not be happening across the state. There may be ways to incentivize local hospitals to work more with this population. Regardless of the strategy, a larger community behavioral health infrastructure is necessary to take the pressure off API. This cannot happen if there is nowhere else for people to go for stabilization and treatment.

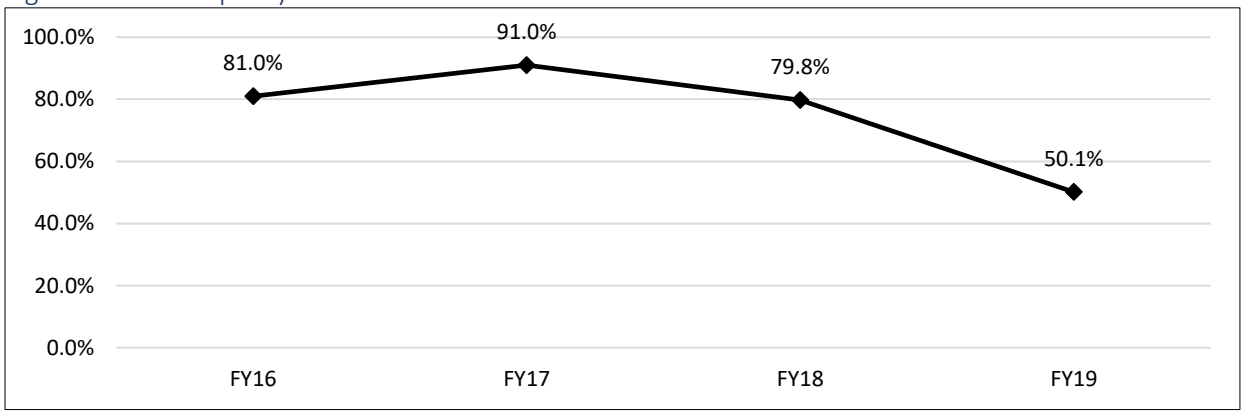
API Performance Measures in Comparison to Other Western State Hospitals

A review of API's performance on several national measures may be helpful in understanding the status quo of API and analyzing various operating scenarios. A review of these measures identifies the "chronic" challenges that have faced API and that will be present, at least initially, whether the state continues to operate API, or all or part of the hospital is placed under an alternative management structure. To evaluate historical performance, the WICHE Team analyzed census, utilization, admissions, average length of stay (ALOS), discharges, readmissions, staffing, and other data for the last several complete state fiscal years. Data used in this section of the report were obtained from several sources, including: the federal Substance Abuse and Mental Health Services Administration (SAMHSA); Center for Medicare and Medicaid Services (CMS) Medicare care cost report data and the Western Psychiatric State Hospital Association (WPSHA).

Occupancy / Census

Figure 1 shows the annual occupancy rate at API from FY16 through FY19. As the chart indicates, the occupancy rate grew to a high of 91 percent in FY17, and then began declining to 50 percent in FY19. The lower occupancy rates in FY18 and FY19 reflect increasing number of vacant direct care positions and as a result, a reduction in the number of operating beds. FY20 data were not available at the time of this analysis.

Figure 1: API Occupancy Rate from FY16 to FY19[2]



Source: Western Psychiatric State Hospital Association, Benchmarking data

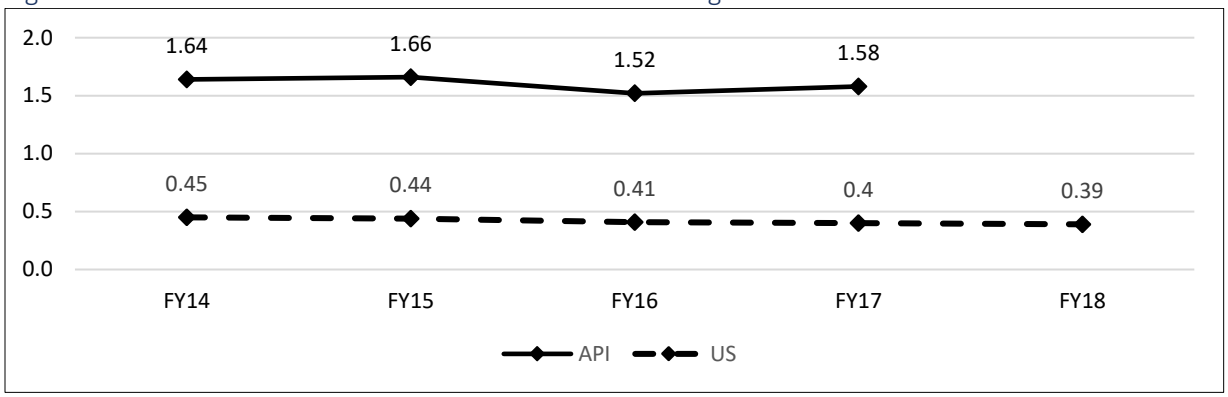
Utilization

A state's utilization of state hospital beds reflects how the state uses its state hospital. Some states utilize state hospitals to stabilize individuals with acute psychiatric disorder and then discharge them to a lower level of care as soon as appropriate. Other states use state hospitals for patients with longer-term needs, such as psychosocial rehabilitation. Most states must also serve patients involved in the criminal justice system who may be found not guilty and committed to longer-term treatment. API's FY17 statewide utilization rate as shown in Figure 2 was almost

[2] Assumes an 80-bed capacity for each of these fiscal years, although DHSS temporarily reduced the operating capacity in FY 18 and FY19 (60 and 38 beds, respectively) due to staffing shortages.

400% greater per 1,000 individuals than the national average. API's utilization per 1,000 people was 1.58, while the U.S average for state hospital utilization per 1,000 people was 0.40. A higher utilization rate may indicate that API has proportionately more short-term stays on average and thus each bed can serve more patients during the year than a state with lower utilization rate. Figure 2 shows the annual utilization rate compared to the national average for API from FY14 through FY17. National data are currently only available through FY18, Alaska did not report data on this measure for FY18.

Figure 2: API and National Utilization Rates from FY14 through FY18[3]



Source: http://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system

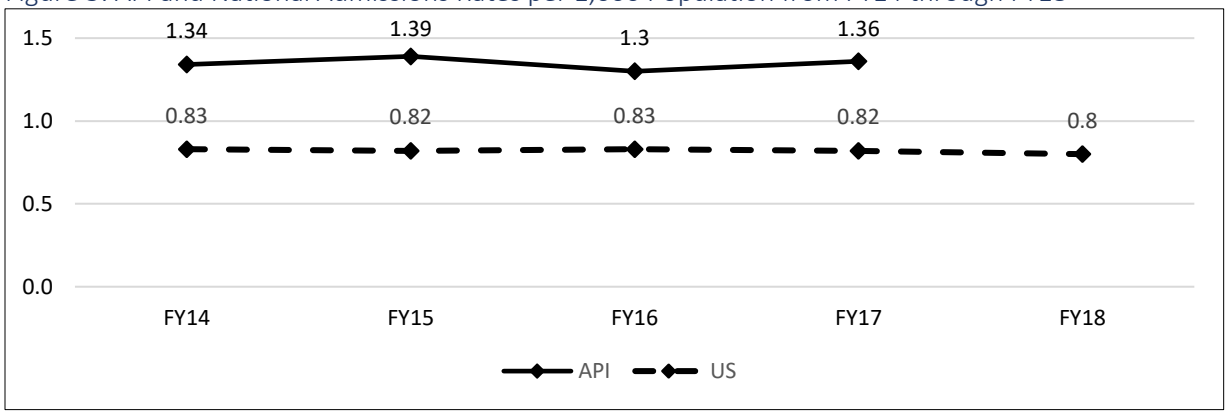
Adult Admission Rate

Similar to utilization rates, state hospital admission rates reflect dependence on the hospital for serving individuals with behavioral health needs. Over the past several years, Alaska's adult admission rates for API have been significantly higher than the national average[4]. As Figure 3 indicates, the Alaska rate of 1.36 is 66% higher than the national average of 0.82. Similar to the utilization rate, the high Alaska adult admission rate may indicate limited community behavioral health services, including crisis stabilization services, in Anchorage and elsewhere in Alaska (See Figure 3). National data are currently only available through FY18, Alaska did not report data on this measure for FY18.

[3] API did not report these data to SAMHSA for FY18. FY18 are the most recent year of available SAMHSA data.

[4] The admission rate represents the number of adult admissions during the fiscal year divided by the total number of individuals served during the fiscal year.

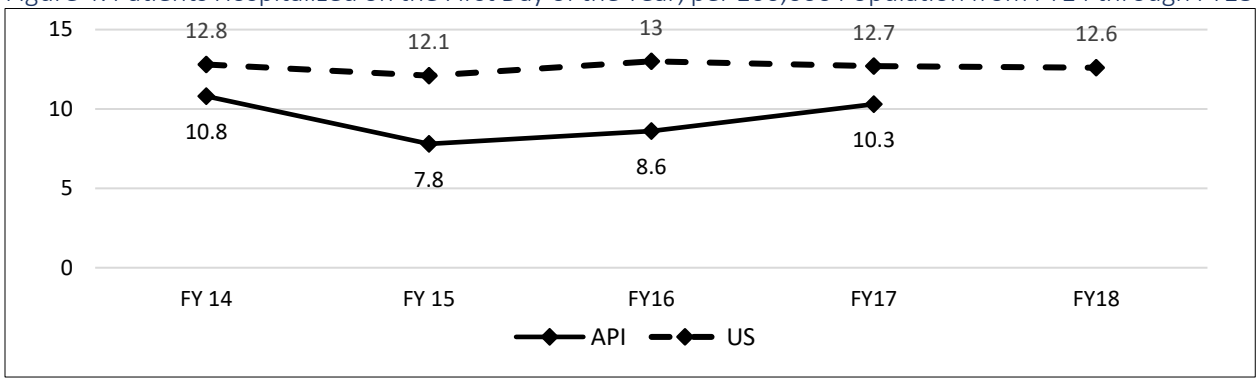
Figure 3: API and National Admissions Rates per 1,000 Population from FY14 through FY18



Source: http://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system

Looking at the number of patients in state hospitals on a single day (first day of the FY), Alaska had 10.3 per 100,000 population, ranking API in the middle at 28th in the nation (see Figure 4). API's higher adult admission rate, when compared to the rest of the U.S., also likely reflects the policies regarding how Alaska uses its state hospital. API has acute short-term units that allow each bed to serve more clients (more admissions) during the year. National data are currently only available through FY18, Alaska did not report data on this measure for FY18.

Figure 4: Patients Hospitalized on the First Day of the Year, per 100,000 Population from FY14 through FY18



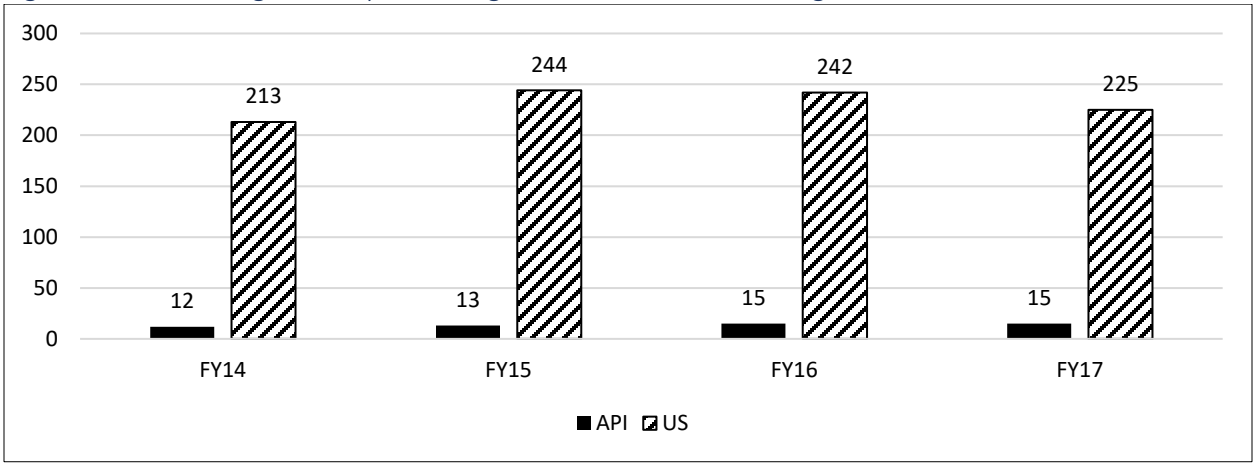
Source: http://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system

Length of Stay for Discharged Patients

API's median length of stay for both adults and adolescents remained relatively constant from FY14 to FY18 (see Figures 5 and 6; while API did not report these data to SAMHSA in FY 2018, an examination of all discharges submitted to the NRI-BHPMS in CY18 found a median length of stay of 13 days.) National data are currently only available through FY18, Alaska did not report data on this measure for FY18, therefore data are only presented through FY17, the last year with comparison data for API and the nation. The median length of stay represents the most frequent length of stay occurring during the period. The median length of stay is presented in place of the more typical average length of stay (ALOS) statistic. The ALOS measurement fails to distinguish the "typical" length of stay for most patients from the significantly longer stays seen within small

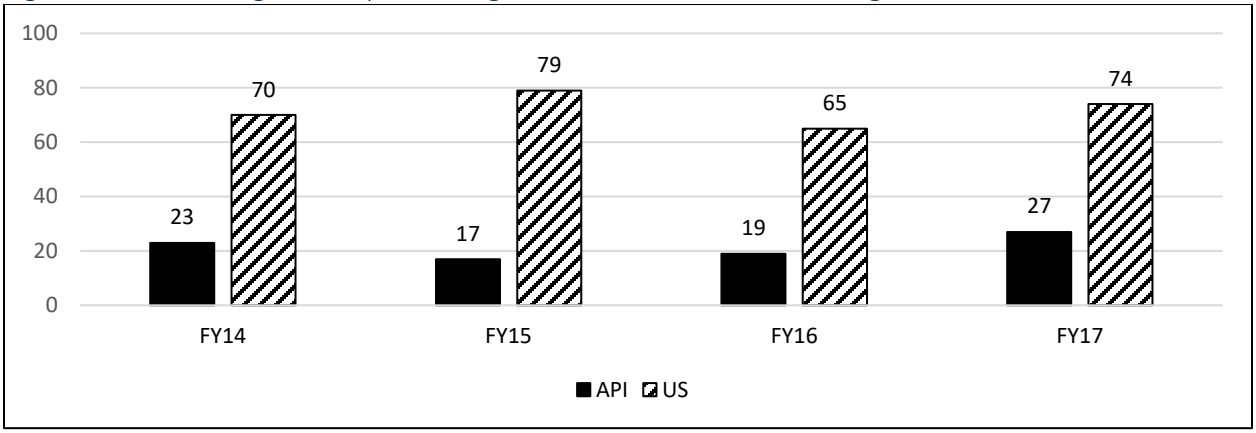
subsets of a state hospital's patient population. Median lengths of stay can often be better indicators of typical experience, while diverging significantly from a hospital's average length of stay.

Figure 5: Median Length of Stay - Discharged Adults from FY14 through FY17



Source: http://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system

Figure 6: Median Length of Stay - Discharged Adolescent from FY14 through FY18



Source: http://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system

The significant difference between API and the national rate reflects the role that API plays in seeking to stabilize, and then discharge, patients. Other state hospitals often have both acute and long-term programs for adults, and in some states, adolescents. As a result, higher median lengths of stay will be seen in these states. In most states, private hospitals act in a gatekeeper/triage role for managing acute crises to allow the state hospital system, if it sees acute patients at all, to receive the more complex cases requiring longer, higher-intensity intervention.

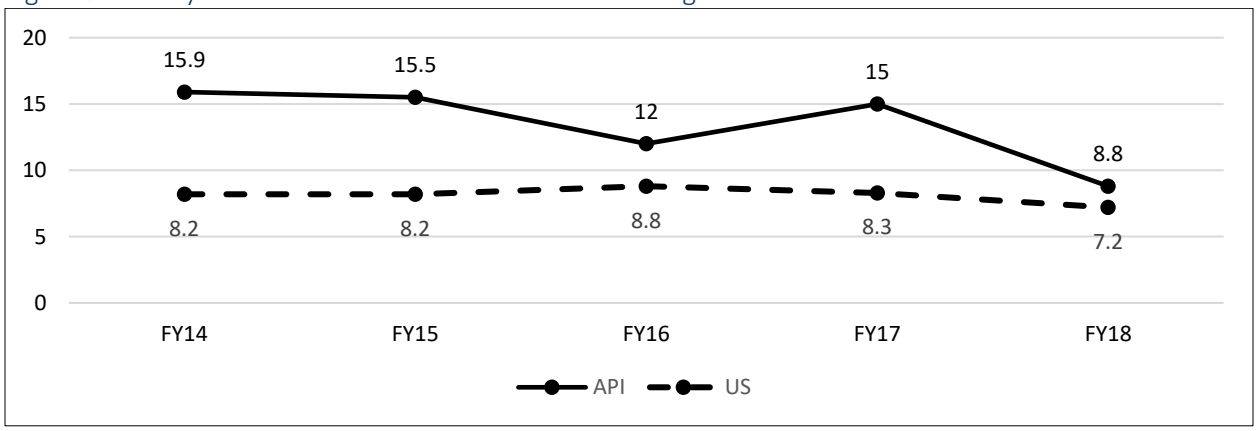
Interestingly, when compared to all types of hospitals that provide inpatient psychiatric services, the ALOS at API is consistent with national averages. For example, federal Agency for Healthcare

Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP) data reveal that the ALOS for mental and/or substance use disorders was 6.4 days. The ALOS for any principal SUD related diagnosis was 4.7 days and any principal mental disorder related diagnosis was 7.2 days. The ALOS for schizophrenia and related disorders was 10.5 days[5].

Readmissions

A hospital's readmission rate is measured as the number of patients readmitted within a set period of days. Readmission rates are viewed as one of the most important measures for evaluating the effectiveness of treatment. They can be symptomatic of both inadequate inpatient treatment and inadequate community treatment, or inadequate community resources, or both. API's readmission rates had been significantly above the national average for many years; however, in FY18 the 30-day rate (8.8 readmissions) declined to slightly above the national average (7.2) this may, in part be relation to the decreased bed availability at API. Similarly, in FY19, the 180-day rate (19.4) declined from 31.2 in FY17 to slightly above the national average (17.1). HCUP readmission rates for 2016 indicate that readmissions for mental/behavioral disorders ranked sixth at a rate of 16.8 among all 30-day readmissions by principal diagnosis[6]. This compares to API's rate of 27.5 in FY16. See Figures 7 and 8 data are currently available through FY18.

Figure 7: 30-Day Adult Readmission Rate from FY14 through FY18

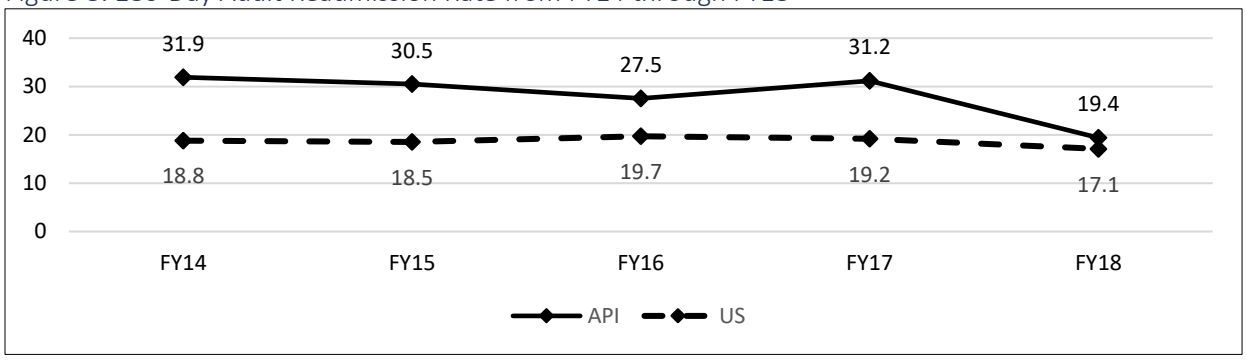


Source: http://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system

[5] AHRQ, HCUP Statistical Brief #249 (March 2019). https://www.hcup-us.ahrq.gov/reports/statbriefs/sb249-Mental-Substance-Use-Disorder-Hospital-Stays-2016.pdf

[6] AHRQ, HCUP Statistical Brief #248 (February 2019). https://www.hcup-us.ahrq.gov/reports/statbriefs/sb249-Mental-Substance-Use-Disorder-Hospital-Stays-2016.pdf

Figure 8: 180-Day Adult Readmission Rate from FY14 through FY18



Source: http://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system

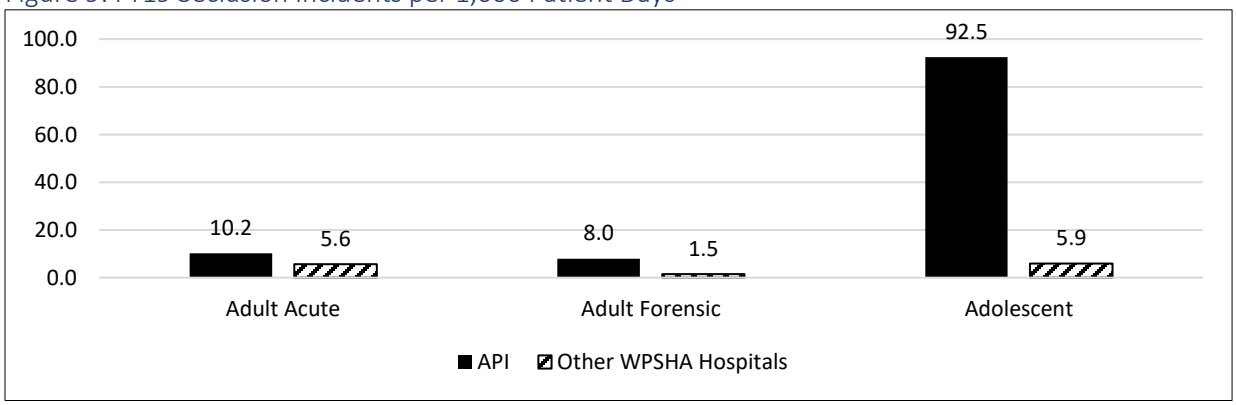
Seclusion and Restraint

Seclusion and restraint are considered negative outcomes and treatment failure in an inpatient psychiatric hospital, irrespective of the reasons for use of these two measures. The use may be founded in some cases; however, well-managed hospitals continually work to reduce these rates. Both events are typically measured in the number of incidents per 1,000 patient days and the number of hours per 1,000 patient days. This allows for comparison irrespective of changes at one hospital over time (e.g. census) and differences between hospitals (e.g., number of beds).

Seclusion

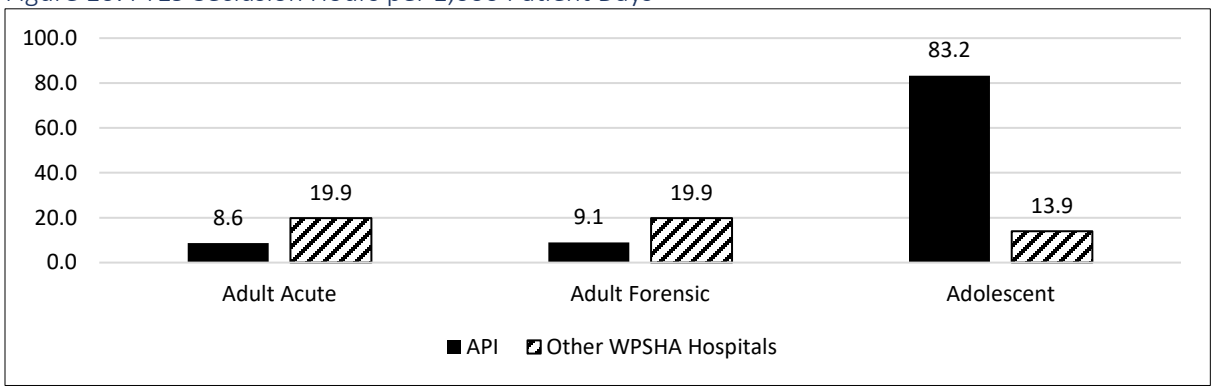
The number of seclusion incidents exceeds the average for the other WPSHA hospitals by significant margins (Figure 9); however, API patients spend less time in seclusion, with the exception of adolescent patients (Figure 10) (FY19 data are the most current available). Several reasons may exist for the significantly higher API incident rate. API admits patients in acute crisis and the proportion of patients who were actively psychotic and aggressive could be significantly greater than other WPSHA hospitals. The amount of training and skill possessed by API staff to deescalate patients with aggressive behavior could be lacking. API staff may turn to the use of seclusion more quickly than other hospitals, rather than more fully making use of de-escalation skills and techniques.

Figure 9: FY19 Seclusion Incidents per 1,000 Patient Days



Source: Western Psychiatric State Hospital Association, Benchmarking data

Figure 10: FY19 Seclusion Hours per 1,000 Patient Days

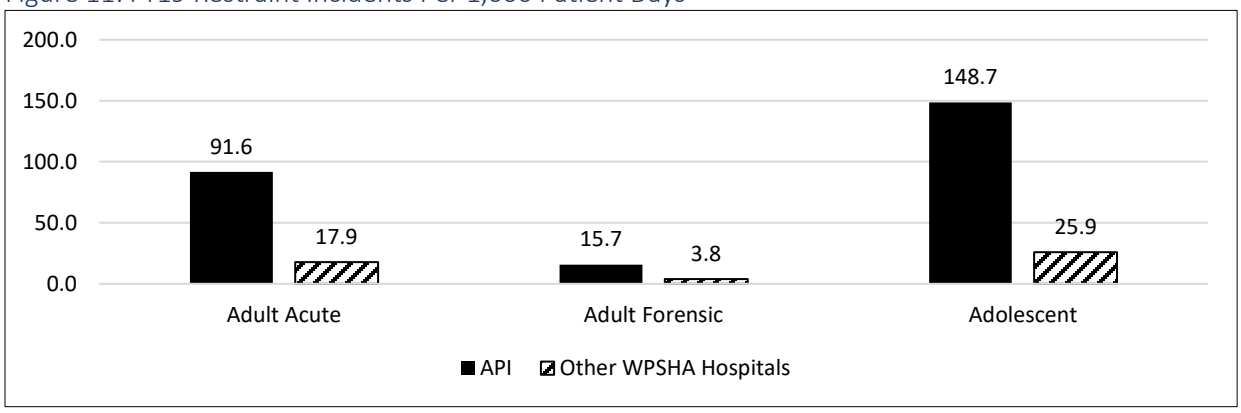


Source: Western Psychiatric State Hospital Association, Benchmarking data

Restraint

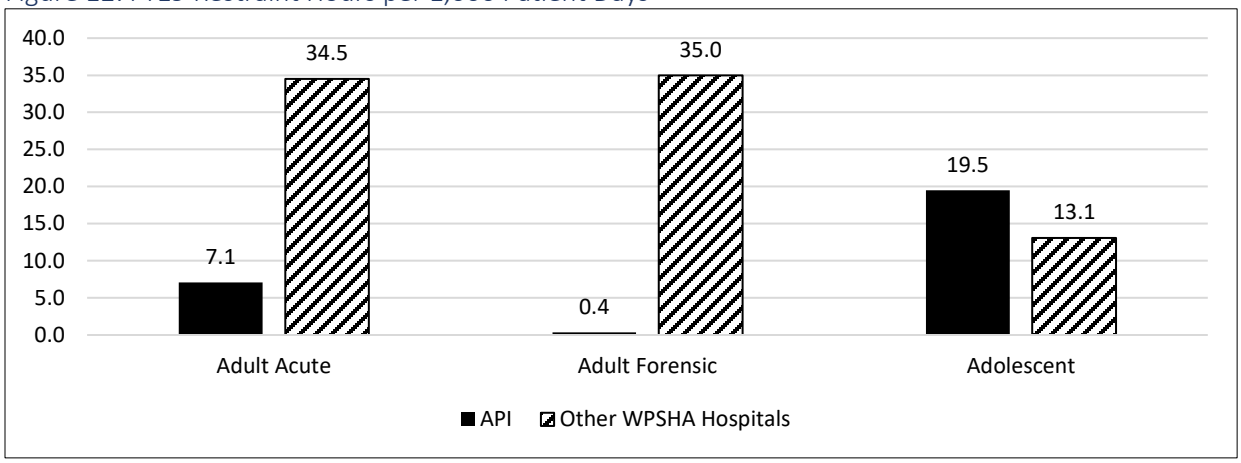
The number of incidents (Figure 11) of restraint at API exceed the average for the other WPSHA hospitals by significant margins (FY19 data are the most current available). The number of hours (Figure 12) exceed the average for other WPSHA hospitals only for adolescents by a large margin. The same reasons that API seclusion rates are higher than other WPSHA hospitals also apply to restraint rates.

Figure 11: FY19 Restraint Incidents Per 1,000 Patient Days



Source: Western Psychiatric State Hospital Association, Benchmarking data

Figure 12: FY19 Restraint Hours per 1,000 Patient Days

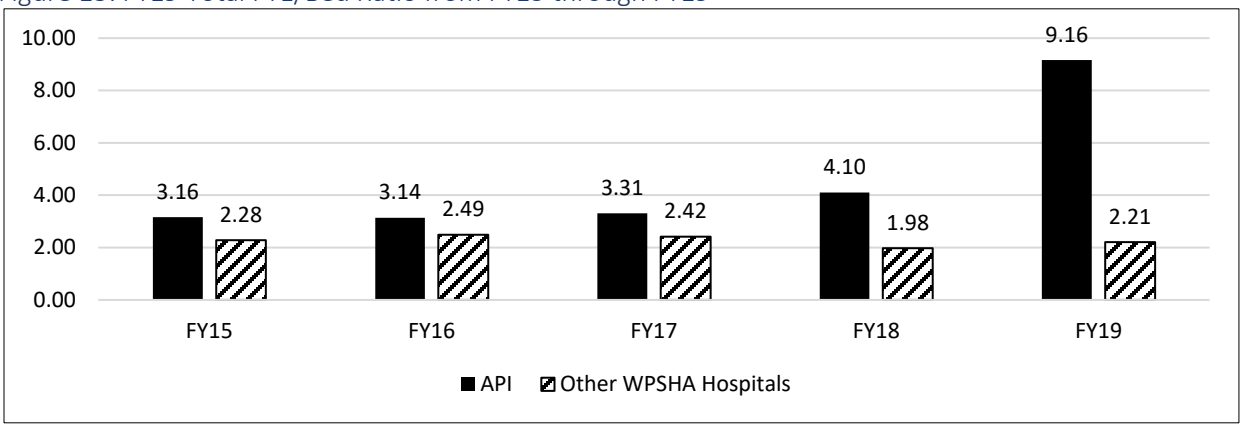


Source: Western Psychiatric State Hospital Association, Benchmarking data

Staffing

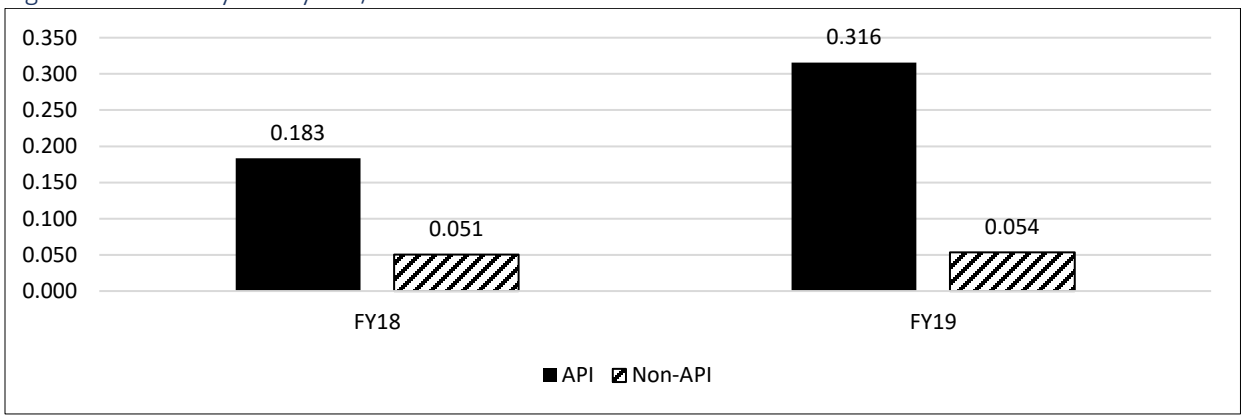
API has a greater number of budgeted staff than the average of other WPSHA hospitals. Figure 13 illustrates the number of API Full Time Equivalent (FTE) employees per bed in comparison to other WPSHA hospitals for FY15 through FY19 (FY19 data are the most current available for comparison). As the figure indicates, in FY19 API had 9.16 FTE per bed, compared to a WPSHA average of 2.21 FTE per bed. API reported a bed capacity of 60 beds to WPSHA for FY18 and 38 beds in FY19; however, the hospital is funded and staffed for 80 beds, despite significant numbers of vacancies that limit operating at 80 beds. The following figures (Figures 14 – 17) detail API ratios in comparison to WPSHA for various groups, including psychiatrists, registered nursing, and direct care staff. FY18 data are based on the reported 60 beds and FY19 data are based on the reported 38 beds. While FY20 data are not available from other WPSHA hospitals for comparison, data for the first half of FY20 show a total FTE/bed ratio of 6.7 on July 1, 2019, and 5.3 on October 1, 2019. This indicates a trend toward the staff ratio lowering to closer to levels seen in FY18 (data provided by API). Additional staffing data are discussed in the "API Costs" section below.

Figure 13: FY19 Total FTE/Bed Ratio from FY15 through FY19**



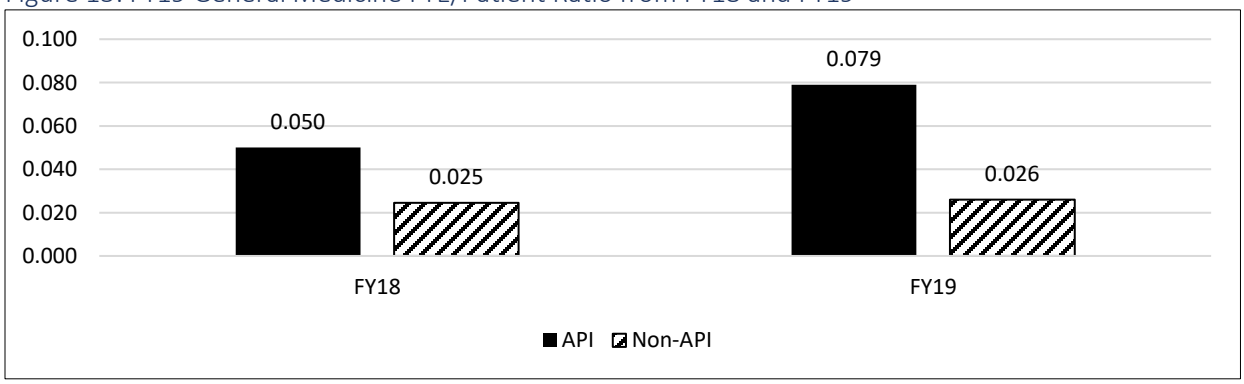
Source: Western Psychiatric State Hospital Association, Benchmarking data
***FY15-FY17 based on 80 beds; FY18 based on 60 beds; FY19 based on 38 beds*

Figure 14: FY19 Psychiatry FTE/Patient Ratio from FY18 and FY19



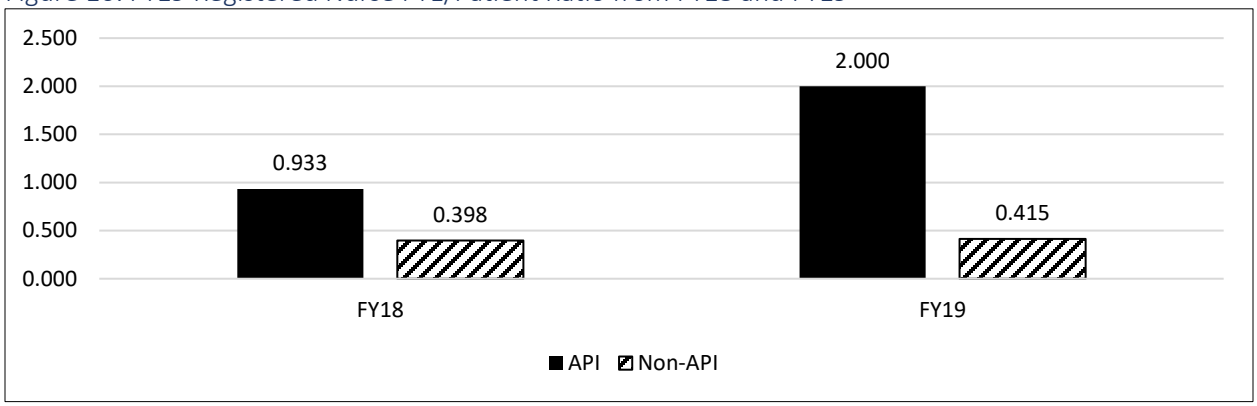
Source: Western Psychiatric State Hospital Association, Benchmarking data

Figure 15: FY19 General Medicine FTE/Patient Ratio from FY18 and FY19



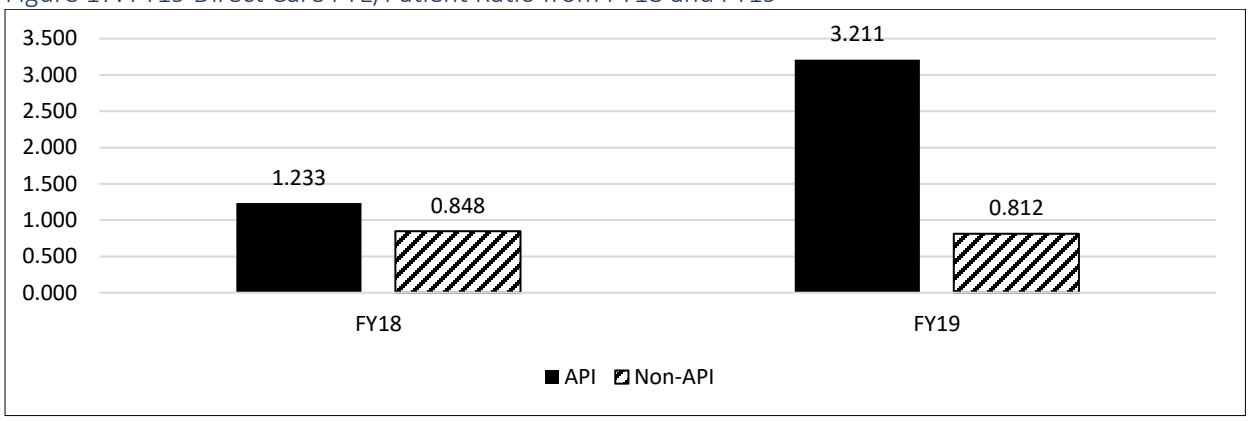
Source: Western Psychiatric State Hospital Association, Benchmarking data

Figure 16: FY19 Registered Nurse FTE/Patient Ratio from FY18 and FY19



Source: Western Psychiatric State Hospital Association, Benchmarking data

Figure 17: FY19 Direct Care FTE/Patient Ratio from FY18 and FY19



Source: Western Psychiatric State Hospital Association, Benchmarking data

API Performance Measures in Comparison to U.S. Psychiatric Hospitals

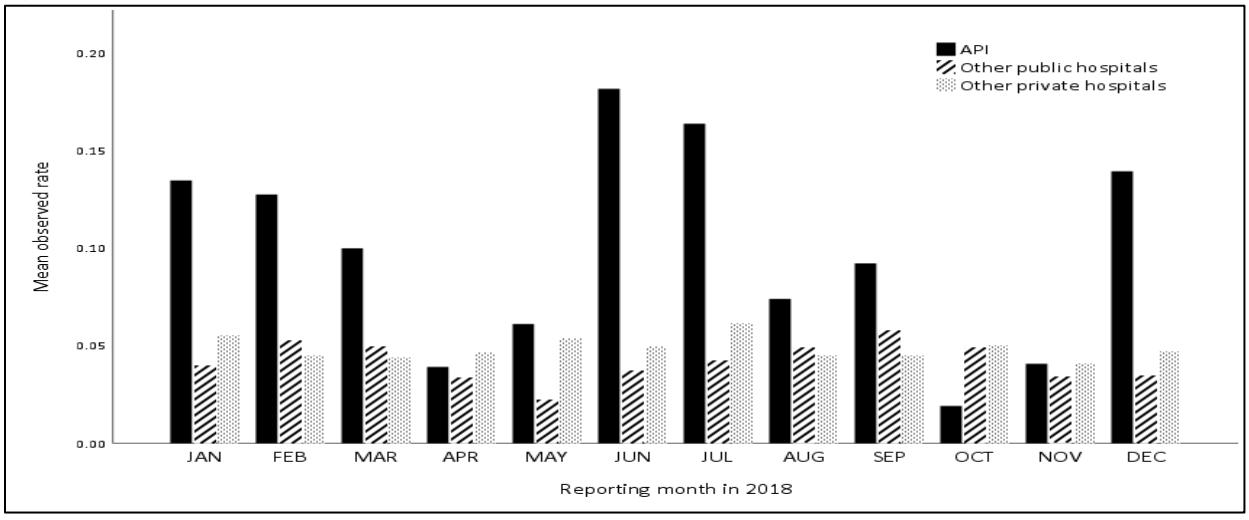
This section of the report provides comparative performance measure data between API and other public and private inpatient psychiatric hospitals. The data were extracted from the NRI Behavioral Healthcare Performance Measurement System (NRI-BHPMS), a comprehensive, proprietary, national database of patient-level data submitted by U.S. inpatient psychiatric hospitals to participate in common quality of care measures and to meet requirements from accrediting and regulatory agencies such as the Joint Commission and CMS. Data from the NRI-BHPMS represent a cross-sectional view for calendar year (CY) 2018 and include 12 public and 17 private psychiatric inpatient hospitals.

While no inclusion criteria were applied to private hospitals, public hospitals included for analysis were similar to API in total bed capacity. ***Note: data presented in this section may not match similar data in the previous section due to significantly different criteria for inclusion (Western State Hospitals vs Public and Private hospitals across the country with similar bed size to API) and time-period for presentation (CY vs FY).*** Calendar year 2018 represents the most current data available.

30-Day Readmission Rate

The 30-day readmission rate (Figure 18) represents the proportion of the total number of discharges in 2018 that were subsequently readmitted to the same facility within 30 days of discharge (CY18 represents the most current data). In CY 2018, API had higher 30-day readmission rates than the other public or private hospitals. In June 2018, API had the highest readmission rate of 18%. While at the end of 2018, this rate dropped to 14% it was still almost five-time greater than the 30-day readmission rate for the other public hospitals (3%) and almost three-times greater than the rate for private hospitals.

Figure 18: 30-Day Readmission Rate for CY18

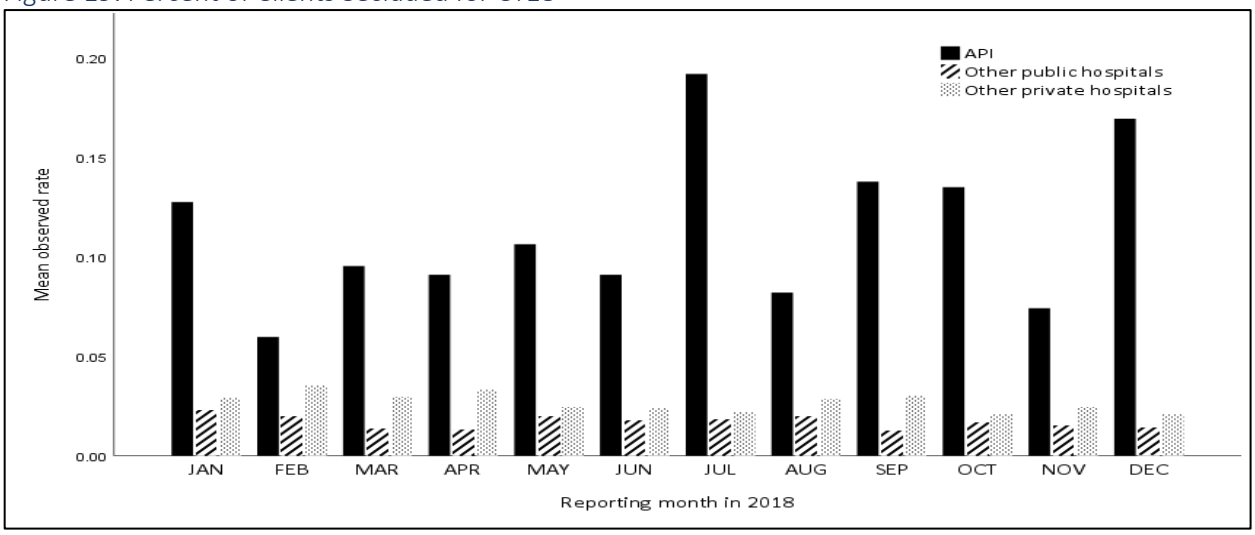


Source: NRI's BHPMS Data

Seclusion and Restraint

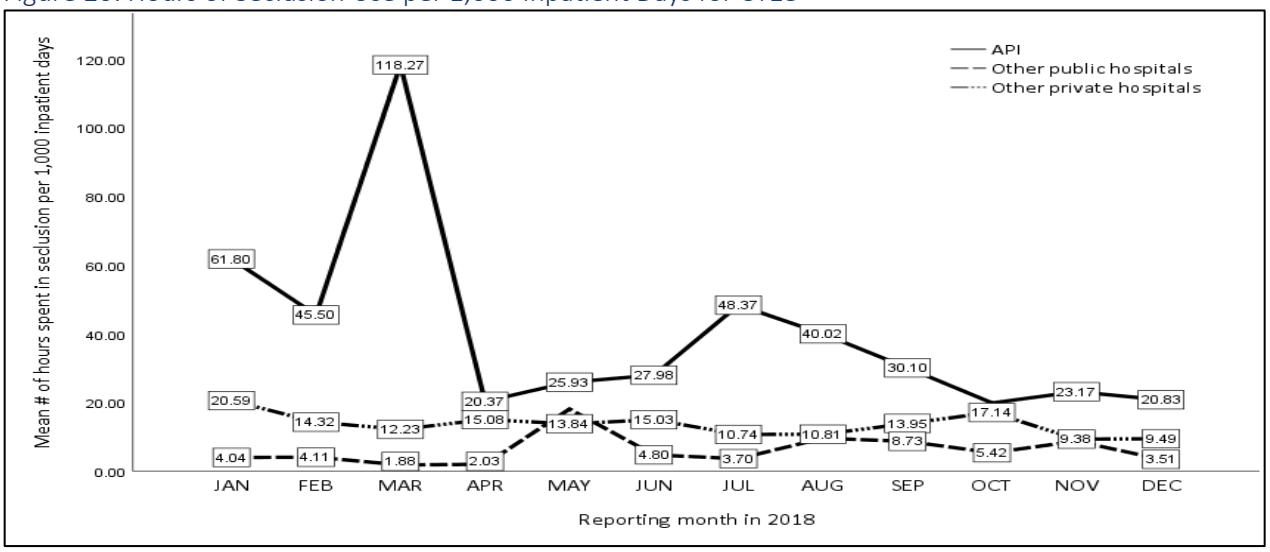
Figures 19 through 22 present the information related to seclusion and restraint. The information is presented as the percent of individuals who were secluded or restrained in CY18 and as the total number of hours that all patients admitted to the hospital were maintained in seclusion or physical restraint per 1,000 inpatient days (CY18 represents the most current data). API started and ended 2018 with greater percent of people secluded or restrained and greater number of hours people were secluded or restrained than other public or other private psychiatric hospitals. At the end of 2018, the seclusion time at API was nearly six-times longer than the seclusion time at the other public hospitals and more than double the hours in private hospitals (Figures 19 and 20). At the end of 2018, the restraint time per 1,000 patient days was nearly twice as high at API than other public or private hospitals (Figures 21 and 22). While restraint and seclusion measures may be used to prevent harm to self or to others, it is highly recommended that these restrictive modalities be minimized and closely monitored. Over-utilization of highly restrictive interventions may describe a facility that lacks appropriate and less restrictive methods or the presence of treatment providers who lack respect for the patient's autonomy and dignity.

Figure 19: Percent of Clients Secluded for CY18



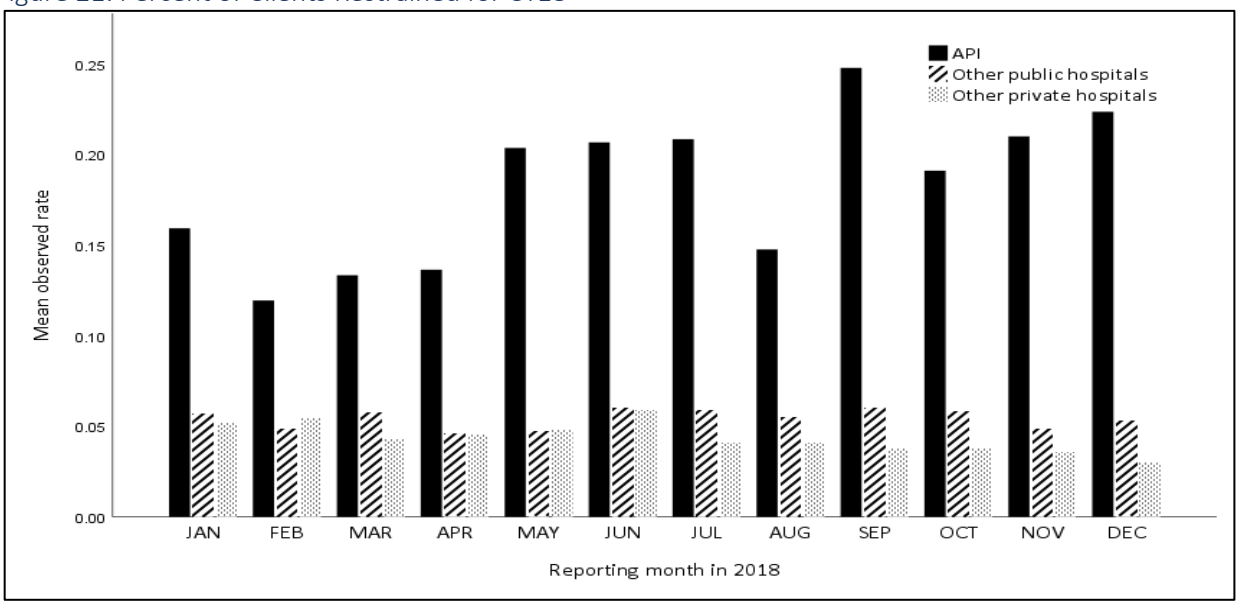
Source: NRI's BHPMS Data

Figure 20: Hours of Seclusion Use per 1,000 Inpatient Days for CY18



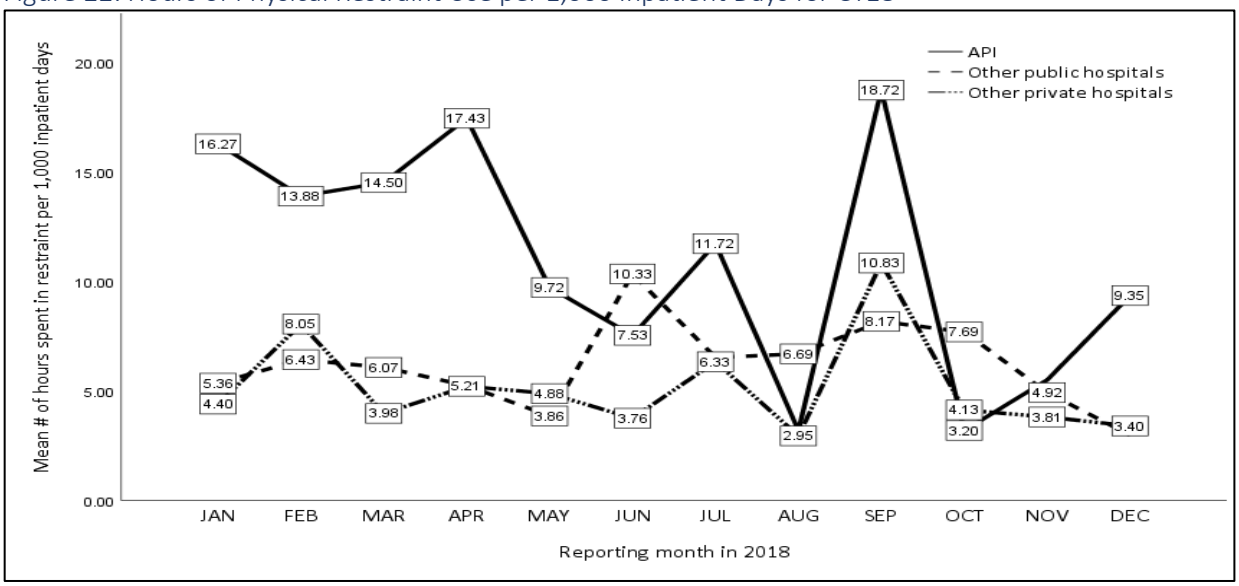
Source: NRI's BHPMS Data

Figure 21: Percent of Clients Restrained for CY18



Source: NRI's BHPMS Data

Figure 22: Hours of Physical Restraint Use per 1,000 Inpatient Days for CY18

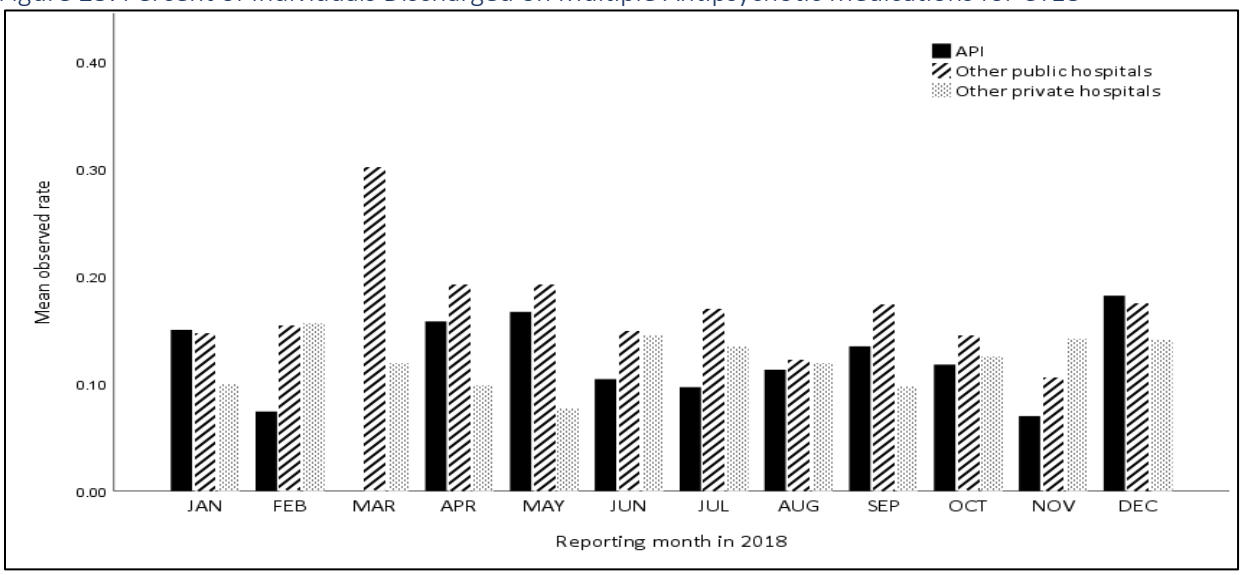


Source: NRI's BHPMS Data

Multiple Antipsychotic Medication Use Measure

Figure 23 shows illustrates the percent of patients discharged from hospitals on multiple antipsychotic medications. In March (CY18) 0% of patients discharged from API were on multiple antipsychotic medications, this went up to 18% in December of 2018 (CY18 represents the most current data). On average, the range was higher for the other public hospitals reporting between 11% and 30% of the patients were discharged on multiple antipsychotic medications. The percent range for private hospitals was similar as to API (8% - 14%). API presents an unstable trend that fluctuated to a high of 18%. Antipsychotic polypharmacy can lead to greater side effects, often without improving clinical outcomes. Practice guidelines encourage the reduction of unnecessary use of multiple antipsychotic medications and the adoption of polypharmacy only when monotherapy has proven to be ineffective. It is important to note that as the census at API drops the impact of outliers becomes more pronounced. As such, a small number of discharges may be driving the trends in Figure 23.

Figure 23: Percent of Individuals Discharged on Multiple Antipsychotic Medications for CY18

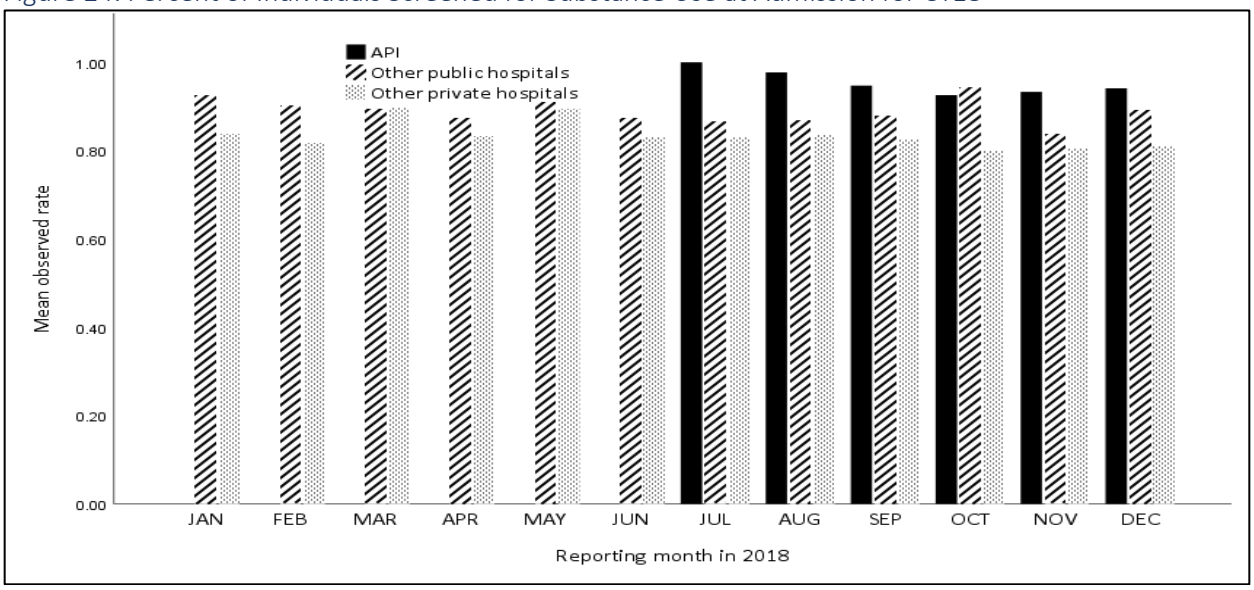


Source: NRI's BHPMS Data

Substance and Tobacco Use Measures

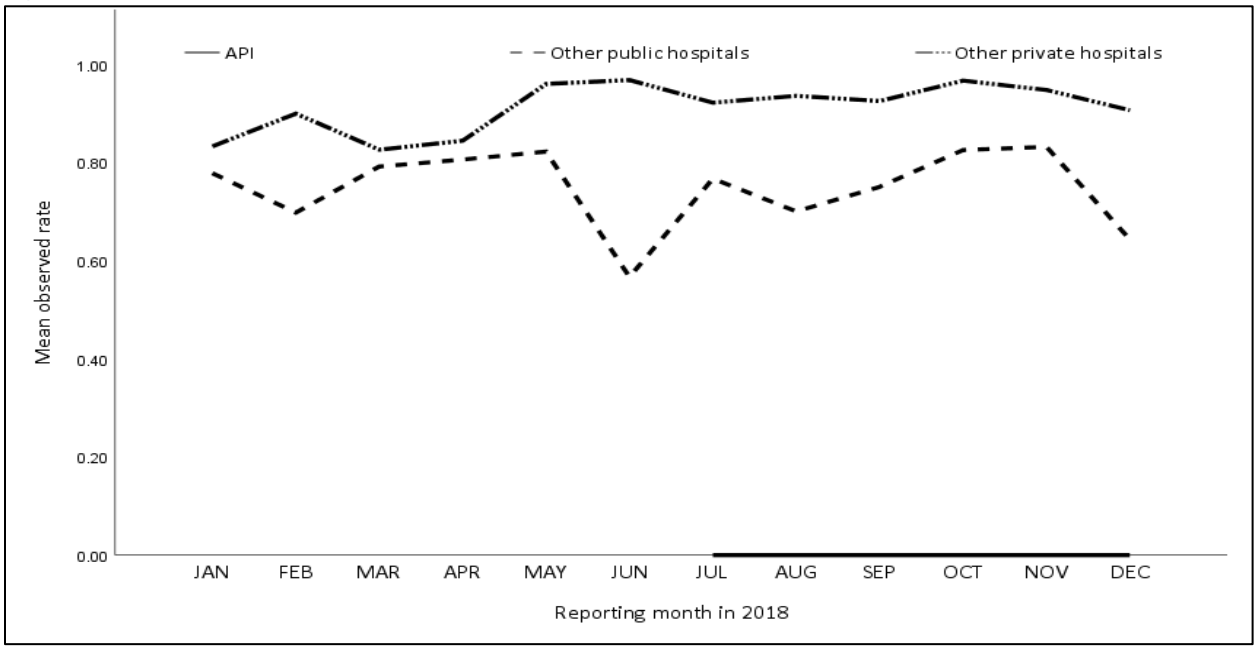
Figure 24 shows the percent of hospitalized patients 18 years and older who were screened within the first day after admission using a validated screening questionnaire for unhealthy alcohol use. During the first half of CY 2018 API did not provide screenings for substance use, however, at the end of 2018, API screened 94% of admitted patients (CY18 represents the most current data). Figures 25 and 26 show that API is not providing brief counseling and/or treatment for alcohol or drug abuse. This suggests the need for continuous monitoring of API performance. Excessive use of alcohol and drugs has substantial harmful impacts to the patient, the family and the overall society. Patients that present with substance use problems are at greater risk of severe injuries and medical problems.

Figure 24: Percent of Individuals Screened for Substance Use at Admission for CY18



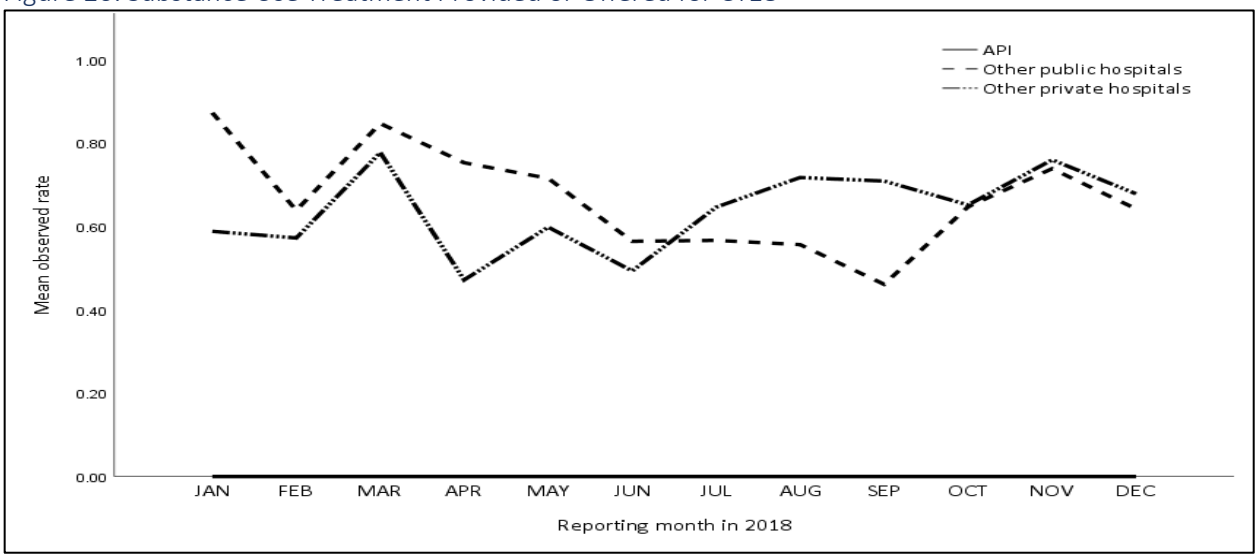
Source: NRI's BHPMS Data

Figure 25: Brief Intervention Provided or Offered for CY18



Source: NRI's BHPMS Data

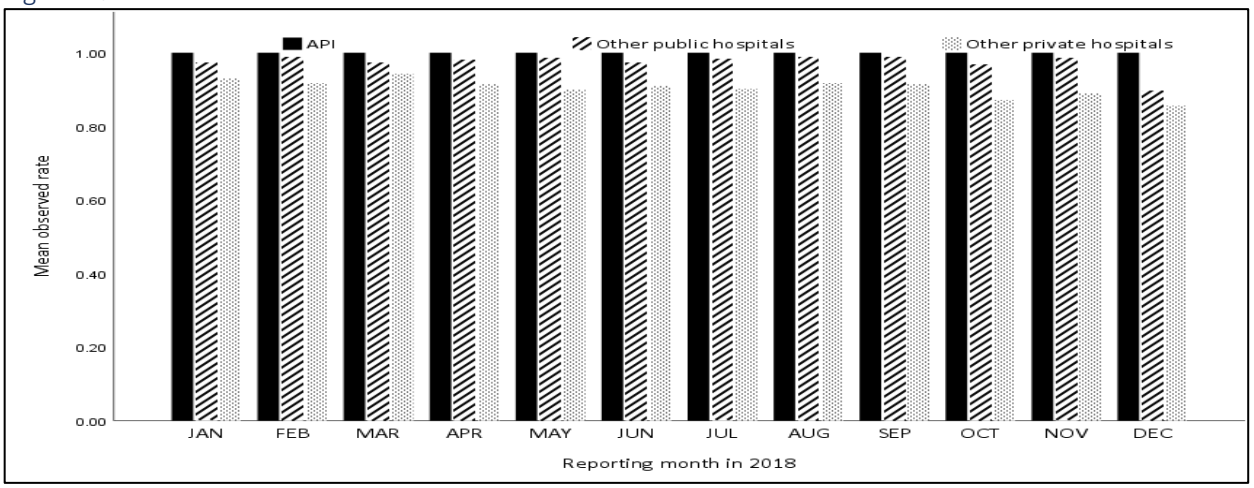
Figure 26: Substance Use Treatment Provided or Offered for CY18



Source: NRI's BHPMS Data

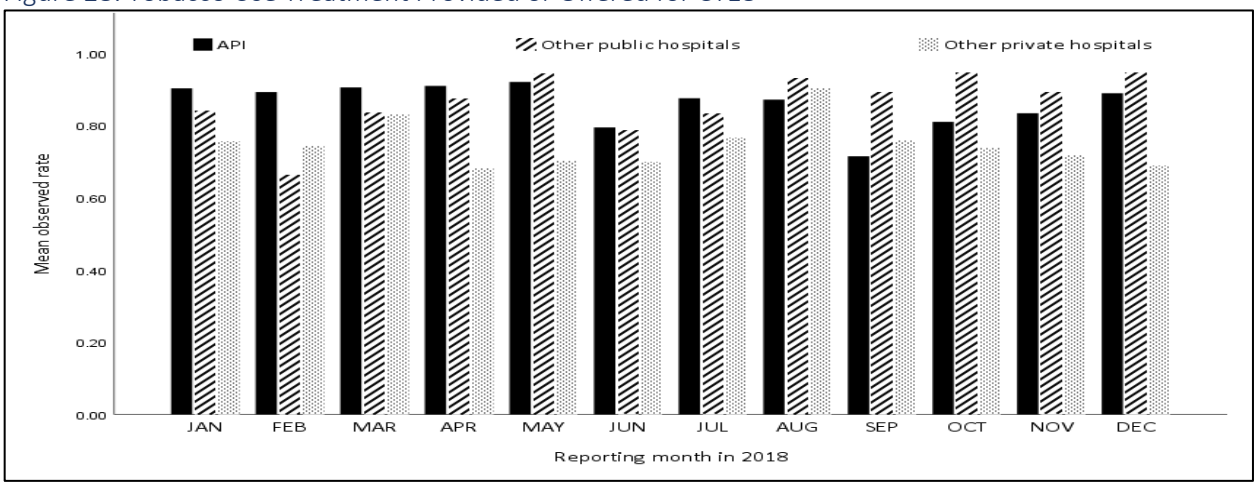
Figure 27 shows the percent of hospitalized patients who were screened within the first day after admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days. In 2018, API screened 100% of patients (CY18 represents the most current data). Figure 28 shows that, on average, API provided or offered tobacco treatment to 86% of the individuals screened positive for tobacco use compared with 87% in other public hospitals and 75% in private hospitals. Tobacco use continues to be the leading cause of preventable death and interventions to reduce use will likely have significant benefits for patients.

Figure 27: Percent of Individuals Screened for Tobacco Use at Admission for CY18



Source: NRI's BHPMS Data

Figure 28: Tobacco Use Treatment Provided or Offered for CY18

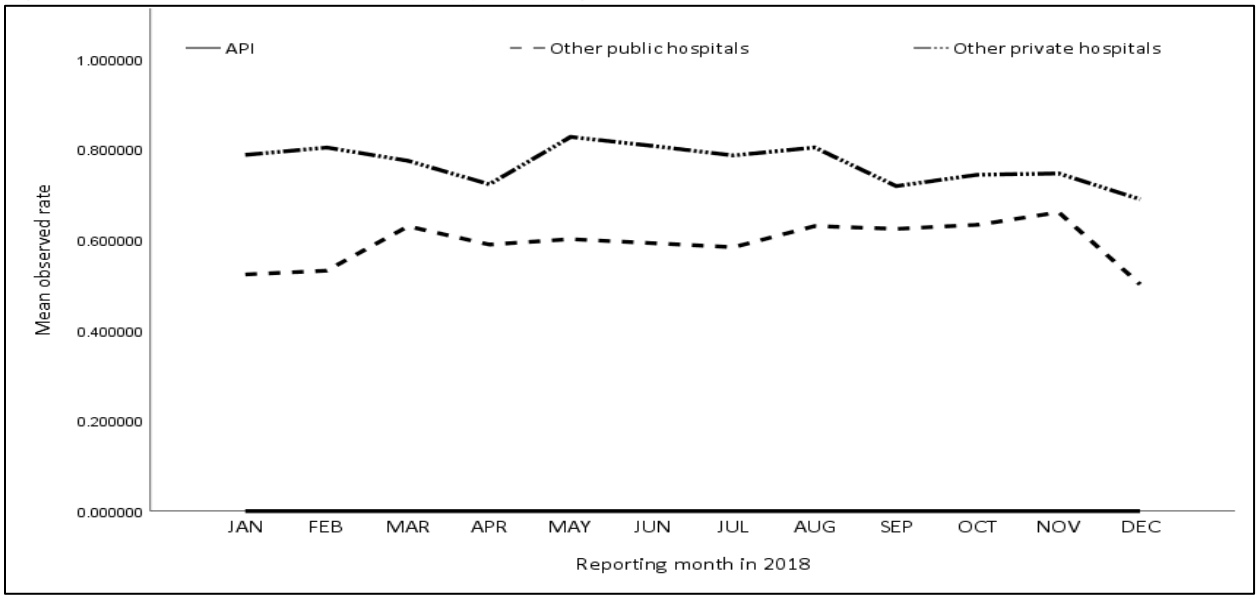


Source: NRI's BHPMS Data

Transition Record Measures

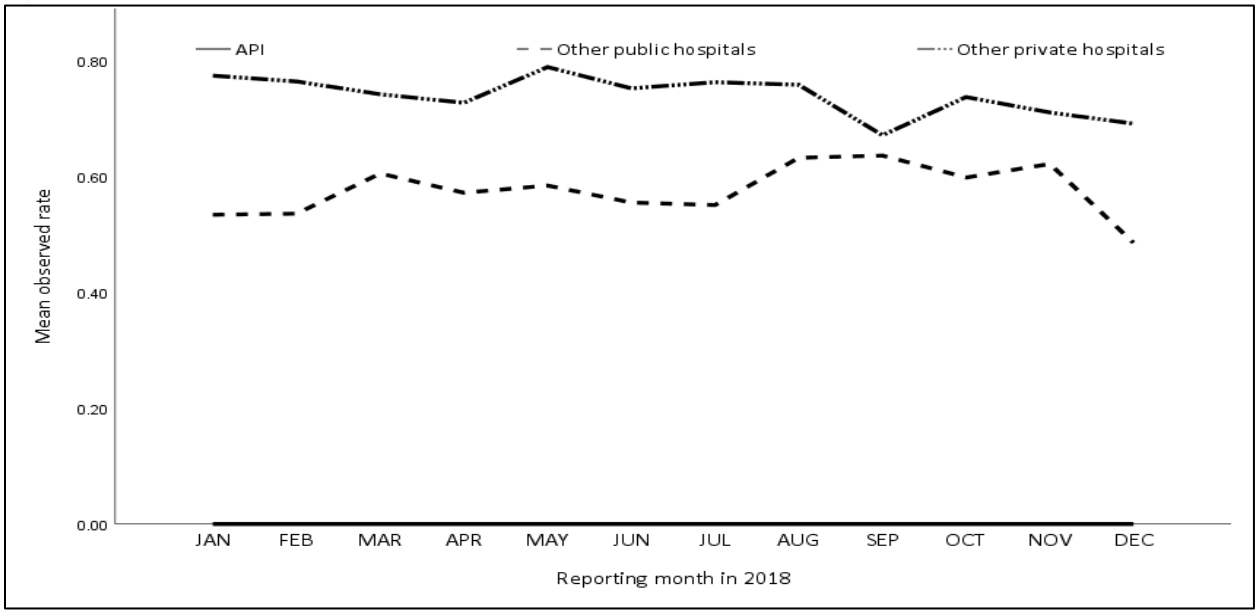
Figures 29 and 30 relate to the provision and transmission of patients discharge records to the individuals and the next level of care provider. Effective and timely communication of the patients' clinical status and other essential information about their treatment during hospitalization may support continuity of care. Giving discharge instructions to patients may assist them in maintaining their care after discharge and reduce preventable readmissions. As can be seen in both Figures 29 and 30, there are no transition records from API, and therefore is an area for improvement. Currently data are reported by API as "unknown/unable to determine from medical record" as CMS transitions to a pay-for-performance model in the future, API's reimbursement may be in jeopardy if these data are not accurately reported going forward. CY18 represents the most current data.

Figure 29: Transition Record Received by Discharged Patients for CY18



Source: NRI's BHPMS Data

Figure 30: Transition Record Received by Next Level of Care Provider for CY18



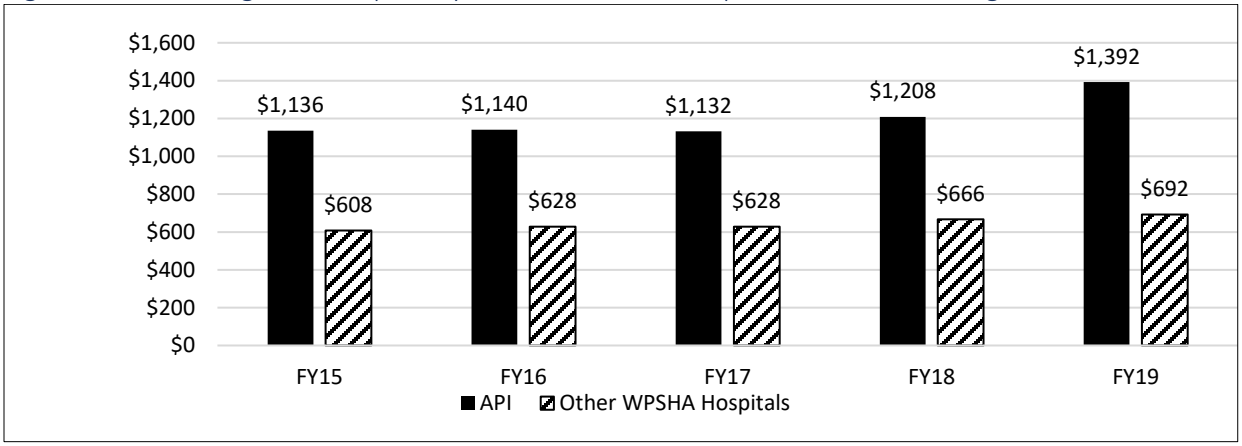
Source: NRI's BHPMS Data

API Costs

API Costs Compared to Other Western State Psychiatric Hospitals

Compared to other Western state hospitals, API has a higher budgeted cost per day than the other WPSHA hospitals. Figure 31 provides a comparison of the budgeted cost per day between API and all other WPSHA hospitals. As the figure indicates, API's budgeted cost has significantly exceeded the WPSHA average total cost per day for the last five fiscal years. API's cost per day was almost double the other WPSHA hospitals in FY18 at $1,208 per bed and over double the cost for FY19 at $1,392 per bed (vs. $692 for WPSHA hospitals). WPSHA reports a $657 median cost per day for all hospitals in FY19 and $651 per day for FY18. FY19 data are the most current available for comparison between API and other WPSHA hospitals.

Figure 31: Total Budgeted Cost per Day - API and WPSHA Hospitals from FY15 through FY19*



Source: Western Psychiatric State Hospital Association, Benchmarking data
**Note: Assumes API at 80 beds in FY18 and FY19.*

API-specific data were provided to allow for analysis of the number of staff working, the census, cost per patient (daily cost/census), and FTE to bed ratio (number of staff/census) for the first day of each quarter for FY18, FY19, and the first half of FY20. Table 2 below represents those data. These data will not match those above as these are point in time data whereas the above data are a fiscal year average. The table shows a census that fluctuated from a high of 80 patients on October 1, 2017 to a low of 21 patients on April 1, 2019. As the census dropped in April 2019, the number of staff working did not drop in kind (245 staff on April 1, 2019 and 229 staff on October 1, 2017). With staffing staying consistent and the number of patients dropping, the cost per patient and the FTE/bed ratio increased significantly in April 2019.

Table 2: API Staffing, Census, and Cost Actuals for FY18, FY19, and the First Half of FY20

Date	# of Staff	Census	Daily Cost	Cost/Patient	FTE/Bed Ratio
1-Jul-17	226	70	$ 71,097.31	$ 1,015.68	3.2
1-Oct-17	229	80	$ 68,958.65	$ 861.98	2.9
1-Jan-18	224	68	$ 73,788.68	$ 1,085.13	3.3
1-Apr-18	218	52	$ 64,896.08	$ 1,248.00	4.2
1-Jul-18	221	56	$ 69,945.17	$ 1,249.02	3.9
1-Oct-18	221	54	$ 65,280.94	$ 1,208.91	4.1
1-Jan-19	248	34	$ 65,751.67	$ 1,933.87	7.3
1-Apr-19	245	21	$ 59,502.82	$ 2,833.47	11.7
1-Jul-19	220	33	$ 59,163.90	$ 1,792.85	6.7
1-Oct-19	222	42	$ 59,753.17	$ 1,422.69	5.3

API and National Costs

Medicare cost report data for 2017 were used to conduct a financial analysis of API and to compare API costs to national inpatient psychiatric hospital costs. (Less than a dozen hospitals were excluded due to missing data.) Data for 2017 were selected as it is the most recent year with complete Medicare cost report data for the greatest number of psychiatric hospitals in the United States. Medicare cost reports are often not finalized for months, or sometimes a year or two, after a hospital's reporting period ends. In addition, 2017 represents the most recent year when API operated near bed capacity. Thus, our analysis is not affected by significantly lower staffing levels and occupancy rates beginning in state FY18 and FY19 and into the current fiscal year.

The national psychiatric hospital data were organized into three groups based on the hospital's ownership designation as reported to CMS: state-owned, profit, and not-for-profit. It is important to note that a hospital may be designated by CMS as state owned or owned by a not-for-profit organization and have a private management company operating or managing the facility. As these arrangements are not typical, and the total sample of hospitals includes 251 hospitals, any impact on the findings based on hospital ownership should be very minimal.

CMS requires hospitals to report costs based on three categories: general services, inpatient adult and pediatrics, and ancillary. The general services category includes administrative and operational costs, including hospital and nursing administration, maintenance and repair, dietary, laundry, employee benefits, pharmacy, medical records, capital equipment and improvements and social services. CMS refers to this cost category as *administrative and general*. The inpatient adult and pediatric category includes salaries, benefits and operating costs for nursing, medical providers, and psychiatric providers and is referred to as *direct care*. Finally, the ancillary category includes the clinical support services common to most psychiatric hospitals – laboratory, radiology, occupational therapy, physical therapy, and any speech pathology. This category is called *direct care support*. The table below (Table 3) shows the average percentages of each of these cost categories of total costs, based on ownership status.

Table 3: 2017 Medicare Cost Categories by Hospital Ownership Status

	General Services	Inpatient Adult and Pediatrics	Ancillary
API	**69.7%**	**29.4%**	**0.9%**
Government	64.9%	33.7%	1.4%
Profit	65.5%	33.6%	1.0%
Not-for-profit	72.5%	25.3%	2.2%
All Psychiatric Hospitals	**66.2%**	**32.4%**	**1.4%**

Source: CMS 2017 Medicare cost report data obtained from the Rand Corporation.

Cost Per Patient Day

Based on Medicare cost report data, the 2017 cost per patient day at API was $1,392, compared to a national average (irrespective of ownership category) of $879 per day. Table 4 below shows the average cost per day based on ownership category. As the data indicate, API's cost per day is near the average for not-for-profit hospitals and is over twice the average cost of profit hospitals and 38% greater than the cost per day for government hospitals.

Table 4: 2017 CMS Psychiatric Hospital Cost per Day Based on Ownership Type

Ownership or Hospital	Cost Per Day
API	**$1,392**
Government	$1,008
Profit	$639
Not-for-profit	$1,498
All Hospitals	**$879**

Source: CMS 2017 Medicare cost report data obtained from the Rand Corporation

Annual Cost Per Bed

Table 5 details the average cost per day based on ownership category. API's annual cost per bed (at $433,220) is 99.1% greater than the national average ($217,548) of psychiatric hospitals. API's annual cost per bed is also 75.1% higher than other government hospitals ($247,403).

Table 5: 2017 CMS Psychiatric Hospital Cost per Bed Based on Ownership Type

Ownership or Hospital	Annual Cost Per Bed
API	**$433,220**
Government	$247,403
Profit	$158,288
Not-for-profit	$318,434
All Hospitals	**$217,548**

Source: CMS 2017 Medicare cost report data obtained from the Rand Corporation

API and National Costs – Salaries and Benefits

As described above, API's average salaries and benefits per FTE were compared to government, for-profit, and not-for-profit hospitals. Those data show API's average salaries and benefits for

FY17 were $106,896 (Table 6). This amount is 36.7% greater than the average for All Hospitals ($78,196) and 10.6% greater than the average for Government hospitals ($94,896).

Table 6: 2017 CMS Average Salaries and Benefits Based on Ownership Type

Ownership or Hospital	Average Salaries and Benefits
API	**$106,896**
Government	$94,896
Profit	$62,485
Not-for-profit	$102,386
All Hospitals	**$78,196**

Source: CMS 2017 Medicare cost report data obtained from the Rand Corporation

API and Peer Group Costs

Using CMS Medicare cost report data, WICHE selected a peer group of sixteen hospitals (including API) to examine API costs in detail in comparison to similar size hospitals in the three ownership categories. (A list of these hospitals is included as Appendix F). Table 7 provides basic information about each peer group category.

Table 7: API and CMS Peer Group - Beds and Occupancy Rates

Peer Group / API	Average # Beds	Average Occupancy Rate
API	**80**	**85%**
Government (Six hospitals, including API)	88	95%
Profit (Six hospitals)	91	74%
Not-for-profit (Four hospitals)	89	78%

Source: CMS 2017 Medicare cost report data obtained from the Rand Corporation

Table 8 shows the percentage of total costs by each of the three CMS cost categories: administration and general, direct care, and direct care support. As the Table indicates, while all three types of hospitals have an average administration and general cost percentage of approximately 60%, API's cost percentage in this category is approximately 70%. We use these percentages to estimate costs under the full privatization scenario later in the report.

Table 8: API and CMS Peer Group - Percentage of Total Costs by CMS Category

	Administration and General	Direct Care	Direct Care Support
API	**69.7%**	**29.4%**	**0.9%**
Government	59.5%	39.2%	1.3%
Profit	61.5%	38.1%	0.5%
Not-for-profit	60.6%	38.4%	1.0%

Source: CMS 2017 Medicare cost report data obtained from the Rand Corporation

Tables 3 and 8 identify general services as the largest percentage of API's budget and the relatively low percent of the budget that covers patient care (Table 3: 'Inpatient Adult and Pediatrics' and Table 8: 'Direct Care'). Reviewing the staffing of API in relationship to patient care needs versus administrative support functions could help API to operate more efficiently.

Operational Scenarios

Operational Scenario Background

Several options exist for significantly changing the management and operation of API. These options range from a commitment to make state operation succeed to the full privatization of the hospital. This section of the report examines four scenarios:

1. Contracting with a for profit or not-for-profit third party to assume responsibility for hospital management and operations (while the state retains all API capital assets);
2. Maintaining the facility under state ownership and operation with an analysis of whether, and how, it is possible for the State to **effectively** operate API if it remains exclusively state-run;
3. Forming a public corporation under state supervision to operate the facility; and
4. Maintaining the facility under state ownership and operations but contracting for specific components of hospital services/operations to reduce costs.

Each scenario is assessed based on the following criteria:

1. Cost savings estimates of privatization vs. remaining under sole State operation, to include both direct and indirect costs, as well as the costs of potential litigation and compliance with post-litigation outcomes.
2. Quality of care, including the ability of the State to provide care should the loss of certification or licensure occur; share which scenario will best optimize community resources/partners; improved patient outcomes.
3. Access to care, including the hospital's operational capacity and the scenarios ability to eliminate waitlists – both civil and forensic.
4. Administrative quality measures, to include administrative response time to emergent or time-sensitive issues (including, but not limited to, staffing, citations on regulatory standards, and any issue that could jeopardize continuity of operations). This also includes an analysis of the ability to implement and use appropriate and modern technology and data management solutions.
5. Workforce: the ability to attract and retain a competent and qualified workforce, which fully meets the needs of patients.

Considerations Across All Scenarios

Olmstead Cases in the U.S.

As noted above, the scenarios include an assessment of the potential risks for litigation and associated cost estimates. Title II of the Americans with Disabilities Act (ADA), commonly referred to as the Integration Mandate or Olmstead, mandates that individuals with disabilities are entitled to receive services and live in the most integrated settings appropriate for their care. Entities that receive public funding can be found in violation of Olmstead by failing to provide

services in the most appropriate, most integrated setting. While initial Olmstead cases focused on clients residing in psychiatric hospitals, many of the recent Olmstead cases have focused on whether states are providing an adequate array of community-based services to individuals at risk of institutionalization to avoid unnecessary hospitalization.

An analysis of API's outcome measures shows that, compared to the national averages, API has high utilization and adult readmission rates, and short median lengths of stay. These indicators support the idea that Alaska uses its state hospital to provide short-term, acute care services, which may also reflect a limited availability of community-based behavioral health and crisis services. In addition to a lack of community-based services, these data may also indicate a lack of alternative, short-term psychiatric inpatient capacity in general hospitals and private psychiatric hospitals in the state, forcing API to serve more acute patients. Such a high reliance on state hospital psychiatric beds at API to provide short-term, acute care and crisis services may lead to individuals who require hospital-level of care languishing in other, less appropriate settings, such as emergency departments or jails and prisons, as they await for hospital beds to become available at API. This issue may be exacerbated by API's current difficulties where they are operating at approximately half their licensed bed capacity.

High rates of readmission at API may also indicate improper and inadequate discharge planning at API or inadequate working with community-based behavioral health providers to deliver timely community-based follow-up for discharged patients. Poor discharge planning, and the lack of availability of appropriate services, either in the community or the state hospital, may put Alaska at a high risk of an Olmstead violation. Lessons from other states that have faced Olmstead violations may be helpful to the State of Alaska as it works to improve its behavioral health service delivery system, and can give the State an idea of what the potential financial impact of an Olmstead lawsuit might be.

Olmstead Expenses

Proactively improving Alaska's behavioral health system can reduce the state's risk of an Olmstead violation, which will allow DHSS to allocate resources toward system improvement rather than toward court fees and penalties. It is WICHE's opinion that API is at greatest risk for an Olmstead lawsuit with Scenario 2, continued state operation, given its history. Therefore, the risks and associated costs are only included in this scenario. The WICHE Team reviewed settlement agreements on www.ada.gov, reviewed newspaper articles, and reached out to a handful of states that have faced Olmstead lawsuits in an attempt to determine costs to related to Olmstead litigation and Settlement compliance. Potential fees associated with an Olmstead violation include:

- Plaintiffs' fees: In some instances, the state may be responsible for covering both their own legal expenses, as well as any expenses incurred by the Plaintiffs. Many states use a combination of private attorneys and the State Attorney General's office to defend themselves and these legal fees can be quite high.
- Court Reviewer/Monitor fees: An independent reviewer is a neutral third party who is

responsible for monitoring compliance to a Settlement Agreement or Consent Decree.

- Penalties for inaction: In some instances, the court may require states to pay penalties for non-compliance (e.g., a fee per-person, per-day until that person is on a wait list to be admitted to a hospital, transitioned to the community, when continued inpatient level of care is not clinically indicated, or to receive a competency evaluation).
- Cost of system improvement/Consent decree implementation: These expenses reflect the investment the state is required to make to its system. For instance, these expenses may cover the cost of transitioning individuals out of inpatient settings into the community, expanding the availability of community-based and crisis services, and establishing trust funds for vouchers that support independent living.

Legal Considerations[7]

There are a number of statutory and contractual issues that may inform the analysis of the potential operational scenarios for the Alaska Psychiatric Institute (API) proposed by the Department of Health and Social Services (Department).

1. **The Department Has Legal Authority to Delegate API Staffing and Services.**

Alaska's Civil Commitment Statutes (Alaska Statutes ("AS") 47.30.660 and 47.30.670 – 47.30.915) have several provisions that bear on the Department's ability to privatize API. First, AS 47.30.660 dictates that the Department must "designate, operate, and maintain treatment facilities equipped and qualified to provide inpatient and outpatient care and treatment for persons with mental disorders." AS 47.30.660(b)(4). Second, AS 47.30.760 and AS 47.30.800 require that mental health treatment be available at "state-operated" hospitals at all times for individuals who have been involuntarily committed on an inpatient basis.

The obligation for the Department to "operate" or "maintain" mental health treatment facilities must be read in the context of the Department's general powers, as well as the State's framework for licensing specialty hospitals. Under AS 47.30.660(b)(13), the Department may enter into contracts for the provision of mental health services and "delegate upon mutual agreement to another officer or agency of it, or a political subdivision of the state, or a treatment facility[8] designated, any of the duties and powers imposed upon it by" the Civil Commitment Statutes. Additionally, though the Civil Commitment Statutes do not define what it means for a hospital to

[7] The purpose of this section is to provide the Department with a summary of certain legal issues and considerations. The purpose is not to provide the Department with legal advice and should not be construed as creating an attorney-client relationship between WICHE and the Department or between WICHE's counsel and the Department.

[8] Note that under AS 47.30.915 "designated treatment facility" or "treatment facility" means a hospital, clinic, institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under AS 47.30.670 -- 47.30.915 other than correctional institutions. If the Department wishes to delegate any of its statutory duties to a contractor that does not meet this definition, it may need to obtain a statutory amendment. However, the statute could also be interpreted more broadly to permit delegation to any contractor that is operating a treatment facility on behalf of the licensee.

be "state-operated," a license is required to "operate" a specialty hospital such as API, and a license holder is ultimately responsible for the facility's operations. AS 47.32.020, AS 47.32.140 and AS 47.32.900(6). Thus, as long as the Department through its API Division holds the specialty hospital license for API, API will be state-operated under Alaska law.

In this context, it appears that each of the operational scenarios being considered by the Department is compatible with the Department's statutory obligations under the Civil Commitment Statutes. As discussed below, Scenarios 1, 2, and 4 contemplate that the Department's API Division would continue to hold the license to operate API. This means that the Division would be responsible for the operations of API and that API would remain a state-operated facility under Alaska law. Additionally, the Department has the specific statutory authority under AS 47.30.660(b) to contract with, and delegate its statutory obligations to, other entities. This authority is confirmed by State licensing regulations that expressly permit specialty hospital facilities like API to "contract with another facility or agent to perform services or provide resources to the facility." 7 Alaska Administrative Code ("AAC") 12.910(a). API can enter into a support services arrangement, provided the relationship is disclosed and complies with the minimum requirements of 7 AAC 12.910(c).

Scenario 3 contemplates creation of a separate public corporation under State supervision to operate or provide services to the facility. The Legislature would need to enact legislation to create a new public corporation. If the Department determined that its Division would retain the license to operate the facility, *see* discussion *below*, the legislation could authorize the public corporation to contract with the Division to provide staff and services necessary for operation of the facility. Alternatively, if the Department determined that the public corporation should hold the license to operate the facility, the Legislature could state expressly in its implementing statute that the facility will be considered to be "state-operated" for purposes of AS 47.30.760 and AS 47.30.800 or, alternatively, could amend AS 47.30.760 and AS 47.30.800 to make clear that mental health treatment will be at a hospital operated by the Department or the public corporation at all times for individuals who have been involuntarily committed on an inpatient basis.

2. The Department's Contemplated Contractual Relationship Could Be Structured to Comply with Alaska Licensing Rules and CMS Conditions of Participation.

The Department's RFP states that whatever scenario is proposed, the Department intends to retain (a) ownership of patient medical records and (b) ultimate control, oversight, and approval over operations through the API governing body. Absent a statutory change, the only way for the Department to achieve both objectives would be for the API to continue to hold the license to operate the facility as a Division of the Department. API would continue to be the licensee and delegate all or certain staffing and services to a private or public corporation.

This delegation could take the form of a support services agreement whereby the contractor agrees to provide the full or partial range of staff and services necessary to operate the facility. The support services agreement would need to meet the requirements of 7 AAC 12.910(c):

> (1) specify the respective functions and responsibilities of the contractor and the facility, and the frequency of onsite consultation by the contractor;
> (2) identify the type and frequency of services to be furnished;
> (3) specify the qualifications of the personnel providing services;
> (4) require documentation that services are provided in accordance with the agreement;
> (5) specify how and when communication will occur between the facility and the contractor;
> (6) specify the manner in which the care or services will be controlled, coordinated, supervised, and evaluated by the facility;
> (7) identify the procedures for payment for services furnished under the contract; and
> (8) include the current license or registration number of the contractor, if required by state statute or regulation.

Under this type of agreement, the Department's API Division would retain the license and ultimate responsibility for the operation of the facility as the license holder. The API Division would also be the owner of all facility records, including patient records, and would have oversight responsibility through its Governing Body.

The API Governing Body would also likely need to retain the responsibility to exercise oversight authority to meet the Conditions of Participation ("COP") established by the Centers for Medicare & Medicaid Services ("CMS"). 42 C.F.R. § 482.12; CMS State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.[9] CMS COPs require the governing body to be ultimately responsible to ensure that the hospital meets all COPs. For example, the governing body duties include (a) appointing the chief executive officer to manage the hospital; (b) participating in the development of an institutional plan and budget; (c) determining which categories of practitioners are eligible for appointment to the medical staff; (d) approving medical staff bylaws; (e) exercising oversight along with the medical staff of the practitioners granted privileges at the hospital and determining which practitioners should be granted privileges; and (f) overseeing the quality of care provided at the facility. 42 C.F.R. § 482.12(a). State licensing rules contain similar governing body requirements. 7 AAC 12.630. The API Governing Body would also be responsible for ensuring that the contractor's services permit the hospital to comply with all COPs. 42 C.F.R. § 482.12(e).

[9] CMS guidelines state that in "the absence of an organized governing body, there must be written documentation that identifies the individual or individuals that are legally responsible for the conduct of the hospital operations." CMS State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, § 482.12 (Oct. 12, 2018).

Labor Issues

API is subject to the State's collective bargaining agreements ("CBAs") covering API's employees, including supervisors. The information below addresses the legal impact on API's labor relations that results from each of the four proposed scenarios.

Under any scenario in which the new employer adopts, or the State maintains, the terms and conditions of the existing CBAs, the employer could attempt to bargain a supplemental CBA that appropriately addresses the unique workforce issues that arise in a psychiatric hospital setting. This could be done at any time, including but not limited to upon expiration of the current CBAs.

Under Scenarios 1, 3, and 4, where the State transfers management of at least some part of the workforce to another employer, existing CBAs require the State to provide the unions 30 days' notice and the option to submit an alternative plan before releasing any bids. See CBA between the State of Alaska and the Alaska Public Employees Association (supervisory unit), Art. 6.01 C.1; CBA between State of Alaska and the Alaska State Employees Association, American Federation of State, County, and Municipal Employees, Local 52, Art. 13.01. The State is not obligated to adopt the union's plan. If the State's action displaces bargaining unit members, the State must make a good-faith effort to place those employees elsewhere in State government, with the following order of priority: (1) within the division; (2) within the department; or (3) within State service generally.

Finally, under Scenarios 2 and 3, where API's employees remain public, the State has the option to enact legislation that exempts certain public employees (such as API supervisors) from its State labor laws, thereby eliminating their eligibility to participate in union activities and reducing the number of unionized employees at API. This of course would likely provoke intense lobbying and pressure from Alaska's unions in opposition and likely generate significant media attention.

Incorporation of Regulatory Compliance Requirements

Any contract with a private for profit or nonprofit entity or a public corporation would need to allocate responsibility between the Department and the contractor for compliance with multiple regulatory systems. The Full Legal Considerations and Olmstead Analyses can be found in Appendix D and Appendix E respectively, and details of calls the WICHE Team conducted with other states around their consideration of privatization can be found in Appendix C.

Electronic Health Record

The costs and time required for purchasing and successfully rolling out a new electronic health record (EHR) will vary depending on several variables (system chosen and functionality of the system – does it need to be customized for API or can an off-the shelf option be found, does a private contractor already have licenses and experience with a system, how much training does the staff need – this will vary depending on how different the new system is from the current system MEDITECH). Any new system should meet the requirements of the Office of the National Coordinator for Health Information Technology (ONC). This voluntary program defines the

requirements for health information technology and the process by which it may be tested, certified, and maintain its certification[10]. Many programs on the market are certified[11], giving API many choices in selecting a program that will meet their needs.

Staffing Models, Census Levels, and Standard of Care

Staffing is largely static and dependent upon bed utilization, acuity of patients, and other factors. Typically, private and many state hospitals can operate with fewer staff, but the operating entity would likely require the freedom to determine their staffing requirements. Additionally, private entities often have off-site administrative staff that support multiple hospitals, lowering these costs for individual hospitals. However, this is dependent on the private vendor and their infrastructure.

One of the staffing issues faced by API is the perception of rigidity of the CBA, including where within API staff can be assigned and to an extent, their work duties, such as not being permitted to engage in performance improvement activities.

Another factor resulting in increased direct care staffing costs is providing 24/7 coverage on the three, 10-bed units, which drives higher per bed/patient costs than 16-30 bed units. This is a factor given the design of API and the lack of a 'hub and spoke' nursing station, which would allow for some shared coverage, especially on evening and night shifts. Census levels are largely dependent upon leadership and changes to current operations. Increasing census would need to be established as an outcome for API leadership, whether that be State staff or a contractor. Similarly, the standard of care expected to be delivered in each scenario will need to be established by the Department and API leadership. There are well-accepted best practices including recovery-focused, trauma informed individualized care that should be considered regardless of the scenario, and implementation of these is not contingent of the scenario.

[10] https://www.healthit.gov/sites/default/files/PUBLICHealthITCertificationProgramOverview.pdf
[11] https://chpl.healthit.gov/#/resources/overview

Scenario #1: Full Privatization – Profit and Not-for-Profit Scenarios

Full Privatization of API assumes the hospital's operation and management is assumed by a private, for-profit contractor or a not-for-profit contractor. Each of these scenarios is provided below. In this scenario, the state would take on the role of contract administrator, monitoring the contract operator's performance.

Assumptions

The following assumptions are included in this scenario:

- WICHE conducted a literature review to determine differences between public and private sector salaries. This estimate is based on data from the Bureau of Labor Statistics, Current Population Survey 2019, which found that the private sector typically pays 20% more in salaries compared to their public counterparts[12]. Based on these findings, WICHE took API's FY19 total salaries and increased them by 20% to model private salaries.
- An analysis performed by the University of Alaska Anchorage's Institute of Social and Economic Research (ISER), prepared for the Alaska Department of Administration, found that employee benefits contribute to a substantially greater portion of total compensation in the public sector than in the private sector[13]. Based on the ISER report, WICHE estimates private sector benefits to be 22% of total compensation. In FY19, an average of 32% of total compensation at API was paid through employee benefits [14].
- The state would retain ownership of the building(s) and land associated with API.
- The contractor would be responsible for all incurred capital costs and would manage the operation and maintenance of the physical plant. It is assumed DHSS would require a full inventory of capital assets upon transfer of operation to a private operator and a written agreement with strong language that the private entity must ensure proper maintenance of the facility and other capital assets. This will require the State to determine what a proper level of maintenance would be for the facility and other capital assets.
- Currently, the State pays overtime to any employee working over 37.5 hours per week, who are covered by the General Government Bargaining Unit and are Exempt. This is a contractual requirement in place with the collective bargaining units that represent current API employees who are not included in the Supervisory Unit Bargaining Agreement or the Labor, Trades and Crafts Unit Master Agreement API employees, who have a 40-hour work week. Therefore, under a private contractor scenario, overtime eligibility would begin once an employee exceeded 40 hours per week instead of the 37.5 hours per week for the majority of the API employees. This change would reduce overtime costs, as a private employee would have a higher ceiling for overtime eligibility.

[12] Bureau of Labor Statistics, Current Population Survey 2019

[13] https://iseralaska.org/static/legacy_publication_links/2016_07-OverpaidOrUnderpaidReport.pdf

[14] For the purposes of this report, WICHE's calculation of API staff benefits includes insurance (health, life, short-term disability, and long-term disability), retirement and savings (defined benefits, defined contributions) and legally required benefits (Social Security, Medicare, and state and federal unemployment).

- It is assumed that under all privatization options, patient revenue from federal and third-party sources remains a constant regardless of the operational costs. Therefore, this scenario assumes that all additional costs or savings would be paid from or credited to the state's General Fund. (While not within the scope of this project, we believe that API could increase its non-state revenue from Medicare and Medicaid – For example, CMS allows states to bill both Medicaid and Medicare for forensic patients, as Oregon does).
- WICHE assumes that a contractor operating all or part of API will be provided a profit margin as part of an operating agreement. This assumption extends to both for profit and not-for-profit operators. WICHE reviewed profit margins in Becker's Hospital Review and found similar profit margin standards to those found by PCG in its 2017 API study. The estimated for-profit contractor margin is assumed at eight percent (8%) and the expected margin for a not-for-profit contract would be four percent (4%).
- Note: workman's compensation, and liability costs are not included in these scenarios.

Legal Considerations

API is currently subject to the State's collective bargaining agreements ("CBAs") covering API's employees, including supervisors. Under Scenario 1, contracting with a private third party that would assume responsibility for API management and operations would result in dissolution of API's supervisory bargaining unit, because supervisors are precluded from organizing under federal labor law that governs private employers. As for nonsupervisory bargaining units, the third party – the "successor" employer – would assume the terms and conditions of existing nonsupervisory bargaining agreements if it promises continued employment to a majority of the existing bargaining unit employees. If the successor employer makes no such commitments, but nonetheless builds a majority of workforce with bargaining unit members, it would likely be required to recognize the union as the exclusive bargaining representative of the employees. In that case, however, the successor employer would be entitled to establish the initial terms and conditions of employment, subject to subsequent bargaining.

Also, under this scenario, where the State transfers management of at least some part of the workforce to another employer, existing CBAs require the State to provide the unions 30 days' notice and the option to submit an alternative plan before releasing any bids. See CBA between the State of Alaska and the Alaska Public Employees Association (supervisory unit), Art. 6.01 C.1; CBA between State of Alaska and the Alaska State Employees Association, American Federation of State, County, and Municipal Employees, Local 52, Art. 13.01. The State is not obligated to adopt the union's plan. If the State's action displaces bargaining unit members, the State must make a good-faith effort to place those employees elsewhere in State government, with the following order of priority: (1) within the division; (2) within the department; or (3) within State service generally.

Immunity and Indemnification

In contracting with a private for profit or nonprofit contractor, the State should consider that absent a legislative change the contractor will not enjoy the same protections from civil action currently provided to API under state law. Currently, under Alaska State law, state employees who are acting within the scope of their employment cannot be sued directly. Instead, the State is substituted as the defendant party to the civil action upon certification by the attorney general that the employee was "acting within the scope of the employee's office or employment at the time of the incident out of which the claim arose." AS 09.50.253(c). Employees of a private contractor would not have this same protection and therefore would need to be protected by insurance policies as contemplated by the DHSS RFP. In addition, the qualified immunity protections that are currently available to the State under AS 09.50.250 would not apply to a private contractor but likely would still apply to the extent a litigant were to sue the State for its actions or inactions in overseeing operations assuming the Department retains its status as licensee.

In contracting with a private contractor to perform any functions, the State will want to be very clear which functions it is delegating to the private contractor and which it is retaining for itself, if any, as this division of responsibilities will also define liabilities. In addition, any contract should specify the duty of the private contractor to indemnify, hold harmless, and defend the Department against claims from any third parties. The contract should also specify robust insurance requirements.

Alaska Public Employee Retirement System

The DHSS would be required to pay a Public Employee Retirement System (PERS) termination liability for the FTE being privatized. However, given that these costs are already included in the DHSS budget, they will not directly impact API's cost so are not included in this analysis.

Contract Monitoring

Contract monitoring costs are estimated at 3.0 FTE, 2.0 FTE as clinical monitors of treatment and care at API and 1.0 FTE as a contract manager. This estimate is based on WICHE's review of other contracted programs that are monitored by state behavioral health FTE.[15] The salary, benefits, and operating costs for these three positions are detailed in the cost estimate provided later in the report.

[15] In Colorado, a multisite 114-bed, jail-based restoration to competency program is monitored by 3.0 FTE employed by the Colorado Office of Behavioral Health. Also, conversations with contract monitoring staff in Florida's Department of Children and Families indicate API could be well managed by employing 3 FTE.

Staffing Scenarios

Cost estimates are based on staffing scenarios, which vary depending on the operational scenario and associated assumptions. To compare scenarios, "API Status Quo" costs are provided. This scenario represents FY19 actual expenditures. This scenario does not build in any additional staffing efficiencies from any of the operational scenarios.

Full Privatization Cost Scenario – For Profit Contractor

Table 8 provides a comparison of FY19 API actual expenditures to estimated expenditures under a full privatization, for profit operator scenario. As discussed earlier, salaries are estimated to increase by 20% under a private operator, while benefits are estimated to decrease to 22.0% of total compensation costs. We estimate 3.0 FTE and approximately $300,000 annually for DHSS to monitor API and contractor performance. FY19 Actuals "All Other Costs" includes $5,075,131 in payments for consulting and management of API. We also estimate a 10% reduction (or $949,891) in General Services expenses based on a comparison of these costs per day between other state, private, and not-for-profit inpatient psychiatric hospitals. It is assumed a private operator, either profit or not-for-profit, would be obligated to identify reductions in expenditures totaling approximately $950,000 annually.

As Table 9 indicates, full privatization is estimated to result in a decrease in state general fund expenditures of roughly $1.2 million in the first year. This includes an 8% (or $2.9 million) profit margin for a private contractor to operate the facility.

Table 9: Cost Comparison API - For-Profit Contractor

	API FY 19 Actual	Year One - Full Privatization	Year One Change from FY19 Actual Increase/(Decrease)
Salaries	$17,710,538	$21,252,645	$3,542,108
Benefits	$8,507,129	$6,635,560	($1,871,568)
Contract Monitoring	$0	$300,000	$300,000
All Other Costs	$14,574,042	$8,549,020	($6,025,022)*
Subtotal - All Expenses (Ongoing)	$40,791,708	**$36,737,225**	**($4,054,483)**
Licensure		**$2,000**	**$2,000**
Profit @ 8%		$2,938,978	$2,849,717
Total	**$40,791,708**	**$39,678,203**	**($1,202,766)**

*this includes approximately $5 million in FY19 contracted management support

Other Savings

- **Indirect costs.** As part of receipt of federal funding, including Medicare and Medicaid, each state must identify indirect costs[16]. Based on API's FY19 Medicare cost report, these indirect costs total $1.7 million annually. Examples of these costs include DHSS and other state agency services which provide support to API (i.e., human resources, payroll). These functions would become the responsibility of the private operator and there should be a reduction in workload in the various DHSS agencies that provide support to API, thus generating potential cost savings with the transfer of these duties to a private operator. We did not have access to detailed Statewide Cost Allocation Plan (SWCAP) data to examine the functions included in the $1.7 million and whether any or all of these costs could be reduced; however, DHSS should conduct this examination to identify possible savings from privatizing API.

Full Privatization Cost Model – Not-for-profit Contractor

Table 9 provides a comparison of FY19 API actual expenditures to estimated expenditures under a not-for-profit contractor scenario. As discussed earlier, salaries are estimated to increase by 20% under a private operator, while benefits are estimated to decrease to 22.0% of total compensation costs. We estimate 3.0 FTE and approximately $300,000 annually for DHSS to monitor API and contractor performance. FY19 Actuals "All Other Costs" includes $5,075,131 in payments for consulting and management of API. We also estimate a 10% reduction (or $949,891) in General Services expenses based on a comparison of these costs per day between other state, private, and not-for-profit inpatient psychiatric hospitals. It is assumed a private operator, either profit or not-for-profit, would be obligated to identify reductions in expenditures totaling approximately $950,000 annually.

As Table 10 indicates, full privatization is estimated to result in a decrease in state general fund expenditures of roughly $2.6 million in the first year. This includes an 4% (or $1.4 million) profit margin for a private contractor to operate the facility.

[16] The U.S. Office of Management and Budget issued OMB Circular A-87 (2 CFR Part 225), which defines allowable expenditures for Federal grants. The circular establishes procedures for recovering both direct and indirect costs of programs. The circular requires that a state wishing to claim indirect costs as charges against federal grants, prepare an annual SWCAP and submit the plan for approval to a designated federal department for review and approval.

Table 10: Cost Comparison - Not-for-profit Contractor

	API FY 19 Actual	Year One - Full Privatization	Year One Change from FY19 Actual Increase/(Decrease)
Salaries	$17,710,538	$21,252,645	$3,542,108
Benefits	$8,507,129	$6,635,560	($1,871,568)
Contract Monitoring	$0	$300,000	$300,000
All Other Costs	$14,574,042	$8,549,020	($6,025,022)*
Subtotal - All Expenses (Ongoing)	$40,791,708	**$36,737,225**	($4,054,483)
Licensure		**$2,000**	**2,000**
Profit @ 4%		$1,469,489	$1,469,489
Total	**$40,791,708**	**$38,208,714**	($2,582,994)

*this includes approximately $5 million in FY 19 contracted management support

Other Savings

- **Indirect costs.** As part of receipt of federal funding, including Medicare and Medicaid, each state must identify indirect costs[17]. Based on API's FY19 Medicare cost report, these indirect costs total $1.7 million annually. Examples of these costs include DHSS and other state agency services which provide support to API (i.e., human resources, payroll). These functions would become the responsibility of the private operator and there should be a reduction in workload in the various DHSS agencies that provide support to API, thus generating potential cost savings with the transfer of these duties to a private operator. We did not have access to detailed Statewide Cost Allocation Plan (SWCAP) data to examine the functions included in the $1.7 million and whether any or all of these costs could be reduced; however, DHSS should conduct this examination to identify possible savings from privatizing API.

Full Privatization (Both Profit and Not-for-profit) – Pros and Cons

Full privatization of API includes the following pros and cons:

Pros:

- The State and DHSS would be able to cease operating the hospital and DHSS could focus on working with the API contract operator to "fit in" to the state's behavioral health continuum and DHSS could advocate for using API in its appropriate role and mission.
- Full privatization is estimated to result in a decrease in state general fund expenditures.
- A private contractor would have more flexibility in recruitment and hiring practices and

[17] The U.S. Office of Management and Budget issued OMB Circular A-87 (2 CFR Part 225), which defines allowable expenditures for Federal grants. The circular establishes procedures for recovering both direct and indirect costs of programs. The circular requires that a state wishing to claim indirect costs as charges against federal grants, prepare an annual SWCAP and submit the plan for approval to a designated federal department for review and approval.

might be able to experience more success than API at filling vacant positions.

- A private contractor would not be limited by the State of Alaska's state employee salary structure. Challenges also exist with the classification of clinical positions in the State system.

Cons:

- It may be challenging to find a qualified not-for-profit contract operator given the workforce issues and API's current challenges.
- The state will continue to be responsible to ensure an adequate safety net exists for persons with serious and persistent behavioral health disorders in need of inpatient services, through contract performance management activities.
- Responsibility for patient and staff safety and outcomes will be transferred to a contractor, yet negative outcomes will be perceived to be, at least to some degree, the partial responsibility of the State and DHSS.
- API's supervisors would no longer be eligible to be covered by the supervisory bargaining unit.
- Employees would not be covered by the State's malpractice and workman's compensation programs.
- Should the contract with a private entity need to be terminated, transition to another private contractor or returning to State management and operations, could be disruptive to API operations.

Public Hospital Privatization Efforts: A Review of the Literature

The WICHE Team examined peer-reviewed literature to identify the most up-to-date research analyzing the privatization of state psychiatric hospitals. Unfortunately, the literature specific to the privatization of psychiatric hospitals is limited to non-existent. However, research on the privatization of general hospitals in the U.S. is available and can provide valuable insight into the types of outcomes that could reasonably be expected from the privatization of psychiatric hospitals. Four relevant studies were identified during this literature review and demonstrate that the privatization of publicly operated hospitals offers some benefits in terms of efficiency, quality of workforce, and financial performance. Brief findings from each of the studies are described below; more detail is provided in the full literature review in Appendix B:

- Villa and Kane (2013) conducted a retrospective analysis of 22 public acute care hospitals in California, Florida, and Massachusetts that converted to private operations between 1994 and 2001. This study evaluated changes in hospitals' profitability, efficiency, and productivity within three years of privatization. Their study found the following statistically significant changes in the privatized hospitals included in the study:
    - Operating margins increased significantly (+6.08%). Research suggests this is the result of an increase in revenues from decreased operating costs. Decreased operating costs may be achieved through reducing staff, eliminating unprofitable services, increasing profitable services, and reducing beds. The researchers also noted that the increase in revenue could be due to more aggressive pricing policy,

a strategy privately operated public hospitals may not be able to pursue.

- Non-operating margins decreased significantly (-3.81%). Researchers attribute this to a loss in public subsidies.
- Occupancy rates increased by 4.37%, and average lengths of stay decreased 0.72%.
- Decline in delivery of unprofitable community services

- Ramamonjiarivelo, et al (2016) attempted to build on the Villa and Kane (2013) study to determine whether privatization enhances efficiency and productivity, and to further explore if a for-profit or not-for-profit scenario is associated with higher efficiency and productivity. The researchers analyzed longitudinal data (1997 to 2013) for 435 public hospitals in the U.S, 104 of which privatized during the study period (75 converted to not-for-profit, 29 converted to for-profit).
  - For-profit facilities had higher efficiency in working capital utilizations and the number of FTE employees per occupied bed.
  - For-profit hospitals had higher productivity in terms of increased admissions per FTE.
  - Not-for-profit experienced greater increase in efficiency related to long-term assets utilization and work hours per adjusted patient day.
  - Not-for-profit hospitals were more efficient related to capacity utilization.
  - Researchers concluded that privatization could be considered as a viable strategy to increase productivity and efficiency among struggling public hospitals. However, additional considerations should be made. Privatization to a for-profit scenario results in significant improvement in productivity; however, it does not necessarily result in significant efficiency compared with privatization to a not-for-profit scenario. Hospitals that privatize to not-for-profit tend to focus more on work-hour reduction, while privatized for-profit hospitals tend to focus more on reducing the number of employees and increasing working capital efficiency. This implies that "privatization is not a panacea that can solve all aspects of public hospitals' efficiency [but] is a strategy that can improve some areas but not others."
  - Additional studies are needed to determine how privatization affects patient satisfaction, employee satisfaction, physician satisfaction, pricing on health care services, access to services, and quality of care.
- Ramamonjiarivelo (2014) examined the financial performance of 524 privatized public hospitals in the U.S. between 1997 and 2009. Ramamonjiarivelo found the following:
  - Similar to the Villa and Kane (2013) study, privatization was associated with five percent higher operating margins, and two percent higher total margins than hospitals that remained publicly operated.

  - Hospitals that privatized to a for-profit scenario had an eight percent higher operating margin than those that remained public, and a four percent higher operating margin compared to those that transitioned to a not-for-profit model.
  - Additional research is needed to understand how the hospitals achieved increased margins, and if quality of care changed as a result.
- Ramamonjiarivelo, et al (2017) analyzed the impact of privatization on nurse staffing levels at 436 non-federal, acute care public hospitals between 1997 and 2013. They found that privatization is associated with an increase in FTE registered nurses (RNs); an increase in RNs compared to FTE LPNs; and a decrease in FTE LPNs. The researchers note that "privatized hospitals tend to have more educated nurses than hospitals that remain public," which may be attributed to increased financial resources that result from privatization. They also found that for-profit entities tend to have more educated nurses than their not-for-profit counterparts, concluding that "for-profit, privatized hospitals may use RN staffing as a competitive strategy to increase quality, reduce cost, improve market share," and enhance financial performance

Evaluation Criteria and Scenario #1 - Full Privatization – Profit and Not-for-Profit

Table 11 provides an assessment of this scenario using the evaluation criteria requested by DHSS.

Table 11: "Effective Operation" Evaluation Criteria - Full Privatization – Profit and Not-for-Profit

Evaluation Criteria	Findings
Cost Savings - For Profit	Decrease in state general fund expenditures of $1.2 million (largely due to discontinuation of $5,075,131 in payments for consulting and management of API. (Does not include possible reductions in support services (indirect costs) provided to API by DHSS and valued at $1.7 million annually.) Based on anticipated improved operational effectiveness and efficiencies, and on improved clinical outcomes, the risk of potential litigation is considered low, and therefore not identified as a potential cost.
Cost Savings - Not for Profit	Decrease in state general fund expenditures of $2.6 million (largely due to discontinuation of $5,075,131 in payments for consulting and management of API. (Does not include possible reductions in support services (indirect costs) provided to API by DHSS and valued at $1.7 million annually.) Based on anticipated improved operational effectiveness and efficiencies, and on improved clinical outcomes, the risk of potential litigation is considered low, and therefore not identified as a potential cost.
Quality of Care	Quality of care expected to improve over the current situation, as it is assumed that staff development and competency will improve significantly, as will the culture of safety and the provision of active, trauma focused treatment and effective discharge planning. API will be managed by a firm with a track record of successful inpatient psychiatric operation. Expect to see improvement in key quality indicators or contract should impose sanctions.

Evaluation Criteria	Findings
Access to Care	Contract will require private or not-for-profit provider to admit statutorily required civil and forensic populations over other identified referrals. State will have final say on who is admitted. Ability to restore API to an occupancy rate more quickly than the status quo, thus helping to reduce forensic and civil waitlists.
Administrative Quality Measures	Administrative accountability may increase under this scenario. For example, the CEO would have performance targets to meet. Repeated failure to meet these targets would result in loss of employment and potentially sanctions or loss of contract for operations. A private operator will have experience with an electronic health record, implementation and training staff to use the system. Existing licenses may reduce costs and experience in implementation and training may facilitate the process reducing the time for fully rolling out the new system. However, there may be additional costs including for time to transition to new system (including moving legacy data from the current system)
Workforce	A private third party would assume responsibility for API management and operations, and this would result in dissolution of API's supervisory bargaining unit, because supervisors are precluded from organizing under federal labor law that governs private employers. The third part, successor employer would be entitled to establish the initial terms and conditions of employment, subject to subsequent bargaining. Greater flexibility with staffing patterns, recruitment and other compensation could help reduce number of direct care vacancies, along with the potential for more competitive salaries.

Contract Terms and Conditions

The following requirements, designed to ensure patient safety and care and contractor performance, are typically included in contracts between state agencies and private providers operating inpatient hospitals and other inpatient behavioral health programs.

- API will continue operating as an acute care hospital and must continue to meet obligations from court-ordered commitments (both civil and forensic).
- *Accreditation and Certification*: A private operator of API would be required to maintain compliance with and accreditation, licensing, and certification by all relevant regulatory authorities, including OSHA, the Joint Commission, the Centers for Medicare and Medicaid Services (CMS), and Alaska Health Care and Facilities Licensing. The operator would be required to provide the written results of any federal, state, local government, or private accrediting organization inspections or surveys.
- *Patient Payer Source*: A private operator would be required to assist potentially eligible patients to apply for Medicaid and Medicare to ensure the cost of medical care is covered. A private operator would be prohibited from sending medically indigent and self-pay patients to collections.
- *Medical Records:* The state would retain ownership of patient medical records. The court system, Department of Law attorneys, the Division of Behavioral Health, and the Disability Law Center must have access to the medical records. A private operator would be

expected to deploy its own electronic health record (EHR) system, subject to preapproval of the system by the State. The new EHR system would be required to interface with other systems as deemed necessary (for example, Alaska's Health Information Exchange and the Emergency Department Information Exchange).

- *Insurance Coverage:* A private operator would be required to carry adequate insurance at the rates required for an acute care psychiatric hospital with a forensic unit for the API facility and grounds; medical malpractice insurance; sufficient errors and omissions insurance and general liability insurance; and Workers' Compensation insurance.
- *State Oversight and Access, Performance Review, and Audits*: A private operator would be subject to state oversight. A private operator would be required to submit performance reports to the State based on clinical, operational, and financial measures identified by the State. National state hospital performance measures would be reported to the state for federal reporting, as well as the performance metrics requested by the Western State Psychiatric Hospital Association. The State must have access to the facility at all times and would be permitted unannounced site visits at any time. The State must have access to all private and government audits. The API Governing Body would continue to provide oversight and approval of API operations as required by state and federal regulation and policy.
- *Facility Maintenance and Repair*: Equipment replacements and materials used for maintenance and repair must be of the same or better quality than the materials and equipment replaced and must meet all current hospital level fire and life safety codes.
- *Penalties for Nonperformance, including Contract Termination:* A contract for private operation of API should include performance measures to ensure the contractor focuses on the hospital's success. Basic measures include filling vacant positions within a set number of days and maintaining good standing with The Joint Commission and CMS. Other specific outcome-based performance measures should also be included in the contract.
    - The contract should include the requirement that the contractor develop and submit to the DHSS, for review and approval, a corrective action plan if a measure is not met. In addition, financial penalties for failure to meet basic performance measures (e.g. vacant positions) may be imposed. These penalties could be structured as a percentage reduction in the monthly payment to the contractor until the deficiencies are corrected.
    - State contracts typically allow for unilateral termination with as little as 30-day notice, though contracts for operation of a residential facility or hospital might allow more time. The contactor may also be allowed to unilaterally terminate the contract, typically the notice requirement would be 120 days or longer.

Full Privatization Cost Model – Transition and Implementation

Transitioning from state operation to private operation requires development of a transition plan in partnership with the contract operator. Typically, state staff at the hospital would be notified several months in advance of the transition date. DHSS would require that the private operator meet with each staff member to assess if a position is available for the individual under the new operational structure. Or, DHSS could require that the private operator employ all employees (not in a disciplinary situation due to poor performance). Consideration must be given to communicating and clarifying any relationships between the private operator and the bargaining unit.

API's role in Alaska's Behavioral Health System if the Hospital is Privatized

It's critical that API, if privatized, continue its role as the state's safety net hospital and that the first two priority populations admitted are: 1) patients placed under the civil commitment laws requiring evaluation and treatment; and (2) patients who are criminal defendants requiring evaluation and restoration services prior to standing trial. Numerous stakeholders voiced concerns that a private operator will admit patients who are easier to treat than others. The public behavioral health systems of states have populations that are behaviorally and sometimes medically complex to serve. These patients may have co-occurring substance use needs; medical comorbidities; intellectual disabilities; challenging behaviors; organic disorders, or any combination of these conditions. As a result, they often pose challenges for staff to serve, and may be physically aggressive, resulting in increased patient to staff assaults, and the need for close observation staffing. DHSS will need to clearly articulate the admission and approval criteria for all API referrals, to ensure API has the capacity to serve its target population.

Contract language and robust monitoring of admissions referrals and medical suitability screening by DHSS contract monitors can successfully prevent a private operator from avoiding, and even significantly delaying, admission of individuals appropriate for API admission; while also seeking appropriate alternatives for individuals who are not identified as the target population and unlikely to benefit from inpatient psychiatric treatment. The contract should state that DHSS will have final say on who is admitted to API. This will allow the DHSS to overrule the contract operator in any such situation.

Scenario #2 – State Operations

This option examines whether, and how, it is possible for the State to ***effectively operate*** API if it remains exclusively state-run. As stated in the RFP for this study: "Assumption of future change to laws, regulations, state policies, or other state frameworks currently in place is not an acceptable form of analysis." While this requirement limits options for strengthening the operation of API (e.g., changes to the State's compensation plan, including raising salary ceilings for Registered Nurses and other direct care staff), the State could make some changes at API that would support more effective the hospital performance.

Before considering operational changes to API it is important to understand the mission and historical context to inform the current problems and why change is necessary. The mission of API is *"To provide emergency and court-ordered inpatient psychiatric services in a safe environment using culturally-sensitive, effective, person-centered treatment followed by a referral to an appropriate level of care and support for recovery from mental illness"*.

Responding to concerns with waitlist and timely access to API, in approximately 2011 efforts were made to transition to a shorter-term more acute treatment focus. Additionally, it was thought that would bring the hospital into alignment with the initial Certificate of Need to establish short-term psychiatric inpatient hospitalization for adults with serious mental illness and youth with serious emotional disturbances.

The intent was to also achieve:

- Alignment with healthcare reform to limit long and unnecessary hospitalizations
- Alignment with the state's vision of home and community-based treatment services
- Greater access to available psychiatric inpatient acute care beds
- Support for a recovery-oriented model of care

Objectives included:

- With a staffing effectiveness analysis, provide adequate professional staffing to assure active treatment, admissions and discharges seven days a week;
- Re-align the API admissions to coordinate incoming admissions from rural areas and minimize adults with mental illness pending civil admissions from jail;
- Optimize functionality with the API Electronic Health Record (EHR) demonstrating meaningful use of the system (reducing paperwork and inefficiency in clinical and administrative departments); link basic patient demographic information in AKAIMS.
- Refine the current utilization review and quality improvement management system to meet the needs of an acute care hospital and provide data to Behavioral Health for systems planning;
- Prompt screening and referral of substance induced psychiatric conditions to other treatment resources;
- Complete Quality Improvement plan for forensic population;

- Continue to provide a safety net for exceptional, difficult-to-treat individuals who meet level of care criteria for psychiatric hospitalization; and
- Work in conjunction with the Behavioral Health Emergency Services Steering Committee to make improvements to the gate keeping system for psychiatric urgent/emergent treatment.

It is unclear how well the transition to a short-term acute treatment focus was operationalized within API, however, clearly active treatment was not regularly occurring, although the length-of-stay was reduced. The existence of any evaluation, either formally or informally, on the impact this shift had on the community is unknown, however, several stakeholders identified the need for API to serve individuals requiring a more moderate to longer length-of-stay. This underscores the need to regularly assess the role of API and align its mission within the broader behavioral health system.

Changes in the areas of leadership and performance improvement, and investment in workforce development, along with improving staff and patient culture, would greatly benefit API. Choosing this option will require that the status quo approach to Executive Branch management and oversight of the hospital change. The major changes we suggest to continue state operation of API include: maintaining HR staff onsite at API, which recently began during the period of this study; creation of a staff development office to improve staff competency, skills, confidence, and therefore staff as well as patient safety; and a greater investment in performance improvement and management, described in the performance improvement section of this report.

Leadership

There have been a series of key staff transitions across all areas of hospital leadership, with multiple recruitments and poor retention of key positions, including the CEO, Chief Medical Officer, Chief of Psychiatry, staff psychiatrists, psychology leadership, nursing leadership (including both the Director of Nursing and Unit Nurse Managers), quality assurance, and social work; which inevitably leads to the kinds of problems facing API in recent years. This turnover is typically either due to low pay rates or a challenging, if not toxic, workplace environment. Since staff know their salary when they accept employment, workplace environment and culture may contribute more to turnover and vacancies in state hospitals than low salaries.

Essential roles and responsibilities of hospital leaders are to ensure that the mission, vision, and values of the hospital are clearly articulated, and to inspire staff to move in the same/desired direction, so as to achieve challenging goals by building commitment and enthusiasm in the workforce. Because there has been, and continues to be, such frequent turnover in leadership positions (eight or more CEO's in three years, several new/acting clinical leaders, etc.) none of these roles and responsibilities have been carried out effectively. Thus, the daily operations of API are carried out in a pressurized, crisis-driven environment, where the ability to focus on the overall mission of the hospital is nearly impossible. Simply put, the status quo regarding leadership is unacceptable. API needs to have a stable, qualified leadership team.

It is assumed that under this scenario, API's senior leadership team have the authority and flexibility, within current laws, regulations, state policies, or other state frameworks, to make decisions and manage the hospital in the interest of what is best for the needs of patients and staff. It is also assumed that API and DHSS leadership strengthen their involvement and engagement with the community behavioral health system and broader systems and agencies that interface with API.

Additionally, leadership "above" API need to demonstrate support and commitment to the hospital's success and take an active role in its progress, and outcomes, be they positive or negative. The partners in the hospital's operation need to include the senior leadership of DHSS, any other state agencies involved in providing support services to API, the Governor's Office, and the legislature. While some problems at API may appear "intractable", especially given how long some have been allowed to persist, they should be promptly and openly examined, discussed, and resolved with the active participation of all key parties. API needs to be recognized as a unique element of state government, and exceptions may need to be made to support its operation so that it may function more effectively and produce positive patient outcomes and financial performance, however the initial step should be to engage key parties to determine problems/issues that can be addressed through alignment versus exception.
Several stakeholders point to the lack of "specialized" administrative focus to support the operation of a specialty hospital, including:

- Centralized procurement through State Administration Services, that does not support rapid response to hospital needs ("nurses bring spoons from home, because of procurement delays.");
- EHR planning, design, implementation, updating, and maintenance delays
- Physical plant upgrades for suicide mitigation delays;
- HR staff with the capacity to assist with rapid recruitment of essential staff;
- Labor agreement designed and operationalized to meet a hospital workforce and demands; and
- Capacity to terminate staff with substantiated findings of patient abuse and/or neglect.

The API CEO needs the authority and resources to promptly resolve these types of administrative issues that directly impact patient care and outcomes (e.g., suicide mitigation of the physical plant). The unions have stated their willingness to work with API leadership to clarify expectations and processes, and to help resolve issues when possible.

Legal Considerations

In many state hospitals that have successfully addressed the same/similar problems seen at API, the process of problem identification, prioritization, and resolution has required a positive, collaborative relationship between hospital and union leaders. But, in the current state at API, the relationship is, and has historically been, the opposite. Many serious problems are attributed by hospital leaders to the requirements of the Unions' collective bargaining agreement (CBA),

along with an assertion that the Unions are unwilling to work with leadership to modify the CBA. However, in our discussions with Union leaders, they have clearly described their desire to form a collaborative relationship, to be part of a problem-solution process, even to the point of modifying the CBA if necessary.

Under the continued State Operations Scenario, API's labor obligations with the existing CBAs would not change. However, it is necessary for the hospital leadership to develop a better, more collaborative relationship with Union leadership. The current state is untenable and impacts patient and staff safety and patient treatment. Mediation with the Union and API leadership is recommended to enhance communication and clarify the protocols to improve the outcomes for all parties.

Additionally, if mediation efforts do not lead to desired results, there are potential opportunities to enhance operational efficiencies such as by negotiating a CBA supplemental agreement with specific terms and conditions to address the workforce recruitment and retention issues.

Alternately, the State could consider exempting some of the API employees from State labor law, relieving its obligation to have a supervisory union, through the legislative process. Regardless, the State needs to address the historical and current staffing challenges that reduce the availability of inpatient psychiatric beds, which provide a safety net for Alaskans with behavioral health and related disorders.

The API Governing Body would also likely need to be granted the authority and responsibility to exercise oversight authority to meet the Conditions of Participation ("COP") established by the Centers for Medicare & Medicaid Services ("CMS"). 42 C.F.R. § 482.12; CMS State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.[18] CMS COPs require the governing body to be ultimately responsible to ensure that the hospital meets all COPs. For example, the governing body duties include (a) appointing the chief executive officer to manage the hospital; (b) participating in the development of an institutional plan and budget; (c) determining which categories of practitioners are eligible for appointment to the medical staff; (d) approving medical staff bylaws; (e) exercising oversight along with the medical staff of the practitioners granted privileges at the hospital and determining which practitioners should be granted privileges; and (f) overseeing the quality of care provided at the facility. 42 C.F.R. § 482.12(a). State licensing rules contain similar governing body requirements. 7 AAC 12.630. The API Governing Body would also be responsible for ensuring that the contractor's services permit the hospital to comply with all COPs. 42 C.F.R. § 482.12(e). Granting the Governing Body this authority would require significant system changes including procurement, HR, and other changes.

[18] CMS guidelines state that in "the absence of an organized governing body, there must be written documentation that identifies the individual or individuals that are legally responsible for the conduct of the hospital operations." CMS State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, § 482.12 (Oct. 12, 2018).

Patient Rights and Abuse Investigations

Currently, serious incidents, including allegations of abuse and neglect, are investigated internally by API staff. Within 24 hours of the initial report, these staff determine whether an investigation is warranted (e.g., by reviewing video, or by determining whether the allegation is related to psychiatric symptomatology). If an investigation is warranted, it begins within 72 hours and is finished within 30 days, usually, the accused employee is reassigned until the investigation is completed. During this process, the DHSS licensing staff are notified of the investigation and determine their level of engagement, which can range from a review of the findings to conducting an independent review/investigation. Having these investigations completed by API staff (objectivity can be questionable), who may or may not be specifically trained, and who may well have other duties to perform could be problematic. However, having the additional support of the DHSS licensing staff to assist with these reviews helps to mitigate this concern.

Population Served

In the current state, API has clearly become, as several stakeholders described, a "catch all" hospital. Several patients, now and in the immediate past, are acknowledged to be inappropriate for the care and treatment that API is designed to provide. Specifically, this includes patients with dementia, traumatic brain injuries, autism, drug/alcohol addiction, and significantly violent behavior.

Such patients have care and treatment needs that API is unable to provide (i.e., they have no training and competency in these areas, so these patients are often just 'contained' at API until their situation changes or another alternative presents), and their presence on the units, mixed in with patients who are appropriate for API, creates a chaotic environment there. These are inappropriate admissions. Alaska needs to develop a system of care that obviates the need for so many people to be admitted to API simply because, as many stakeholders advised, there are no alternatives in the community.

Provision of Active Treatment

In the current state, meaningful appropriate treatment planning cannot be accomplished, in large part because there is an inadequate number of clinicians, inadequate training, and daily crises. Thus, the provision of recovery-oriented, trauma-informed, discharge-focused care and treatment is not possible. During our recent tour of API, similar to previous tours, we noted only one patient receiving treatment on a treatment mall, and little-to-no interaction between staff and patients on the units (including with patients on 1-to-1 supervision). In short, active treatment was nowhere to be seen. Individuals needing inpatient psychiatric treatment should receive active individualized treatment seven days per week, including days and evenings, during their stay at API. Void a structured milieu with active treatment, the risk of behavioral issues increases, which may result in seclusion and restrain episodes, along with an increased risk for patient and staff injuries.

The absence of active treatment also results in poor discharge planning, since patients receive no/little programming and support related to the transition back to community life. Thus, it is not surprising to note such a high readmission rate at API. High readmission rates are regarded by CMS as being associated with poor quality of and suboptimal care.

In summary, the current state of API's provision of active treatment is unacceptable.

Physical Environment

The current unit environment is significantly problematic, especially since a very high number of ligature risks are present, despite the fact that these have been identified by API staff and cited and by The Joint Commission and CMS surveyors. In combination with too-few and undertrained staff, the presence of these ligature points and no sense of urgency to resolve them, poses a significant risk to patient safety.

Beyond this, our tours of API units revealed problems with the general appearance of the unit. Routine maintenance work orders take too long to address (possibly an indication of too-few maintenance staff, competing priorities, or staff not proactively identifying maintenance needs. For example, there are large patches of spackled areas on many corridor walls, where handrails were removed months ago, that remain unpainted. The units where patients reside need to be clean, well-lit, and a positive contribution to care and treatment being provided in a safe and therapeutic environment. Such is not the case at API.
Efforts should be made to make API a welcoming therapeutic environment and well-maintained treatment facility.

Performance Improvement

In the current state, performance improvement processes at API are in a very early stage of development and enhancement, with the hire of a new Director of Quality Assurance and Performance Improvement. API has inadequate processes for the creation of reliable data, on which solutions must be based and priorities can be established. In the absence of reliable data, there can be no reliable understanding as to a problem's cause(s), and so proposed corrective actions often fail. Successful performance improvement efforts, as seen in many successful state hospitals, rely on the inclusion of many relevant stakeholders (staff, patients, families, advocates, etc.), but no such process exists currently at API. While this may be able to occur incrementally over time with existing staff resources dedicated to performance improvement and management efforts, given the breadth and duration of multiple complex issues that have hindered API's performance for many years, a performance improvement and management transformation is recommended.

To support the effective operations of API, this scenario includes an increase and investment in performance improvement staff from 6 FTE to 10 FTE, including 2 Performance Management Leader positions, supported by an additional data analysist and Standards Compliance Officer. Given the relatively high number of general and nursing administration positions at API, as

compared with other similar-sized hospitals, it is suggested that current vacancies and/or other positions be considered for re-assignment and/or re-classification to focus on QAPI activities, as this is a priority for the effective operations of API.

With these resources in place, API would implement and embark upon a performance management transformation of the hospital. One well-accepted model for this is to implement Lean Six Sigma training. This training can occur onsite for approximately $25,000 to $50,000 and offers a set of performance improvement skills tools that allow for rapid process improvement and the relentless pursuit of waste elimination. Onsite consultation beyond the training could increase the investment cost to approximately $100,000 to $200,000 depending on the level of involvement, is recommended for the first year to facilitate the roll-out of performance improvement.

A case study example of a state psychiatric hospital transformation, aided in large part by Lean Performance Improvement, exists with the Oregon State Hospital (OSH). In 2008 the United States Department of Justice found that OSH violated patient civil rights, specifically, they found the hospital failed to protect patients from harm, provide adequate medical care, conducted inappropriate use of seclusion and restraint, provided inadequate nursing care, and failed to provide adequate discharge planning.

As a result of these problems, the state and OSH decided to radically transform the operation of OSH. They started this process in 2010, with the use of a Lean consulting firm to orient and train all hospital staff to Lean principles. It is important for all staff to be trained as engagement in performance improvement efforts is the responsibility of everyone and needs to be supported by the Unions and the collective bargaining agreements. The following year, OSH created an Office of Performance Improvement and hired several Lean leaders. Since then, the number of Lean staff has grown as Lean changes have resulted in positive outcomes for patients and staff. The former OSH Administrator, Greg Roberts, indicates that many long-standing serious problems were successfully resolved using Lean. In all cases, better performance, and, in many cases, cost savings (and/or revenue enhancement) occurred. As a result of Lean, the hospital had fewer assaults, less seclusion/restraint, fewer patient and staff injuries, fewer injury claims, fewer lost workdays, and lower overtime costs.

In other examples, OSH developed innovative schedules for direct care, security, food service, and housekeeping staff that helped the hospital eliminate mandatory overtime, helped reduce overtime in general, reduced sick calls, and helped do a lot of training without relying on overtime. Half of the staff worked Monday thru Friday (they had every weekend off), the other half worked three 13-hour and 20-minute shifts on Friday-Saturday-Sunday or Saturday-Sunday-Monday). In all of the areas, OSH eliminated an entire weekend shift, and thus lots significant use of overtime.

Staffing

The current state of API's staffing is significantly problematic, including an inability to hire qualified staff, to compensate staff at competitive salaries, to retain staff at all levels, and to adequately provide training to ensure a competent workforce, especially for the direct care staff. Currently, salaries are not competitive, making not only recruitment very difficult, but also retention, as staff leave API for higher salaries in analogous positions in the community. Retention is currently problematic, not only because of non-competitive salaries, but also because the working conditions at API are so difficult, especially regarding worker safety, which is at least in part related to staff training and competency, along with the workplace culture.

These problems have led to the current situation, where API is operating at about 40-60% of its full capacity. Several units, including the child/adolescent unit, are vacant, leading to an inability to admit people in desperate need of API's services. As a result, some individuals with civil commitments are now held, without any treatment, in jails, and others are sent to remote States for treatment, separating them from their families and communities.

Human Resources (HR)

Based on the serious problems we learned about regarding hiring, retention, and labor relations; we placement of these functions that have recently been placed at API with the support of 2 dedicated API HR FTEs. Direct, onsite responsibility and customer service for API should strengthen all HR functions. Many stakeholders interviewed stated that the process of posting and filling positions does not support rapid and effective response to staff shortages. The ability to make timely offers to selected candidates can take weeks to months, the latter likely if the selected applicant is argued to deserve a salary above a set threshold. In a privately-operated hospital, this decision would most likely be made in a matter of days, in time to hire the candidate before s/he becomes discouraged and accepts another offer. Additionally, the HR staff should oversee the timeliness and completeness of staff performance evaluations. This was an issue identified by several stakeholders and was cited as a contributing factor in addressing disciplinary issues.

Staff Development

Perhaps the most important consideration for moving API in the necessary direction, providing patient-centered, recovery-focused, trauma informed care and treatment in a safe and therapeutic environment, is the need to address the issue of staff training and demonstrated competency. Training at API is currently inadequate and does not lead to demonstrated competency. The lack of adequate training regarding recovery principles and trauma-informed care, especially for the direct care staff, is likely to result in the observed overreliance on the use of seclusion and restraint, which must be regarded as treatment failures and jeopardizes patient and staff safety. The seclusion and restraint data shared in this report, clearly illustrate that the use of these restrictive interventions tends to be higher at API than the comparison Western and psychiatric hospitals.

In order to be effective, an adequate number of qualified staff must be available to provide the necessary training and post-training supervision, to all staff primarily on day and evening shifts.

Some of these staff would work as unit coaches/mentors to ensure (or at least increase the likelihood) that classroom training results in demonstrated competency in the real world of the unit. Classroom instruction is necessary, of course, but is usually ineffective unless it's coupled afterward with coaching/mentoring in the live environment. The addition of these positions at the OSH resulted in fewer assaults, less seclusion/restraint, fewer patient and staff injuries, fewer injury claims, fewer lost workdays, lower overtime.

Staffing for a more effective staff development unit at API would include includes the following current API staff:

- 1 FTE Director, Staff Development
- 2 FTE Trainers
- Administrative Assistant

Additionally, the following positions are recommended to support more effective training and staff competency:

- 4 FTE Trainers/coaches/mentors

Staffing Needs in Other API Departments

We reviewed the FY20 targeted staffing detail provided by DHSS (Appendix A) for other needs to improve the continued operation of API and do not have any additional adjustments to FTE.

Accreditation, Certification and Licensure

API is licensed as a hospital by DHSS, accredited by the Joint Commission and certified by CMS. As with many hospitals, the Joint Commission's hospital accreditation is deemed by CMS, therefore indicating the accredited hospitals are thereby also certified by CMS; given the alignment of the Joint Commission Elements of Performance to the CMS Conditions of Participation. Given the number and complexity of the problems described in this report, it is evident that API is at risk of receiving a 'provisional' license, which occurred in 2018, or losing its Alaska hospital license, Joint Commission accreditation, and/or CMS certification. Simply stated, there is no consistent evidence that API can maintain substantial compliance with the applicable requirements and standards. API achieved full compliance on December 27, 2019. This success was preceded by achieving full compliance on July 29, 2019, but a new termination date was imposed several weeks later. Losing CMS certification would result in the inability bill and seek reimbursement from CMS; however, losing Joint Commission accreditation would not impact revenue.

In comparison to US psychiatric hospitals, API has underperformed in such measures as seclusion and restraint use, provision of brief intervention and treatment of substance abuse disorders,

and transition records. As CMS considers shifting to a pay-per-performance model, such low performance puts API at risk of losing a portion of its current reimbursement rate.

Olmstead

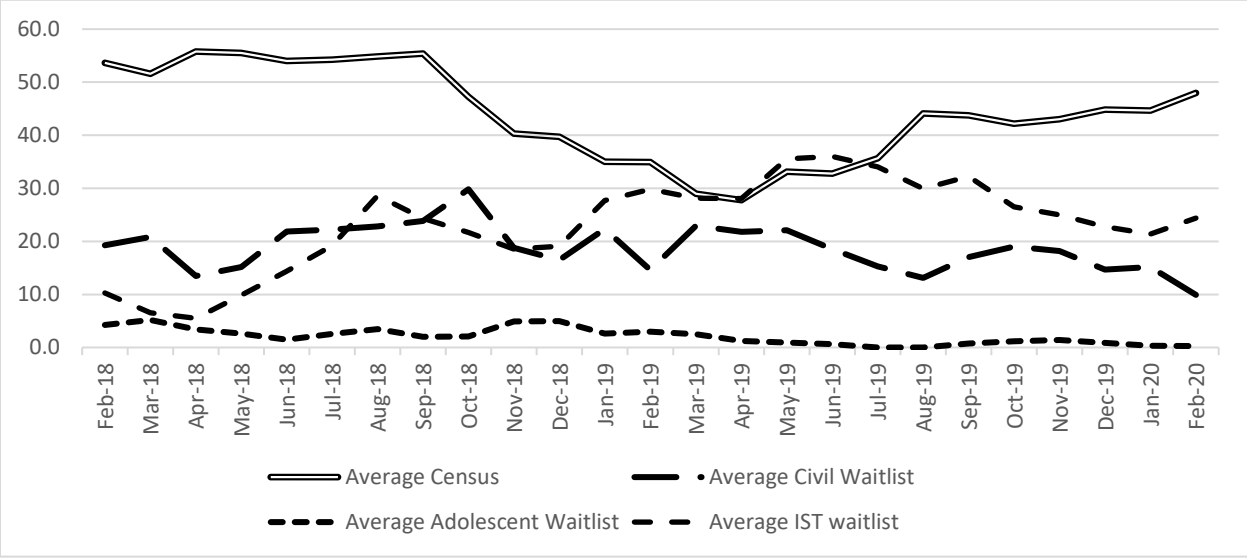
In the current operational state, API risks being found to be in violation of several important federal laws, including the Civil Rights of Institutionalized Person ACT (CRIPA) the Americans with Disabilities ACT (ADA), specifically regarding the US Supreme Court's 1999 Olmstead decision.

On average, between February 2018 and February 2020 an average of 18.8 people were on the API waitlist for civil admission (Table 12). During the same time frame, an average of 2.1 adolescents were on the waitlist for admission to API. There was an average of 23.2 people on the incompetent to stand trial waitlist for admission to API. An average of 41 people were on the waitlist during this time frame for forensic admission. Figure 32 shows the average number of people on waitlists for admission to API by civil, adolescent, and incompetent to stand trial waitlists. The forensic waitlist includes all people who have an order for an evaluation of competency to stand trial and are waiting for evaluation outside of API (DOC or in the community). The incompetent to stand trial waitlist includes people who have been evaluated and found incompetent to stand trial and are then placed on a waitlist to be admitted to API's forensic unit for restoration of competency.

Table 12: API Waitlist data February 2018 to February 2020

	Forensic (order date to evaluation date)	Civil	Adolescent	Incompetent to Stand Trial (evaluation to admission)
Average Number of People on Waitlist	41	19	2	23
Average Wait Time (days)	40	10	14	74

Figure 32: Average Number of People on the Waitlist for Admission to API



Olmstead Risks

Title II of the Americans with Disabilities Act (ADA), commonly referred to as the Integration Mandate or *Olmstead*, mandates that individuals with disabilities are entitled to receive services and live in the most integrated settings appropriate for their care. Entities that receive public funding can be found in violation of *Olmstead* by failing to provide services in the most appropriate, most integrated setting. Entities that receive public funding can be found in violation of *Olmstead* by failing to provide services in the most appropriate, most integrated setting. While initial Olmstead cases focused on clients residing in psychiatric hospitals, many of the recent Olmstead cases have focused on whether states are providing an adequate array of community-based services to individuals at risk of institutionalization to avoid unnecessary hospitalization.

Should Alaska continue operating API as it has in the past, the State is exposing itself to a potential Olmstead lawsuit. If faced with an Olmstead violation, and a Settlement Agreement is reached, Alaska will – at minimum – be required to pay for the cost of an independent court monitor once a settlement agreement or consent decree is reached. Based on other states' experiences, this expense may range between $175,000 to $300,000 per year. The total amount allocated to a court monitor will depend upon the length of the Settlement Agreement.

Depending on who the litigating party is, Alaska may also be faced with covering the cost of the Plaintiff's legal expenses. Based on prior Olmstead lawsuits, if the U.S. brings the charges, then the Department of Justice will likely bear its own legal costs. However, if an individual party represented by a private attorney (e.g., state Protection and Advocacy Attorney) files suit, the state may then be liable to cover the Plaintiff's legal fees as well as its own. Based on other states' experiences, this can range from $800,000 (New Jersey) to more than $2.2 million (and counting; Illinois).

Systems improvements required by Olmstead Settlement Agreements also require a significant investment by the state. Our research shows that states have invested between $30 million (New Hampshire) and $362 million (Illinois) to make the improvements required under Olmstead Settlement Agreements. The smallest amount identified, from a small state that wishes to remain anonymous, is $20 million for the expansion of community-based programs. These investments cover the cost of transitioning individuals out of institutional settings into the community, and the cost of services and supports required to ensure a successful transition. Illinois has budgeted more than $362 million over seven years to improve its system based on the findings of Williams v. Quinn.

While not common, states may also be required to pay penalties for non-compliance. Washington State accrued $83.4 million in fines from October of 2017 through 2018 for non-compliance under its Trueblood Settlement Agreement. This fine resulted from penalties of $750 per person, per day for individuals waiting beyond 14 days to receive competency evaluations[19]. Another example from South Carolina is a case pending in the U.S. District Court charging the Plaintiffs fees of $500 per day for unnecessary and unjustified hospitalization, typically due to an inability to access appropriate community mental health supports [20].

The variation in amounts spent by states for legal fees is dependent upon multiple factors, including the length of time a state spends in litigation, whether the case is settled quickly or goes to trial, and the strength of the state's negotiating position. In addition, the amount spent to make improvements to the behavioral health system is also dependent upon the quality and amount of infrastructure the state already has in place. To summarize what Alaska may expect in terms of expenses should it be faced with an Olmstead lawsuit for access to API and/or the quality of care provided at API, the range of typical legal expenses identified through the WICHE Project Team's research are listed in the Table 13.

[19] https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2019Trueblood/679_1_ExhibitA_FinalPlan.pdf
[20] http://www.bazelon.org/awvmagill/

Table 13: Possible Legal Fees

Expense	Minimum	Maximum	Comments
Plaintiff's Fees	$0	$2.4 million	Amount dependent on filing party. If DOJ files suit, the U.S. typically bears the cost of its own legal fees (based on these examples).
Independent Reviewer/ Court Monitor	$25,000 plus expenses *annually*	$350,000 *annually*	Total dependent upon length of Settlement Agreement/time to remedy. Shortest identified is five years.
Penalty Fines – Civil	$0	$500/person/day**	Fees imposed of $500 per day for unnecessary and unjustified hospitalization.
Penalty Fines- Forensic	$0	$19,568.18 $750/person/day	Fines imposed for individuals waiting beyond 14 days to receive competency evaluations. Data from API waitlist between 2/2018 and 2/2020 (average number of days/month over 14 days *$750)
Total	**$125,000+**	**$4,150,000**	Assuming the ***least*** amount of time to reach compliance (5 years). Does not account for any potential penalties for delayed compliance or failure to comply, or for any of the expenses associated with system improvements.

**API data not available

While not directly Olmstead-related, API has incurred increasing legal fees (Table 14). Between CY2015 and CY2019 there has been a 61% increase from $193,292.26 in 2015 to $310,544.66 in 2019. There was a 37% increase in legal fees between 2018 and 2019.

Table 14: Total Legal Fees from CY15 to CY19

Calendar Year	Total Legal Fees
2015	$193,292.26
2016	$154,828.26
2017	$151,821.00
2018	$226,909.80
2019	$310,544.66

Additionally, more information about Olmstead cases, including those that are more relevant to Alaska can be found in Appendix E.

State Operations Cost Model

Per 7 AAC 12.615(k) - (k) A facility that the state owns and operates is exempt from paying a fee set out in this section, so there will be no fee for licensure.

Cost and Staffing Analysis

The current cost and staffing ratios were analyzed using data provided by Alaska, specifically for this report, for the first day of each quarter for FY 2018, 2019, and the first half of FY20. This point-in-time analysis differs from other data sets presented in this report as it is more granular and comparison data for other hospitals is not available.

Due to fluctuating patient census, there was some variation in cost per patient per day. The lowest cost was in October 1, 2017, when there were 70 patients in the hospital resulting in a cost per patient per day of $861.98. The highest cost was April 1, 2019 with a census of 21 resulting in a cost of $2,833.47. The average cost per patient per day for FY18 was $1,053, for FY19 $1,806, and for the first two quarters of FY20 $1,608. Staffing ratio analysis followed a similar pattern with a low staff to patient ratio of 2.9 on October 1, 2017 and a high ratio of 11.7 on April 1, 2019. The average staff to patient ration for FY18 was 3.4, for FY19 6.7, and for the first two quarters of FY20 6.0. The varying census drives the cost per patient per day and the staff to patient ratio. Stabilizing the census will help to create consistency in these two measures which may help API to better manage costs. See Table 2 for additional details.

Administrative Efficiencies

We estimate a 5% reduction (or $309,815) in administration and general expenses (CMS General Services costs) expenses based on a comparison of these costs per day between other state, private, and not-for-profit inpatient psychiatric hospitals. This amount represents one-half of the savings assumption included in Scenario #1 and should be relatively easy to obtain given the assumption that API commits to process improvement and management as a central tenet of the hospital's operation. Opportunities for efficiency and cost savings will emerge over time, as the hospital conducts process improvement events and identifies waste. We do not expect that filled positions would be eliminated or that staff would be laid off. Instead, we assume vacant positions will be eliminated and operating costs will be reduced to achieve these savings.

Summary

In summary, the effectiveness of operations at API could be enhanced with an investment in mediation with the Unions, workforce development, and a sustained focus on performance improvement and management. Without these investments, the quality of patient care and outcomes will continue to be in jeopardy, risking suspension of licensure, CMS certification and Joint Commission Accreditation. Additionally, the risk of potential litigation for violation of *Olmstead* will remain.

Table 15 summarizes the cost adjustments to the API budget required to implement this scenario. This represents an increase of $342,289 over FY19 actuals.

Table 15: Scenario 2 - Continued State Operations Costs

API Department	Annual Cost / (Savings)	FTE Change
Staff Development	$402,104	4.0
Administrative Efficiency Savings	($309,815)	
Process Improvement Training and Consulting (One-time Cost)	$250,000	
Total	**$342,289**	**4.0**

Enhanced State Operations Pros and Cons:

Enhanced state operation of API includes the following pros and cons:

Pros:

- With significant commitment of leadership and the reallocation of some staff resources in addition to four (4) additional FTE to support performance management transformation, API could become an effective public psychiatric hospital.
- As API's performance improves and a positive work culture develops, it is expected that more employment candidates would accept employment offers from API and staff retention would improve.
- The state and DHSS would avoid the disruption and delays (e.g., litigation) that might occur from a decision to privatize API.
- While this scenario suggests an increase in funding, this investment will gain efficiencies and improvements to API's operation, which may result in reductions in expenditures, given time, while improving patient treatment outcomes.

Cons:

- Improving API would require investing more financial resources to support effective operations, the sustained engagement of DHSS leadership and a commitment to engage community partners to support the state behavioral health system.
- It may be difficult for DHSS leadership to give API the time and attention required to implement this scenario, given other competing demands.
- Given the long-standing concerns about API expressed by many stakeholders, it may be challenging to get support for giving API a 'fresh start' to begin changing public perceptions.

Evaluation of the Scenario Based On "Effective Operation" Evaluation Criteria

Table 16 provides an assessment of the "Continued State Operations Scenario" using the evaluation criteria included in the RFP.

Table 16: "Effective Operation" Evaluation Criteria - Continued State Operations

Evaluation Criteria	Findings
Cost Savings	Investment of four (4) FTE, $342,289 in workforce training, development and competencies coupled with efforts to improve operational effectiveness through process improvement and management transformation activities. Assumes administrative efficiencies are identified and litigation risks are reduced result in budgetary savings and/or cost avoidance.
Quality of Care	Patient outcomes and quality of care will improve, with time it will equal or exceed the quality of care provided by a private or not-for-profit operator, given a commitment to process improvement, additional performance improvement and staff development resources.
Access to Care	Continued state operation should not impact to access to care. Ability to restore API to an occupancy rate more quickly than the status quo, thus helping to reduce forensic and civil waitlists. Also assumes that process improvement projects will reduce civil and forensic length of stay and thus reduce admission waiting times in hospitals and jails.
Administrative Quality Measures	Process improvement, including rapid cycle quality improvement efforts, will increase administrative quality as projects identify and remove waste from current administrative processes. Updating or changing the electronic health record system would incur significant cost for the purchase of the system, any customization, and training staff. Additional costs (staff time) would come from staff training and the migration of legacy data.
Workforce	Additional staff development resources will provide staff with the training, improved competency and ongoing support needed to function effectively. This will result in reduced turnover and vacancy rate as API becomes a safe, rewarding place to work. Mediation efforts with API leadership and the Unions to clarify processes and improve communications will help expedite personnel actions and improve overall staffing efficiency and effectiveness.

The GGU CBA shows that effective July 1, 2020 the employer contribution will be $1,555, representing a $25 increase from the current rate of $1,530. The same agreement shows a 1% cost of living increase in wages, effective July 1, 2020 over the FY20 rate. These increases should be considered in the FY21 budget.

Scenario #3: Public Corporation

This option examines the creation of a not-for-profit, public corporation, or public authority, to operate API with State supervision. In an effort to create an organizational structure that is more flexible and nimbler and yet still ensures accountability to the public, stakeholders, patients and families, several Alaska behavioral health experts have suggested that API become a not-for-profit, public benefit corporation.

Scenario Description

A public authority could oversee changes in the areas of leadership and performance improvement, and investment in workforce development, along with improving staff and patient culture. The authority could also implement the specific changes included in Scenario #2: by maintaining HR staff onsite at API; creation of a staff development office to improve staff skills, confidence, and thus staff safety; and a creation of a performance improvement office to manage and support the hospital's implementation of process improvement skills and projects. Operation under a public corporation would provide API with the dedicated management resources, including a governing board, a public authority staff, and a CEO. As the authority would be a newly formed entity, creating a culture and management approach within the public corporation and the CEO as described in Scenario #2 should be more realistic than expecting an existing state agency to "redefine" API and successfully implement the necessary changes to support more effective and efficient operations described in Scenario #2.

Key Elements of a Public Corporation

To succeed, a public corporation should:

- Have a governing board to ensure accountability to the public and stakeholders.
- Have an advisory structure to ensure input from key constituencies.
- Have control over its budget (revenue and costs) and be able to use excess revenues created through efficiencies to create, improve or modify services and programs within the psychiatric center that lead to better patient outcomes.
- Be mandated (through regulation and policies and procedures) to conduct its business in an open and transparent manner.
- Use data to make decisions through the use of clearly defined internal and external reporting expectations and mechanisms. These expectations should be articulated in regulation and policies and procedures as well.
- Focus on the role API plays in the broader system of care. API cannot conduct its business in isolation from the community-based system.

Examples of Similar Entities

In Alaska there are numerous examples of such entities throughout the country i.e. airports, public transportation, energy, public services, etc. Both the Alaska Railroad Corporation and

Alaska Housing Finance Corporation are examples of public authorities. With API, however the agency that mostly closely resembles a model the State of Alaska might emulate would be the Alaska Mental Health Trust Authority.

The Trust (as it is commonly referred to) has a similar mission to API. To ensure the health and wellbeing of those Alaskans (beneficiaries) experiencing a serious mental illness, chronic alcoholism (or serious substance use disorder), a developmental or intellectual disability and/or Alzheimer's Disease or dementia. In recent years they have also focused on individuals with traumatic brain injury. Populations that have all found their way to API. The Trust is subject to administrative and legislative oversight but is able to undertake activities to meet their mission with fewer constraints than those in State government.

The Trust is governed by a seven-member Board of Trustees appointed by the Governor. The history of those appointed to the Board invariably represent a broad spectrum of the Alaska population that includes: Republicans, Democrats, urban, rural, Alaska Native, young, old, previous patients, family members, professionals, representatives from local governments, service providers, the court system, etc. The Board of Trustees has responsibility (and authority) for hiring (specifically the CEO); creating and following a budget; ensuring there is a high functioning, responsive and efficient management team and structure; developing policies and procedures; articulating and having significant influence over the array of and location of services. In addition to the Board of Trustees, the Trust has an extensive advisory board structure. The Mental Health Board/Advisory Board on Alcoholism and Drug Abuse; the Governor's Council on Disabilities, the Commission on Aging and the Alaska Brain Injury Network all provide input and guidance to the work of the Trust and the State of Alaska so that their "beneficiaries" receive the services they need that will lead to the best outcomes.

Examples of public corporations in other states include: three county-based Health Corporations in New York (Nassau, Erie & West Chester) all of which provide MH services including inpatient within a broader Health Corporation. Additionally, Hawaii Health Systems Corporation operates five regional health systems that may provide psychiatric services but has a larger healthcare focus.

If the State chose to form a public authority to oversee and manage API, it is suggested that a public corporation could operate API with a similar structure as that of The Trust.

Legal Considerations

Scenario 3 contemplates creation of a separate public corporation under State supervision to operate or provide services to the facility. The Legislature would need to enact legislation to create a new public corporation. If the Department determined that its Division would retain

the license to operate the facility, see discussion below, the legislation could authorize the public corporation to contract with the Division to provide staff and services necessary for operation of the facility. Alternatively, if the Department determined that the public corporation should hold the license to operate the facility, the Legislature could state expressly in its implementing statute that the facility will be considered to be "state-operated" for purposes of AS 47.30.760 and AS 47.30.800 or, alternatively, could amend AS 47.30.760 and AS 47.30.800 to make clear that mental health treatment will be at a hospital operated by the Department or the public corporation at all times for individuals who have been involuntarily committed on an inpatient basis.

2. The Department's Contemplated Contractual Relationship Could Be Structured to Comply with Alaska Licensing Rules and CMS Conditions of Participation.

The Department's RFP states that whatever model is proposed, the Department intends to retain (a) ownership of patient medical records and (b) ultimate control, oversight, and approval over operations through the API governing body. Absent a statutory change, the only way for the Department to achieve both objectives would be for the API to continue to hold the license to operate the facility as a Division of the Department. API would continue to be the licensee and delegate all or certain staffing and services to a private or public corporation.

This delegation could take the form of a support services agreement whereby the contractor agrees to provide the full or partial range of staff and services necessary to operate the facility. The support services agreement would need to meet the requirements of 7 AAC 12.910(c):

(1) specify the respective functions and responsibilities of the contractor and the facility, and the frequency of onsite consultation by the contractor;
(2) identify the type and frequency of services to be furnished;
(3) specify the qualifications of the personnel providing services;
(4) require documentation that services are provided in accordance with the agreement;
(5) specify how and when communication will occur between the facility and the contractor;
(6) specify the manner in which the care or services will be controlled, coordinated, supervised, and evaluated by the facility;
(7) identify the procedures for payment for services furnished under the contract; and
(8) include the current license or registration number of the contractor, if required by state statute or regulation.

Under this type of agreement, the Department's API Division would retain the license and ultimate responsibility for the operation of the facility as the license holder. The API Division

would also be the owner of all facility records, including patient records, and would have oversight responsibility through its Governing Body.

The API Governing Body would also likely need to retain the responsibility to exercise oversight authority to meet the Conditions of Participation ("COP") established by the Centers for Medicare & Medicaid Services ("CMS"). 42 C.F.R. § 482.12; CMS State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.[21] CMS COPs require the governing body to be ultimately responsible to ensure that the hospital meets all COPs. For example, the governing body duties include (a) appointing the chief executive officer to manage the hospital; (b) participating in the development of an institutional plan and budget; (c) determining which categories of practitioners are eligible for appointment to the medical staff; (d) approving medical staff bylaws; (e) exercising oversight along with the medical staff of the practitioners granted privileges at the hospital and determining which practitioners should be granted privileges; and (f) overseeing the quality of care provided at the facility. 42 C.F.R. § 482.12(a). State licensing rules contain similar governing body requirements. 7 AAC 12.630. The API Governing Body would also be responsible for ensuring that the contractor's services permit the hospital to comply with all COPs. 42 C.F.R. § 482.12(e).

- Under Scenario 3, where API staff and management are transferred to a public corporation, the public corporation's employees would remain employees of the State. Accordingly, Alaska State labor law would apply, permitting API's supervisors to remain unionized. Whether the public corporation would be required to adopt the existing CBAs or recognize the unions is, like the private third party in Scenario 1, largely dependent on whether it promises employment to or otherwise hires a majority of its workforce from the predecessor.

Under any scenario in which the new employer adopts, or the State maintains, the terms and conditions of the existing CBAs, the employer could attempt to bargain a supplemental CBA that appropriately addresses the unique workforce issues that arise in a psychiatric hospital setting. This could be done at any time, including but not limited to upon expiration of the current CBAs. Where the State transfers management of at least some part of the workforce to another employer, existing CBAs require the State to provide the unions 30 days' notice and the option to submit an alternative plan before releasing any bids. *See* CBA between the State of Alaska and the Alaska Public Employees Association (supervisory unit), Art. 6.01 C.1; CBA between State of Alaska and the Alaska State Employees Association, American Federation of State, County, and Municipal Employees, Local 52, Art. 13.01. The State is not obligated to adopt the union's plan. If the State's action displaces bargaining unit members, the State must make a good-faith effort to place those employees elsewhere in State government, with the following order of priority: (1) within the division; (2) within the department; or (3) within State service generally.

[21] CMS guidelines state that in "the absence of an organized governing body, there must be written documentation that identifies the individual or individuals that are legally responsible for the conduct of the hospital operations." CMS State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, § 482.12 (Oct. 12, 2018).

Finally, under Scenario 3, where API's employees remain public, the State has the option to enact legislation that exempts certain public employees (such as API supervisors) from its State labor laws, thereby eliminating their eligibility to participate in union activities and reducing the number of unionized employees at API. This of course would provoke intense lobbying and pressure from Alaska's unions in opposition and likely generate significant media attention.

Immunity and Indemnification

In establishing a public corporation, the State should consider that absent a legislative change the authority will not enjoy the same protections from civil action currently provided to API under state law. Currently, under Alaska State law, state employees who are acting within the scope of their employment cannot be sued directly. Instead, the State is substituted as the defendant party to the civil action upon certification by the attorney general that the employee was "acting within the scope of the employee's office or employment at the time of the incident out of which the claim arose." AS 09.50.253(c). Employees of and authority would not have this same protection and therefore would need to be protected by insurance policies as contemplated by the DHSS RFP. In addition, the qualified immunity protections that are currently available to the State under AS 09.50.250 would not apply to a private contractor but likely would still apply to the extent a litigant were to sue the State for its actions or inactions in overseeing operations assuming the Department retains its status as licensee.

In establishing a public corporation, the State will want to be very clear which functions it is delegating to the corporation and which it is retaining for itself, if any, as this division of responsibilities will also define liabilities. In addition, any contract should specify the duty of the authority to indemnify, hold harmless, and defend the Department against claims from any third parties. The contract should also specify robust insurance requirements.

While the considerations identified above apply to this Scenario, in establishing the public corporation, the Legislature will likely determine the extent to which the public corporation and its board and employees can be held liable in a civil action and the protections to be afforded to them. For example, the legislation establishing the Alaska Mental Health Trust Authority states that the authority:

- may sue and be sued;
- may retain the services of independent counsel when, in the judgment of the corporation's board of trustees, independent counsel is needed; [and]
- shall insure or indemnify and protect the board, a member of the board, or an agent or employee of the authority against financial loss and expense, including reasonable legal fees and costs, arising out of a claim, demand, suit, or judgment by reason of alleged

> negligence, alleged violation of civil rights, or alleged wrongful act resulting in death or bodily injury to a person or accidental damage to or destruction of property if the board member, agent, or employee, at the time of the occurrence, was acting under the direction of the authority within the course or scope of the duties of the board member, agent, or employee[.]

AS 47.30.011(c). Similarly, the statute establishing the Alaska Railroad Corporation states that the corporation may sue and be sued and permits but does not require the corporation to defend and indemnify board members and employees and purchase insurance. AS 42.40.250, 42.40.310. Any legislation forming a public corporation to operate or contract with API would need to address these issues as well.

Incorporation of Regulatory Compliance Requirements

Any contract with a public corporation would need to allocate responsibility between the Department and the contractor for compliance with multiple regulatory systems. A full list of the laws that govern those regulatory systems and that may need to be addressed in any agreement between the Department and a contractor is included in Appendix D.

Public Corporation Cost Model

Table 17 summarizes the cost adjustments to the API budget required to implement Scenario 3.

Table 17: Scenario 3 - Public Corporation Operation Costs

API Department	Annual Cost / (Savings)	Net FTE Change
Staff Development	$402,104	4.0
Subtotal	**$402,104**	**4**
Administrative Efficiencies	($309,815)	
Performance Improvement Training and Consulting (One-time Cost)	$250,000	
Total Change to API Base Budget	**$342,289**	**4**

Public Corporation Pros and Cons

Below are the pros and cons for a public corporation:

Pros:

- With significant commitment of leadership and more resources, API could become a "success story" by applying "private sector" management techniques, including process improvement transformation.
- As API's performance improves and a positive work culture develops, it is expected that more prospective employment candidates would accept employment offers from API and staff retention would improve.
- The state and DHSS would avoid the disruption and delays (e.g., litigation) that might occur from a decision to privatize API.
- While increased funding is required, efficiencies and improvements to API's operation might result in reductions in expenditures, given time; and will support more effective operations and improved patient outcomes. This cost is less than the management and oversight expenses during FY19 and FY20.

Cons:

- There are unknown costs associated with the formation and initial operation of a Public Corporation.
- Improving API would require increased resources, including to support the necessary administrative infrastructure.
- It may be difficult for DHSS leadership to give API the time and attention required to implement this scenario, given other demands.

Evaluation of the Scenario Based On "Effective Operation" Evaluation Criteria

Table 18 provides an assessment of the "Continued State Operations Scenario" using the evaluation criteria included in the RFP.

Table 18: "Effective Operation" Evaluation Criteria - Continued State Operations

Evaluation Criteria	Findings
Cost Savings	As this Scenario is assumed to include the State Operations Scenario 2, and unknown costs will be required to stand-up operating a public corporation or authority. Following start-up costs for the Authority and establishment and implementation of process improvement outcomes, costs should decline somewhat.
Quality of Care	Patient outcomes and quality of care will improve, with time it may equal or exceed the quality of care provided by a private or not-for-profit operator, given a commitment to performance improvement and staff development resources, and changes in relationships with other agencies supporting API.
Access to Care	An authority and governing board are expected to closely examine the hospital's need to admit safety net and patients committed involuntarily. Ability to restore API to an occupancy rate more quickly than the status quo, thus helping to reduce forensic and civil waitlists. Also assumes that process improvement projects will reduce civil and forensic length of stay and thus reduce admission waiting times in hospitals and jails
Administrative Quality Measures	Process improvement will increase administrative quality as projects identify and remove inefficiencies from current administrative processes. Updating or changing the electronic health record system would incur significant cost for the purchase of the system, any customization, and training staff. Additional costs (staff time) would come from staff training and the migration of legacy data.
Workforce	Additional staff development resources will provide staff with the training and ongoing support needed to function effectively. This will result in reduced turnover and vacancy rate as API becomes a safe, rewarding place to work. Mediation efforts with API leadership and the Unions to clarify processes and improve communications will help expedite personnel actions and improve overall staffing efficiency and effectiveness.

Scenario #4: Privatization of Select Hospital Components

This scenario examines the costs and benefits from privatizing parts of the hospital. Currently, API contracts for food service, campus security, and patient transport services. The WICHE team reviewed the hospital's organizational structure and staffing levels of various departments in an effort to identify potential areas of the hospital that could potentially be privatized. We also reviewed the PCG 2017 analysis of component outsourcing. Based on these reviews, we identified the following potential areas for detailed examination:

- Communication Center, which serves as API's front desk, providing security and reception functions.
- Housekeeping or "Environmental Services" (within Facilities Management) this entails all aspects of maintenance and custodial duties at API.

Both groups of employees belong to collective bargaining unit represented by the GGU and as such, consideration of the provisions in each CBA. The Legal Considerations section below outlines actions required if management of some part of the workforce is transferred to another employer.

Assumptions

- We assume that the private sector will pay 20% more in salaries as compared to their public counterparts.[22]
- An analysis performed by the University of Alaska Anchorage's Institute of Social and Economic Research (ISER), prepared for the Alaska Department of Administration, found that employee benefits contribute to a substantially greater portion of total compensation in the public sector than in the private sector.[23] Based on the ISER report, WICHE estimates private sector benefits to be 22% of total compensation. In FY19, an average of 32% of total compensation at API was paid through employee benefits. [24]
- Currently, the State pays overtime to any employee working over 37.5 hours per week, who are covered by the General Government Bargaining Unit and are Exempt. This is a contractual requirement in place with the collective bargaining units that represent current API employees who are not included in the Supervisory Unit Bargaining Agreement or the Labor, Trades and Crafts Unit Master Agreement API employees, who have a 40-hour work week. Therefore, under a private contractor scenario, overtime eligibility would begin once an employee exceeded 40 hours per week instead of the 37.5 hours per week for the majority of the API employees. This change would reduce overtime costs, as a private employee would have a higher ceiling for overtime eligibility.
- It is assumed that under all privatization options, patient revenue from federal and third-

[22] Bureau of Labor Statistics, Current Population Survey (BLS CPS) 2014

[23] https://iseralaska.org/static/legacy_publication_links/2016_07-OverpaidOrUnderpaidReport.pdf

[24] For the purposes of this report, WICHE's calculation of API staff benefits includes insurance (health, life, short-term disability, and long-term disability), retirement and savings (defined benefits, defined contributions) and legally required benefits (Social Security, Medicare, and state and federal unemployment).

party sources remains constant regardless of the operational costs. Therefore, this model assumes that all additional costs or savings would be paid from or credited to the state's General Fund.

- WICHE assumes that a contractor operating all or part of API will be provided a profit margin as part of an operating agreement. This assumption extends to both for profit and not-for-profit operators. WICHE reviewed profit margins in Becker's Hospital Review and found similar profit margin standards to those found by PCG in its 2017 API study. The estimated for-profit contractor margin is assumed at eight percent and the expected margin for a not-for-profit contract would be four percent.
- The WICHE team assumes API will fund all operating supply and capital outlay expenses for Environmental Services and the Communication Center and the contractor will provide the staff to clean the hospital.
- The cost of worker's compensation is included in the employee benefit cost estimates.

Legal Considerations

API is currently subject to the State's collective bargaining agreements ("CBAs") covering API's employees, including supervisors. Under Scenario 1, contracting with a private third party that would assume responsibility for API management and operations would result in dissolution of API's supervisory bargaining unit, because supervisors are precluded from organizing under federal labor law that governs private employers. As for nonsupervisory bargaining units, the third party – the "successor" employer – would assume the terms and conditions of existing nonsupervisory bargaining agreements if it promises continued employment to a majority of the existing bargaining unit employees. If the successor employer makes no such commitments, but nonetheless builds a majority of workforce with bargaining unit members, it would likely be required to recognize the union as the exclusive bargaining representative of the employees. In that case, however, the successor employer would be entitled to establish the initial terms and conditions of employment, subject to subsequent bargaining.

Also, under this scenario, where the State transfers management of at least some part of the workforce to another employer, existing CBAs require the State to provide the unions 30 days' notice and the option to submit an alternative plan before releasing any bids. See CBA between the State of Alaska and the Alaska Public Employees Association (supervisory unit), Art. 6.01 C.1; CBA between State of Alaska and the Alaska State Employees Association, American Federation of State, County, and Municipal Employees, Local 52, Art. 13.01. The State is not obligated to adopt the union's plan. If the State's action displaces bargaining unit members, the State must make a good-faith effort to place those employees elsewhere in State government, with the following order of priority: (1) within the division; (2) within the department; or (3) within State service generally.

Immunity and Indemnification

In contracting with a private for profit or nonprofit contractor (Scenario 1 and 4), the State should consider that absent a legislative change the contractor will not enjoy the same protections from civil action currently provided to API under state law. Currently, under Alaska State law, state employees who are acting within the scope of their employment cannot be sued directly. Instead, the State is substituted as the defendant party to the civil action upon certification by the attorney general that the employee was "acting within the scope of the employee's office or employment at the time of the incident out of which the claim arose." AS 09.50.253(c). Employees of a private contractor would not have this same protection and therefore would need to be protected by insurance policies as contemplated by the DHSS RFP. In addition, the qualified immunity protections that are currently available to the State under AS 09.50.250 would not apply to a private contractor but likely would still apply to the extent a litigant were to sue the State for its actions or inactions in overseeing operations assuming the Department retains its status as licensee.

In contracting with a private contractor to perform any functions, the State will want to be very clear which functions it is delegating to the private contractor and which it is retaining for itself, if any, as this division of responsibilities will also define liabilities. In addition, any contract should specify the duty of the private contractor to indemnify, hold harmless, and defend the Department against claims from any third parties. The contract should also specify robust insurance requirements.

Incorporation of Regulatory Compliance Requirements

Any contract with a private for profit or nonprofit entity would need to allocate responsibility between the Department and the contractor for compliance with multiple regulatory systems. A full list of the laws that govern those regulatory systems and that may need to be addressed in any agreement between the Department and a contractor is included in Appendix D.

Alaska Public Employee Retirement System

Under this scenario, the DHSS would be required to pay a Public Employee Retirement System (PERS) termination liability for the 13.0 Environmental Services FTE being privatized and the 6.0 FTE Communication Center FTE being privatized. However, given that these costs are already included in the DHSS budget, they will not directly impact API's costs, so are not included in this analysis.

Contract Monitoring

It is assumed that a contract for environmental services and for communication center services may be managed by existing API administrative staff. Therefore, no contract monitoring costs are estimated.

Communication Center Privatization Cost Model – For-Profit Contractor

Table 19 provides a comparison of the FY20 API budgeted salary and benefit costs to estimated costs under a for-profit contractor scenario. As discussed earlier, salaries are estimated to increase by 20% under a private operator, while benefits are estimated to decrease to 22.0% of total compensation costs.

Privatization is estimated to result in an annual savings of $20,137 in state general fund expenditures. The first-year expenditure estimate does not include the one-time cost for retirement benefits related to privatizing 6.0 FTE, as these costs covered in the DHSS budget.

Table 19: Cost Comparison API vs. Contract Communication Center

	API FY 20 Budget	Year One Partial Privatization	Year One Change
Salaries	$251,785	$302,142	$50,357
Benefits	$202,636	$99,973	($102,663)
Contract Monitoring	N/A	$0	$0
Subtotal	**$ 454,421.00**	**$402,115**	**($52,306)**
Profit @ 8%	N/A	$32,169	$32,169
Total	**$454,421**	**$434,284**	**($20,137)**

Environmental Services Privatization Cost Model – For-Profit Contractor

Table 20 provides a comparison of the FY20 API budgeted salary and benefit costs to estimated costs under a for profit contractor scenario. As discussed earlier, salaries are estimated to increase by 20% under a private operator, while benefits are estimated to decrease to 22.0% of total compensation costs.

Privatization is estimated to result in an annual savings of $57,504 in state general fund expenditures.

Table 20: Cost Comparison API vs. Contract Environmental Services

	API FY20 Budget	Year One Partial Privatization	Year One Change
Salaries	$495,788	$594,946	$99,158
Benefits	$422,424	$202,007	($220,417)
Contract Monitoring		$0	$0
Subtotal	**$918,212**	**$796,952**	**($121,260)**
Profit @ 8%		$63,756	$63,756
Total	**$918,212**	**$860,708**	**($57,504)**

Partial Privatization Pros and Cons

Privatization of either or both of these hospital functions includes the following pros and cons:

Pros:

- A private contractor would have more flexibility in recruitment and hiring practices and might be able to experience more success than API at filling vacant positions.
- A private contractor would not be limited by the State of Alaska's state employee salary structure.
- Ensuring 24/7 Communication Center staffing coverage will no longer be the responsibility of the State and API staff would not be pulled from other areas of the hospital to cover gaps.
- No contract administration costs as management would be absorbed by API Administration staff.

Cons:

- Quality of services could decline, requiring intervention with contractor.
- Increased staff turnover may be more likely to occur jeopardizing the continuity and consistency of operations.
- Employees would not be covered by the State's malpractice and workman's compensation programs.
- Should the contract with a private entity need to be terminated, transition to another private contractor or returning to State management and operations, could be disruptive to API operations.

Table 21: "Effective Operation" Evaluation Criteria – Privatization of Select Hospital Components

Evaluation Criteria	Findings
Cost Savings – Communication Center	Privatization of the Communication Center is estimated to result in an annual savings of $20,137 in state general fund expenditures based on 20% salary increase under a private operator, while benefits are estimated to decrease to 22.0% of total compensation costs.
Cost Savings Environmental Services	Privatization is estimated to result in an annual savings of $57,504 in state general fund expenditures based on 20% salary increase under a private operator, while benefits are estimated to decrease to 22.0% of total compensation costs.
Quality of Care	Quality of care/services could improve with clear contract expectations and through contract compliance and management activities. There is also a risk of increased staff turnover in these positions, which could potentially disrupt continuity and clarify of roles and functions.
Access to Care	Access to care is not expected to be impacted by the potential privatization of these functions.
Administrative Quality Measures	Administrative accountability may increase with clear contract expectation and oversight. Electronic health record changes would not be directly influenced by partial privatization. Updating or changing the electronic health record system would incur significant cost for the purchase of the system, any customization, and training staff. Additional costs (staff time) would come from staff training and the migration of legacy data.
Workforce	A private third party would assume responsibility for API management and operations, and this would result in dissolution of API's supervisory bargaining unit for these employees, because supervisors are precluded from organizing under federal labor law that governs private employers. The third party, successor employer would be entitled to establish the initial terms and conditions of employment, subject to subsequent bargaining. Recruitment and other compensation could help fill vacancies, along with the potential for more competitive salaries.

Transition and Implementation

Transitioning from state operation to private operation requires development of a transition plan in partnership with the contract operator. Typically, state staff at the hospital would be notified several months in advance of the transition date. DHSS would require that the private operator meet with each staff member to assess if a position is available for the individual under the new operational structure. Or, DHSS could require that the private operator employ all employees (not in a disciplinary situation due to poor performance). Consideration must be given to communicating and clarifying any relationships between the private operator and the bargaining unit(s).

The GGU CBA shows that effective July 1, 2020 the employer contribution will be $1,555, representing a $25 increase from the current rate of $1,530. The same agreement shows a 1% cost of living increase in wages, effective July 1, 2020 over the FY20 rate. These increases should be considered in the FY21 budget.

Closing Remarks

Stakeholders voice significant concerns about API's future. The hospital, while out of regulatory peril as of the date of this report, remains at risk until conditions are improved and sustained. Outside of API, insufficient community resources significantly impact the hospital's operations. Individuals wait for admission when many could perhaps be served at a lower, and less expensive level of care. Each of the operational scenarios presented in this report is feasible. What is not feasible is continuing the status quo operations at API, given the costs associated with litigation risks, the human cost of patient and staff safety, as well as the effective treatment of patients.

The cost estimates of potential litigation are difficult to estimate. However, delays created from litigation could result in negative patient outcomes at API unless improvements are made under the current, status quo, operating situation. It is reassuring that API is not currently out of compliance with state licensing, CMS certification or Joint Commission accreditation. However, structural problems exist, including numerous direct care vacancies, delays in hiring, and an inappropriate and sometimes toxic "institutional culture" impacting the quality of treatment, and patient and staff safety. The continued uncertainty and operational flux impede API from operating effectively.

Contracting with a private entity offers an opportunity for DHSS to construct an agreement containing the critical components and expectations for the operation of API. This scenario holds DHSS responsible for contract management and oversight without being responsible for the day-to-day operations.

If the hospital remains under state operation and leadership, the current challenges require focused and comprehensive attention and sustained efforts. The time for incremental change is long past. Scenario #2 State Operations Scenario offers a hopeful and exciting future for API but demands significant dedication of DHSS time and API leadership staff time and commitment, to champion the changes required.

For the Governing Body to take on a true oversight role and monitor the performance of API legislative action is required as the group currently has no authority and is only serving in an advisory capacity. The Governing Body currently exists as a representative board, and not a policy-making and fiduciary board. The Department will also need to ensure that the Governing Body meets the Centers for Medicare and Medicaid Services (CMS) conditions of participation requirements.

A focus on key performance indicators (KPI) should be articulated, measured, and delivered with incentives or penalties for performance attached. KPIs should be manageable and attainable to be effective. Given that API is part of a larger behavioral health system, any KPIs implemented at API should apply to similar psychiatric hospitals/units in Juneau, Fairbanks, and now in Mat-Su, reflecting system-wide goals. As CMS transitions to a pay-for-performance model in the future, API's reimbursement may be in jeopardy if these data are not accurately reported going forward.

Creating a not-for-profit public corporation could perhaps provide an alternative and focused leadership solution – recognizing and embracing the unique needs and requirements of API (and of operating a psychiatric hospital). It could also elevate and create interest and discussion about API's exposure, transparency, accountability, and role in the state's behavioral health system. At the same time, DHSS would be placing API's operation in the hands of "subject matter experts with a distinct role" and could focus on initiatives more in common with DHSS's broader role and mission. However, this option would require the development of a new administrative infrastructure, which requires an investment and could take some time to implement but may help to improve operational efficacy and offer API a 'fresh start' while allowing it to remain a public operation.

Regardless of the operational structure of API, it will be important for the State and API leadership to establish a clear mission for API, and to focus on admitting patients who are consistent with this mission. Respondents noted that while the mission of API is to treat people with serious mental illness, the pragmatic reality is that API risks remaining a "catch-all" for the most complex patient presentations requiring a non-jail/prison facility. Additionally, it is suggested that the State consider the following:

- ✓ Establishing clearly articulated admission criteria and alternative treatment options for people who do not meet admission criteria for API.
  - The State could investigate implementing a policy similar to other State Psychiatric Hospitals, including Arizona, that more clearly articulate admission criteria.
- ✓ Conducting a staffing analysis of the Administration and General, Direct Care and Direct Care Support costs/staffing based on the data provided in Table 8.
- ✓ Assessing the role of API within the behavioral health service continuum in Alaska, to best align its mission to serve the needs of adolescents with serious emotional disorders and adults with serious mental illness.
- ✓ Restoring API to full capacity as soon as possible given the number of individuals on waitlists, while at the same time ensuring the development of a therapeutic and welcoming environment with a focus on trauma focused care, active treatment and recovery.
- ✓ Increasing transparency of API operations, including the reporting of key performance measures to stakeholders with a focus on quality improvement that supports staff engagement and patient outcomes.
- ✓ Reporting administrative and clinical measures to the Executive and Legislative Branches in an annual report.
- ✓ Engaging the judicial system to educate them about appropriate API referrals to most likely to benefit from treatment.
- ✓ Investing in increased programs and services in Alaska for individuals with intellectual/developmental disabilities, traumatic brain injury including those with complex behaviors and dementia.

- ✓ Working closely with CMS to ensure that all billing opportunities are pursued for reimbursement.
- ✓ Developing a focused and enduring effort to improve stakeholder confidence in the State's ability to assure high quality psychiatric facility that provides safe and effective treatment.
- ✓ Establishing a mechanism for a 5-year status review of the operational scenario and resulting outcomes of API within the behavioral health continuum of care in Alaska.

Appendix A: API FY20 Budgeted Staffing (Provided by DHSS)

Department	DHSS FY20 Baseline Staffing (FTE)
Admin. & General	28
Business Office	9
Facility Operation	11
Laundry & Linen	
Environmental Services.	13
Nursing Admin.	19
Central Services Supply	3
Health Info Management	4
Comm. Center	5
Medical Director	1
Quality Improvement	6
Nursing Clerk	5
Nursing PNA	102
Nursing RN / LPN	70
Pharmacy	3
ASO - Scheduling	2
Medical Services	1
Recreational Therapy	6
Occupational Therapy	3
Industrial Therapy	1
Psychology	13
Psychiatry	14
DJJ Psych Services	
Tele-psych	
Social Services	22
Peer Support	Incl. in Administration
TOTAL	**341**

Appendix B: State Hospital Privatization Efforts: A Review of the Literature

The purpose of this literature review is to provide an overview of the most up-to-date research analyzing the privatization of state psychiatric hospitals. While the primary goal of this review is to better understand the effects and consequences associated with the privatization of public psychiatric hospitals, the literature and research specific to psychiatric facilities is limited to non-existent. Therefore, the search field was expanded to more generally include studies related to the privatization of any hospitals in the U.S. Studies focused on hospital privatization in other countries are more readily available; however, given the unique approach to healthcare in the U.S., only those studies that address U.S.-based hospitals are included. The following key phrases were used to identify relevant sources of information through Google Scholar and EBSCOhost database searches that took place between December 1, 2019 and January 20, 2020:

- Analysis of psychiatric hospital privatization
- Analysis of hospital privatization
- Impact of hospital privatization on employment
- Impact of hospital privatization on workforce
- Models of hospital privatization
- Models of psychiatric hospital privatization
- Outcomes associated with hospital privatization
- Outcomes associated with psychiatric hospital privatization
- Analysis of financial performance of privatized psychiatric hospitals
- Analysis of financial performance of privatized hospitals

To ensure that the research included in this literature review is timely and relevant, yet robust enough to allow for meaningful exploration, resources published since 2010 were examined. Every attempt was made to ensure that only peer-reviewed and objective sources of information are included in this literature review. Citations are provided in the footnotes.

Given the lack of available literature on the specific effects of privatization on public psychiatric hospitals, an analysis of the effects of privatization on general hospitals in the U.S. can offer valuable insight into the types of outcomes that could be expected from the privatization of psychiatric hospitals. Although the service mix between the two types of hospitals is distinct, there are enough similarities in their cost efficiencies, workforce challenges, and service delivery outcomes that the analysis of one can provide meaningful insight into what can be expected from privatizing the other type of facility.

Public hospitals serve as the safety net in the U.S. health care service delivery system, as they provide services regardless of an individual's ability to pay and provide specialized services that are often considered unprofitable or undesirable by private hospitals. According to the American Hospital Association's Annual Survey, the number of public hospitals has steadily decreased from

1,761 in 1975, to 965 in 2020[25,26]. Ensuring that these valuable public health services are maintained after privatization is crucial, and multiple studies have been conducted to better understand the effects of privatization on the delivery of public health services in public hospitals. Each of these studies defines privatization as the shift in ownership from a public to private entity, either for profit, or not-for-profit.

Villa and Kane (2013) conducted a retrospective analysis of 22 public acute care hospitals in California, Florida, and Massachusetts that converted to private operations between 1994 and 2001. This study evaluated how the hospitals' profitability, efficiency and productivity, and community benefits changed during the three years after privatization. The authors noted that prior to privatization, the majority of the public hospitals in their study were operating with zero to negative total margins, compared to an average margin of 3.1% for all public hospitals across the U.S., suggesting that "poor financial performance may be a contributing factor to why many of these hospitals privatized"[27]. Post-conversion, the researchers found no statistically significant change in total relative to the comparison group; however, further analysis showed operating margins increased significantly after privatization (+6.08%), and non-operating margins decreased significantly after privatization (-3.81%). The increase in operating margins is due to an increase in revenues and/or a decrease in operating costs, which could be achieved by reducing or eliminating unprofitable services, increasing the availability of profitable services, cutting staff, or lowering bed capacities. Researchers attributed the decline in non-operating margins to the potential loss of public subsidies. This study noted a statistically significant increase in the markup ratio, which "suggests that new management adopted more aggressive pricing policies," a strategy that privately operated public facilities may not be able to pursue. Villa and Kane evaluated the efficiency and productivity of the hospitals in their study group by analyzing changes in occupancy rates and lengths of stay. After privatization, hospitals in the study group realized a 4.37% increase in occupancy rates (statistically insignificant when compared to the control group), and a 0.72% decrease in the average length of stay (statistically significant when compared to the control group). The researchers' findings suggest "privatization helped make these hospitals more efficient with respect to their inpatient hospitalization stays"[28]. The authors also examined the types of services offered before and after privatization to see if privatized facilities eliminated unprofitable services after conversion. Initial results

[25] American Hospital Association. (2020). Fast facts on U.S. hospitals, 2020. http://www.aha.org/statistics/fast-facts-us-hospitals.

[26] Villa, S., and Kane, N. Assessing the impact of privatizing public hospitals in three American states: implications for universal health coverage. *Value in Health.* 16 (2013) S24-S33. https://reader.elsevier.com/reader/sd/pii/S109830151204154X?token=4CA28CD1C162CA42F7893CEDECB4F48625962FFD9455B33836D3DC126BCFF19549C2B505FC0EA43A926FE796BBCEAF8D

[27] Villa, S., and Kane, N. Assessing the impact of privatizing public hospitals in three American states: implications for universal health coverage. *Value in Health.* 16 (2013) S24-S33. https://reader.elsevier.com/reader/sd/pii/S109830151204154X?token=4CA28CD1C162CA42F7893CEDECB4F48625962FFD9455B33836D3DC126BCFF19549C2B505FC0EA43A926FE796BBCEAF8D

[28] Villa, S., and Kane, N. Assessing the impact of privatizing public hospitals in three American states: implications for universal health coverage. *Value in Health.* 16 (2013) S24-S33. https://reader.elsevier.com/reader/sd/pii/S109830151204154X?token=4CA28CD1C162CA42F7893CEDECB4F48625962FFD9455B33836D3DC126BCFF19549C2B505FC0EA43A926FE796BBCEAF8D

suggest that privatized facilities do eliminate valuable, but unprofitable, services; however, other additional research would be needed to determine if this was a national trend or specific only to newly privatized facilities.

Ramamonjiarivelo, et al (2016) attempted to build on the Villa and Kane study to determine whether privatization enhances efficiency and productivity, and to further explore if a for-profit or not-for-profit model is associated with higher efficiency and productivity. The researchers hypothesized that public hospitals that privatize to for-profit status will be more efficient and have higher productivity than those that privatize to a not-for-profit status. To determine if their hypotheses were correct, the researchers analyzed longitudinal data between 1997 and 2013 for 435 public hospitals in the U.S., 104 of which privatized during the study period. Of those that privatized, 75 converted to a not-for-profit model, and 29 converted to a for-profit model. Researchers used both financial and non-financial measures of efficiency and productivity and found that overall "privatization enhances efficiency and productivity [29]." They found that privatization to for-profit status is associated with a higher efficiency in working capital utilizations and the number of FTE employees per occupied bed. For-profit hospitals also had higher productivity in terms of increased admissions per FTE They noted several environmental factors that influence the results of their study. Hospital size was positively associated with current-asset turnover; and negatively associated with FTE employee per occupied bed, and work hours per adjusted patient day However, the researchers were surprised to find that not-for-profit hospitals were more efficient related to capacity utilization than their for-profit counterparts. The researchers also made other interesting observations about the privatized hospitals. Hospitals that privatized to not-for-profit status were more likely to be located in more competitive markets compared to their for-profit counterparts and were also located in counties with higher per-capita income than those that remained public. This study could not account for payer mix due to a lack of available data, which could influence a hospital's efficiency. Researchers concluded that privatization could be considered as a viable strategy to increase productivity and efficiency among struggling public hospitals. However, while privatization to a for-profit model results in a significant improvement in productivity, it does not necessarily result in significant efficiency compared with privatization to a not-for-profit model. Hospitals that privatize to not-for-profit tend to focus more on work-hour reduction, while privatized for-profit hospitals tend to focus more on reducing the number of employees and increasing working capital efficiency. This implies that "privatization is not a panacea that can solve all aspects of public hospitals' efficiency [but] is a strategy that can improve some areas but not others [30]." Additional studies are also needed to determine how privatization affects patient satisfaction, employee satisfaction, physician satisfaction, pricing of health care services, access to services, and quality of care.

[29] Ramamonjiarivelo, Z., et al. (2016). The impact of privatization on efficiency and productivity: the case of U.S. public hospitals. *Journal of Health Care Finance.* Fall 2016: pp. 105-123

[30] Ramamonjiarivelo, Z., et al. (2016). The impact of privatization on efficiency and productivity: the case of U.S. public hospitals. *Journal of Health Care Finance.* Fall 2016: pp. 105-123

Ramamonjiarivelo, et al (2017) analyzed the impact of privatization on nurse staffing levels at public hospitals. Researchers examined the intensity and skill mix of nurse staffing across 436 non-federal acute care public hospitals between 1997 and 2013. Their findings suggest that privatization is associated with an increase in full-time equivalent (FTE) registered nurses (RN), a decrease in FTE licensed practical nurses (LPN), and an increase in the proportion of FTE RNs compared to FTE LPNs. Researchers also noted that "privatized hospitals tend to have more educated nurses than hospitals that remain public," which may be attributed to "increased financial resources" resulting from privatization[31]. Researchers also noted differences between the profit statuses of the privatized hospitals, as for-profit entities tend to rely more heavily on educated nurses than their not-for-profit counterparts. Researchers concluded that "for-profit privatized hospitals may use RN staffing as a competitive strategy to increase quality, reduce cost, improve market share" and enhance financial performance[32].

Ramamonjiarivelo (2014) also examined the issue of financial performance and the privatization of public hospitals. The study assumes that "organizations need key resources to successfully fulfill their missions and survive, and the possession of key resources enhances the organization's operating and financial performance."[33] It is a common perception that public services are inefficient since they are protected from market forces, and may not be incentivized to maximize their financial performance to yield optimal results. Therefore, it is reasonable that struggling public entities may look to privatization as a means to improved functioning and efficiency. Ramamonjiarivelo hypothesizes that public hospitals experience better financial performance after privatization, and that public hospitals that are privatized into for-profit entities exhibit better financial performance compared to public hospitals that are privatized into not-for-profit status. To test these hypotheses, Ramamonjiarivelo used national data sets and analyzed the margins for 524 hospitals in the U.S. between 1997 and 2009. Her findings align with her hypotheses and indicate that privatized hospitals yield better financial performance than those that remain publicly operated, and that privatized for-profit hospitals experience better financial performance than their not-for-profit counterparts. Privatization was associated with five percent higher operating margins, and two percent higher total margins than hospitals that remained publicly operated. Furthermore, those hospitals that privatized to a for-profit model had an eight percent higher operating margin than those that remained public, relative to a four percent higher operating margin compared to those that transitioned to not-for-profit status. Although the privatized hospitals improved their financial performance, additional research is needed to understand how the hospitals achieved increased margins, and if quality of care changed as a result.

[31] Ramamonjiarivelo, Z., Hearld, L.R., and Weech-Maldonado, R.J. (2017). The impact of public hospitals' privatization on nurse staffing. *Academy of Management Annual Meeting Proceedings.* https://doi.org/10.5465/AMBPP.2017.1689abstract

[32] Ramamonjiarivelo, Z., Hearld, L.R., and Weech-Maldonado, R.J. (2017). The impact of public hospitals' privatization on nurse staffing. *Academy of Management Annual Meeting Proceedings.* https://doi.org/10.5465/AMBPP.2017.1689abstract

[33] Ramamonjiarivelo, Z. (2013). Is privatization the solution to the financial distress of public hospitals? *Academy of Management Annual Meeting Proceedings.* DOI: 10.5465/AMBPP.2013.245.

The research demonstrates that the privatization of publicly operated hospitals offers some benefits in terms of efficiency, quality of workforce, and financial performance. However, additional research to determine how these efficiencies and improvements are achieved is needed to ensure that valuable public services remain available and accessible. More specific research on how privatization affects psychiatric hospitals would also help establish a more relevant discussion for the State of Alaska as it considers reorganizing the operations of API.

Appendix C: State Activities Related to Psychiatric Hospital Privatization

To help the State of Alaska understand what to expect should privatization of API be pursued, WICHE interviewed a variety of states that have considered or pursued privatization of their state psychiatric hospitals, either in their entirety or partially through the outsourcing of specific services. The WICHE Team identified states to participate in interviews through project staff knowledge of state activities, state responses in NRI's State Profiles System asking whether or not the state had privatized state hospital operations, discussions with the National Association of State Mental Health Program Directors, a review of each SMHA's website, and a Google search of state privatization activities.[34]

Six states were interviewed for this project, Florida, Georgia, Kentucky, Michigan, Missouri, and Colorado. Summaries of these conversations are included below and are occasionally supplemented with external sources of information. When other sources are used, they are cited in the footnotes. Attempts were also made to interview representatives from Indiana and West Virginia; however, scheduling conflicts prevented the Project Team from learning first-hand about their privatization efforts. Brief summaries about privatization activities in these states, based on information found through internet searches, are also included. When possible, lessons applicable to Alaska are provided.

Several common themes emerged from our discussions with other states about their experiences with privatization. One of the most important strategies when beginning the privatization process is to ensure a transparent procurement process, and to be candid about the problems the state hopes to solve with privatization. Alaska can do this by creating an advisory board to guide the privatization process (including RFP development and contracting language) that gives voice to all relevant stakeholders (e.g., hospital staff (including their labor unions), family and patient organizations, community providers, etc.).

When developing the RFP, the State of Alaska should include requirements for the psychiatric hospital it hopes to have moving forward, rather than simply improving the types and quality of services the hospital already provides. By having a diverse group of stakeholders serve on an advisory board, the DHSS can be confident that the needs of all stakeholders are addressed, and any issues that arise after privatization can be quickly mitigated.

Once a vendor is selected, it is important that the contract be specific and detailed enough to protect the interests of the state. This is especially useful should the vendor choose not to renew its contract, or in the event the state decides to terminate the contract. Important issues to consider include not allowing the use of non-compete clauses for employees and allowing the state to have virtual and continued access to the state hospitals medical records. These are important so that the state may retain the right to employ the staff at the state hospital and will retain ownership of client health records should the vendor cease operations. Another important

[34] NRI's State Profiles System data can be accessed at nri-incdata.org.

consideration is for the state to retain the authority to approve or deny admissions to the state hospital. This ensures that the vendor does not deny services to individuals who are difficult to treat, or who have medically complex cases. States we spoke to also recommend requiring the vendor maintain accreditation throughout the life of the contract with either the Joint Commission or CARF (Commission on Accreditation of Rehabilitation Facilities). Should the vendor lose accreditation, it should be clear what financial penalties the vendor will incur. This also helps the state with contract oversight.

Contract oversight is critical to ensuring vendor accountability. The states we spoke to recommend having at least one full-time employee at the state level dedicated to contract oversight. Two or three additional DHSS staff members with clinical backgrounds (e.g., RN, pharmacy) to assist with contract monitoring will be instrumental in conducting quality reviews at the facility.

It is important that a contracted hospital collaborate with all state behavioral health providers to assure an appropriate continuum of care. The hospital should regularly work with local hospitals, crisis programs, and community mental health programs to assure appropriate services are available to avoid inappropriate or unnecessary hospitalization and to assure continuity of care for clients leaving the hospital.

Several states indicated that by engaging in public consideration of potential privatization, that hospital staff and community providers came together with suggestions to improve hospital operations and community liaisons (such as changes in staff shifts/workloads and development of community crisis services) that the state ultimately decided against implementing privatization. The exploration of potential privatization of API opens the window for Alaska to introduce potential system changes short of full privatization.

Florida:

The State of Florida's Department of Children and Families (DCF) oversees the operation of seven psychiatric hospitals. The state owns and operates three of these facilities, and contracts with private vendors to operate the remaining four. The four privatized psychiatric hospitals in the State of Florida are the South Florida Evaluation and Treatment Center, the South Florida State Hospital, the Treasure Coast Treatment Facility, and the West Florida Community Care Center.

The WICHE Project Team spoke with a panel of representatives from the State of Florida to better understand the state's psychiatric hospital privatization efforts. The panel included the Director of Policy and Programs for the State Mental Health Treatment Facilities; the Department of Children and Families' Contract Manager; the Deputy Assistant Secretary for Substance Abuse and Mental Health; and the Chief Hospital Administrator for the Mental Health Treatment Facilities in the state, who is also a former hospital administrator at the state-operated North East Florida State Hospital.

Florida began privatizing its state psychiatric hospitals in 1998. DCF was directed by the state legislature to privatize the South Florida State Hospital, which was facing significant problems, including workforce challenges, and issues of abuse and neglect that resulted in multiple sentinel events. To immediately address these concerns, DCF entered into a short-term contract with a private provider while it could develop a process to fully privatize the facility. The state released a Request for Proposals (RFP) in February 1998 indicating that the state intended to "award two contracts to a single proposer for the finance, design, construction, and operation of a 350-bed mental health facility which will be operated as part of an integrated mental health care continuum in the southeast Florida area"[35]. The funds would be used to construct a new facility to replace or supplement the existing South Florida State Hospital campus. Florida authorized the contractor to issue "tax-exempt bonds, certificates of participation, or other securities to finance the project, and the state was authorized to enter into a lease-purchase agreement for the treatment facility"[36]. Building a new facility allowed Florida to develop additional cost-savings by designing an efficient campus.

Because South Florida State Hospital was a state-operated hospital, staffed with state employees, DCF required the new private vendor to prioritize hiring of existing state employees. The state statute authorizing privatization specifies "current South Florida State Hospital employees who are affected by the privatization shall be given first preference for continued employment by the contractor. The department shall make reasonable efforts to find suitable job placements for employees who wish to remain within the state Career Service System"[37]. For those employees that either opted not to transfer to the private vendor, or were not selected for employment by the vendor, the state's human resources department searched for available state opportunities to help these employees retain positions within the state government. This helped ensure that state employees who were near enough to retirement could maintain their state pensions and other benefits. State employees that did move to the new vendor were not able to retain any state benefits. The employees at South Florida State Hospital were not unionized; therefore, DCF did not need to negotiate with labor unions when pursuing its privatization efforts.

Since Florida privatized the South Florida State Hospital, the state has privatized three additional hospitals. Wellpath was awarded the contract for the South Florida Evaluation and Treatment Center and the Treasure Coast Treatment Facility, which were established as privately operated hospitals from the beginning. The West Florida Community Care Center is a smaller, 80-bed facility run by Lakeview, a not-for-profit community mental health provider. Lakeview has been operating West Florida Community Care Center for approximately 15 years.

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[35] MyFlorida.com. (1998). Advertisement Detail: Department of Children and Families Request for Proposal Privatization of South Florida State Hospital. http://www.myflorida.com/apps/vbs/vbs_www.ad_r2.view_ad?advertisement_key_num=1567

[36] Florida State Statute 294.47865 South Florida State Hospital; privatization 3(a). http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/Sections/0394.47865.html

[37] Florida State Statute 294.47865 South Florida State Hospital; privatization 3(a). http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/Sections/0394.47865.html

Each of the state's four privatized psychiatric hospitals is managed through a contract with DCF. State statute allows DCF to enter into agreements with each contractor for up to 20 years[38]. Lengthier contracts, and giving the contractor a stake in the facility, make it more difficult for the contractor to abandon the initiative. However, it is important that contracts be very specific about what deliverables, outcomes and performance metrics the state expects from the vendor to hold the vendor accountable. DCF assigns a contract manager to work on the procurement of new programs, and to provide ongoing management, oversight, and monitoring of the privatized facilities. Vendors are required to meet with DCF and local community stakeholders to strategize and discuss issues related to admissions and discharge planning to ensure continuity of care for patients. It is clear in the contracts that the state hospitals, whether private or publicly operated, are partners with community providers.

To ensure that the private vendors are meeting their contract requirements, DCF holds monthly quality assurance reviews. These reviews are conducted alongside the reviews of the state-run facilities to ensure that neither group of hospitals (public or private) is lagging behind the other. It creates an environment of competition that raises the standard of care across the state and allows all seven of Florida's state psychiatric hospitals to share best practices and lessons learned.

When asked about any cost savings associated with privatizing the four state psychiatric hospitals, the representatives from Florida indicated that the cost benefit is not so much related to savings, but rather cost containment. The vendors are given a set number of dollars with which to operate, and they have to make that work. The hospital contractors in Florida are responsible for costs associated with the entire physical plant, medical services, dental services, pharmacy services, and maintenance (including the repair and replacement costs of major fixed assets such as the roof, chillers, etc.). DCF, through its contracts, has been able to pass on a lot of the risk to the contractors. DCF funds the state hospitals entirely through state general revenue funds and requires the contractors to bill Medicaid and any private insurance for services, and collect any associated fees from clients, and turn over any funds collected to the state. In the past, DCF incentivized the providers to collect these funds by sharing a percentage of the fees collected above a certain threshold (e.g., if Wellpath collects over $X million in fees, DCF would return X% of any amount collected over the $X million to Wellpath). This incentive structure is not included in the current contracts.

According to the participants in the interview, "Florida has been really pleased with Wellpath as a provider." Stating that, "they do great work, [and they are] wonderful to work with." When asked about the challenges working with Wellpath, the state indicated that it is sometimes challenging to get information (e.g., actual expenditures, policies, etc.) from the company, as Wellpath cites that the requested information is proprietary in nature. The state understand that

[38] Florida State Statute 294.47865 South Florida State Hospital; privatization 3(a). http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/Sections/0394.47865.html

this is to protect Wellpath, a for-profit organization, from competition, and may be more of a challenge in Florida than in other states due to Florida's robust open-records laws.

Lessons Learned and Recommendations for Alaska:

- Be very specific in the contract language about what deliverables, outcomes and performance metrics the state expects to hold the vendor accountable. The state should also require the provider to be accredited by the Joint Commission or CARF, and that accreditation must be maintained during the life of the contract. Should the provider ever lose accreditation, the state should have the right to leverage financial penalties against the vendor. This provides the state with another level of oversight.
- Develop language in the contract that the state can have remote access to client records, and that should the vendor's contract be terminated or is not renewed, the state may retain these client records.
- Specify in the contract that the vendor be required to follow state policies related to adverse and sentinel events (e.g., what needs to be reported, who it needs to be reported to, and what timeline should be followed for reporting)[39].
- The state should retain final authority on all admissions, discharges, and transfers. Florida has had to rely on this language in the contract when the private vendors have not wanted to admit individuals with medical complexity, or difficult-to-treat patients.
- When conducting site visits for quality reviews, the state should bring on-site experts in the field (medical, dental, nursing, programmatic, and clinical) who are not associated with the hospital. This allows for an unbiased, educated review of processes and services.
- Incentivize vendor performance/efficiency in contract language.
- To manage a contract with a private vendor, Florida recommends Alaska's DHSS have one full-time contract manager, plus one or two clinical staff (e.g., Nurse, ARNP, etc.) who can help conduct quality reviews of the healthcare services provided by the vendor. If issues arise that need expertise that is more specialized, DHSS can then contract out for an expert to conduct a more detailed review.

Georgia:

In 2007, the Department of Justice (DOJ) initiated an investigation of Georgia's seven state psychiatric hospitals for alleged violations of the Civil Rights of Institutionalized Person's Act (CRIPA)[40]. The DOJ investigation began as a result of a series of articles published by the *Atlanta Journal Constitution* that highlighted "a pattern of neglect, abuse, and poor medical care" in the

[39] Florida's policies related to reporting can be found here: https://www.myflfamilies.com/admin/publications/policies.asp?path=CFOP 155-xx Mental Health - Substance Abuse. To view the contracts DCF has with its three facilities operated by Wellpath, please visit https://facts.fldfs.com/Search/ContractSearch.aspx, and type in the following codes for the facility's contract you would like to view: LI809 – South Florida State Hospital, LI807 – South Florida Evaluation and Treatment Center, LI808 – Treasure Coast Forensic Treatment Center (TCFTC)

[40] Georgia Department of Behavioral Health and Developmental Disabilities. (2009). Department of Justice CRIPA overview. https://dbhdd.georgia.gov/document/document/doj-cripa-fact-sheet/download

state's psychiatric hospitals that contributed to tragic patient outcomes, including the deaths of 115 patients over five years[41].

Although the state signed a settlement agreement with the DOJ in 2009, and was making steady improvements in the quality of care provided at the state psychiatric hospitals, there was enough doubt among members of the state's legislature that the Department of Behavioral Health and Developmental Disabilities (DBHDD) could effectively oversee and manage the state's psychiatric hospitals. This doubt, coupled with the economic recession of 2008, made it an ideal time for the state to consider an operational overhaul of its state psychiatric hospitals to improve quality of care and reduce costs to the state.

In 2009, the Georgia legislature was approached by a private vendor about the potential benefits of privatization of the state's psychiatric hospitals. There was enough interest in privatization among members of the legislature to explore the potential privatization of Central State Hospital, the state's maximum-security forensic facility in Milledgeville, Georgia as a pilot effort. If this pilot were successful, the state could then expand privatization to the remaining six state psychiatric hospitals.

Two people within the DBHDD were tasked with writing the programmatic piece of the RFP: the Director of Forensic Services and the Director of Hospital Operations. The Department of Administrative Services was tasked with developing the administrative and financial components of the procurement opportunity.

To gain insight into the process Georgia followed when pursuing privatization, the WICHE project team interviewed the Director of Hospital Operations during this procurement process.

When developing the RFP, the Director of Hospital Operations and the Director of Forensic Services, decided to start with "a clean sheet of paper," and wrote a comprehensive RFP describing the type of facility they envisioned that would result in quality services delivered at a "secure psychiatric facility, rather than at a prison with therapy." The RFP prioritized treatment team configurations, approaches to after-care, and follow-up on discharges for the forensic population served at the facility[42].

Responding bidders were instructed to submit responses in two parts: a fiscal piece outlining the costs of privatizing the facility, and a programmatic piece describing the services the vendor would provide. Georgia's Department of Administrative Services was tasked with reviewing the fiscal piece, and for those responses that passed fiscal review, The Director of Hospital Operations and the Director of Forensic Services were assigned with reviewing the programmatic piece. The

[41] Judd, A., and Miller, A. (2007). A hidden shame. *Atlantic Journal Constitution.* https://www.ajc.com/news/state--regional/five-years-115-patients-dead-who-might-have-lived/aUvYQ1Q48A2TG2SsJeCRSK/

[42] An open records request for a copy of the RFP may be made at orr.doas.ga.gov.

process of reviewing the RFP was purposefully bifurcated so that the programmatic reviewers were not unintentionally biased by cost numbers and would be able to solely focus on quality and the ability of the vendor to provide services. Two vendors submitted responses to the RFP; however, neither vendor met the cost threshold to have their response proceed to programmatic review. Therefore, the Director of Hospital Operations and the Director of Forensic Services never had the opportunity to review the responses.

Had a vendor been successful in the procurement process, DBHDD already had a plan in place to manage the contract. The new CEO of the state hospital would have reported to DBHDD's Director of Forensic Services; the hospital's Chief Operating Officer would have reported to the Director of Hospital Operations; and a fiscal analyst within DBHDD's finance division would have provided fiscal oversight.

Georgia does not have any unions operating within their state psychiatric hospitals, so negotiations with unions over the status of current hospital employees should the state move forward with privatization was not an issue. The state's expectation was that the vendor would hire existing state employees as their own. Due to the geographic location of the hospital, employees of the state hospital would not have had many other opportunities for similar positions elsewhere. In actuality, it would have likely been a challenge for the vendor to adequately staff the privatized facility due to workforce shortages in that geographic location.

The Director of Hospital Operations acknowledged that the RFP design process was a good exercise for DBHDD to understand what they should expect from their state psychiatric hospitals and enabled the state to identify areas for improvement in current operations.

Although the state did not pursue privatization, Georgia has partially privatized operations at their state hospitals. All five of Georgia's current state psychiatric hospitals outsource laundry and lab services. When considering privatization of lab services, DBHDD conducted a cost-benefit analysis that examined historical data on volume and the types of lab services that were needed and compared those to the direct and indirect costs associated with delivering the lab services. Through this cost-benefit analysis, DBHDD realized it could save between 40 and 50% of what was spent in-house with no impact on services. Four of the five facilities contract out pharmacy services, as private vendors have been able offer higher salaries to pharmacists than allowed by the state's salary structure. The state psychiatric hospitals are also considering outsourcing food services; however, none of the facilities have considered outsourcing maintenance services. DBHDD is willing to explore privatization of any of these ancillary services.

Lessons Learned and Recommendations for Alaska:

- In developing an RFP, the state may benefit by starting with a "blank sheet of paper," and writing an RFP that describes the type of facility Alaska wants to have moving forward, rather than starting with the quality of services the hospital already provides.

- There may be financial benefits in outsourcing ancillary services without a change in service quality.

Indiana

In 2005, the State of Indiana announced plans to privatize three state psychiatric hospitals, including Evansville, Madison, and Richmond[43]. Indiana's goal with privatization was solely to improve quality of care; anticipated cost benefits were not part of the initial desire to privatize. The plan was for local not-for-profit organizations to assume control of the facilities from the Family and Social Services Administration (FSSA), starting with Richmond State hospital in 2006; the remaining two facilities would privatize soon after. A 2007 CMS audit of Logansport State Hospital identified significant enough problems at the facility that it threatened to cut federal funds unless improvements were made. The CMS audit bolstered the state's plans to reorganize operations of its state psychiatric hospitals.

The state released an RFP for the privatization of Evansville, Madison, and Richmond State Hospitals. The state entered into initial negotiations with BHI as the private vendor for Richmond State Hospital; however, the state received no contractor bids for Evansville State Hospital or Madison State Hospital[44].

Labor unions in the state were skeptical of privatization, as the jobs of 300 registered nurses, psychiatric attendants, and behavioral health technicians represented by the union were at stake. Direct-care positions of 450 union employees at Evansville and Madison would have also been threatened under privatization[45].

In January 2008, FSSA announced that it would not privatize operations of Richmond State Hospital after an independent audit of the privatization plans found that privatization would result in an increased burden on taxpayers ranging from $3 million to $5 million, without increasing quality of care. The audit's findings coincided with state budget shortfalls. In December 2007, the governor requested that state agencies cut spending after lower revenue forecasts, just before the start of the Great Recession. In addition, Indiana's budget was further constrained under a threat from the Inspector General for the U.S. Department of Health and Human Services who found that Indiana "should refund the federal government $88 million for substandard care [at Logansport State Hospital]"[46].

[43] Open Minds. (2005). Indiana plans to privatize three state mental hospitals. https://www.openminds.com/market-intelligence/news/082905privatize/

[44] Pharos Tribune. (2008). State seeks new system for treating mentally ill. https://www.pharostribune.com/news/local_news/article_e0f73073-d916-5806-a22d-313b3e012be1.html

[45] AFSCME Now. (2008). Indiana scraps state hospital privatization. https://www.afscme.org/now/archive/blog/indiana-scraps-state-hospital-privatization

[46]

These cost concerns led Indiana to abandon plans to privatize the three state psychiatric hospitals; instead, the FSSA focused its efforts on prioritizing recovery services in the state hospitals to more quickly and effectively transition patients to less-costly services in the community.

Lessons Learned for Alaska:

- Other financial pressures on the state and departmental budget may affect the state's ability to privatize hospital operations. The additional $3 to $5 million anticipated taxpayer burden may have been tolerable if the state were not facing other budgetary constraints.

Kentucky

The State of Kentucky oversees the operation of four psychiatric hospitals: Central State Hospital, Western State Hospital, Eastern State Hospital, and the Appalachian Regional Health Care (ARH) Psychiatric Center. Kentucky's Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) owns and directly operates Central and Western State Hospitals, and contracts operations at Eastern State Hospital and the ARH Psychiatric Center. WICHE Project staff interviewed DBHDID's Medical Director to better understand Kentucky's psychiatric hospital privatization and reorganization efforts.

Privatization of Eastern State Hospital

Eastern State Hospital, the second oldest psychiatric hospital in the country, opened in its original location in 1824. In 2008, the declining physical facility, and concerns about capacity and quality of care caused the state to consider options for moving operations out of the DBHDID. At the time, Eastern State Hospital was managed by the state through a contract with the Community Mental Health Center (CMHC) of Central Kentucky.

As a community mental health provider, the CMHC of Central Kentucky prioritized the delivery of community-based mental health services. However, this created challenges when trying to operate an inpatient psychiatric facility. Contract funds designated for inpatient care were diverted to subsidize community mental health services, and a lack of adequately experienced medical staff to provide healthcare services in an inpatient setting contributed to adverse outcomes, including higher rates of seclusion and restraint. Kentucky decided the best approach to mitigate these issues and improve services was to build a new, state-of-the-art facility, and transition operations from the CMHC to the University of Kentucky's UK HealthCare System. The state did not need release an RFP for competitive procurement since they contracted with a public university.

When the state decided to shift operations of Eastern State Hospital from the CMHC to the UK HealthCare System, it envisioned an institution that could be used to train professionals to serve in the public health sector by leveraging the University's psychiatry and social work departments, the College of Law, the College of Public Health, and others. Both the University and the state

recognized the opportunity for a flagship training program and the ability to conduct research. With the state and University on board, they now needed to convince UK HealthCare that this was in their best interest as well. Fortunately, the state was able to offer $128 million to build a new facility, and this effort coincided with a push by UK HealthCare to serve under-served, vulnerable populations, and the recognition by leaders that behavioral health is a critical element of overall health. All three entities, the state, the University, and UK HealthCare publicly supported this effort, which garnered additional community support. A public ribbon cutting ceremony was held with the Governor and the University President to open the hospital and showcase this effort.

The state dedicated significant time to developing the contract with UK HealthCare. During the facility construction, the state hired independent consultants to determine what it would cost to effectively operate the hospital, which helped the state and UK HealthCare come to an agreement on budget. The state has retained ownership of the license, so as to protect its assets in the event the contract between the state and UK HealthCare is terminated. DBHDID also requires that UK HealthCare maintain Joint Commission accreditation of Eastern State Hospital.

Employees of Eastern State Hospital transitioned from CMHC employees to UK HealthCare employees. Although the employees were not direct state employees, DBHDID was concerned about their future. As soon as UK HealthCare was brought on as the vendor, large meetings were held at the University of Kentucky to address any concerns and reassure the CMHC employees about the transition process. UK HealthCare's human resources staff arranged individual meetings with CMHC employees and transitioned almost all of the direct care staff and support personnel within months surrounding Eastern State Hospital's re-opening. Transitioning the medical staff was a bit more complicated, as UK HealthCare had concerns about quality and experience, and was reluctant to take on all of the medical staff at one time. Therefore, medical staff remained employees of the CMHC for the first year of Eastern State Hospital's re-opening. Once it became clear that the CMHC medical staff would lose access to their state retirement benefits, Eastern State Hospital lost three-sevenths of its medical staff. This became a problem for UK HealthCare to address, but DBHDID worked closely with the vendor to recruit new medical staff. Until they reached full staffing, the hospital relied on Locus Tenens to fill the gap.

Privatization of the Appalachian Psychiatric Center

Appalachian Regional Healthcare (ARH), a not-for-profit health system, operates 11 hospitals across eastern Kentucky. In 1993, under contract with the State of Kentucky, ARH opened the 100-bed ARH Psychiatric Center to provide inpatient psychiatric care to adults aged 18 and older within a 21-county region. Because ARH primarily provides medical/surgical services, psychiatric services provided at ARH are not subject to the IMD Exclusion and are therefore eligible for reimbursement by Medicaid.

Kentucky's contract with ARH is for $6 million annually. ARH is required to bill all other sources of funding, including private insurance and Medicaid, before seeking reimbursement from the

state to bill against their contract allowance. This arrangement has worked well since the beginning of the contract; however, there have been occasions when ARH was unable to show the full cost of services rendered or have allowed expenses to exceed operational costs.

To ensure all state hospitals, regardless of privatized status, DBHDID requires each facility to have a governing board. For the privatized facilities, DBHDID has a series of quality metrics they are required to report and has specific requirements around incident reporting. All facilities are also required to retain Joint Commission accreditation. Each quarter, facilities participate in a conference call with the state. During these calls, the facilities address psychotropic medication prescribing, staff retention and turnover rates, and budget allowances.

The DBHDID commissioner leads the state hospital oversight efforts, and closely involves the Director of Human Resources, the Medical Director, two Deputy Commissioners, and a Policy Advisor. DBHDID has a Quality Program Division that has two pharmacists who help to monitor incident reports, medical errors, etc.

Kentucky has not noticed any significant difference in outcomes between the privatized facilities and the public hospitals. During the re-opening of Eastern State Hospital, it took DBHDID longer than anticipated to build a quality medical staff. And the fact that UK HealthCare could operate a good general hospital, did not immediately equate to running a good psychiatric hospital. Hiring an effective facility director has been critical to success.

Lessons Learned and Recommendations for Alaska:

- Develop the contract in such a way that the state's interests are protected should the vendor not want to renew the contract.
- Even though Alaska does not have a medical school with which to contract hospital operations, the state could benefit from developing a partnership between API and the various departments at the state university (e.g., nursing, social work, public health, etc.).
- If there is room within the hospital facility, space could be dedicated to NAMI and peer support specialists to facilitate recovery.
- Kentucky requires admission assessments be conducted by the Community Mental Health Center to prevent the contractor from denying care to difficult-to-treat patients.
- Have a plan and a partnership to transfer individuals to the community, and include community stakeholders on the hospital advisory board.

Michigan

The State of Michigan operates five state psychiatric hospitals, including three adult facilities (Kalamazoo Psychiatric Hospital, Henry Ford Kingswood Hospital, and StoneCrest Center), one for adolescents, and one secure forensic facility. During the WICHE Project Team's research for the

API report, staff discovered that Michigan had explored privatizing one of its three adult state psychiatric hospitals around 2011/2012 but did not pursue privatization. To learn more about why Michigan considered privatization, but ultimately decided to retain operations of all three facilities, project staff interviewed the state's former Deputy Director of the Behavioral Health and Developmental Disabilities Administration (BHDDA) of Michigan Department of Health and Human Services (MDHHS).

During her tenure, the state psychiatric facilities were facing significant workforce challenges, specifically with recruiting and retaining psychiatrists and nursing staff. A shortage of psychiatrists led to Michigan's heavy reliance on the use of Locum Tenens. However, organized labor agreements had strict requirements on the length of time a Locum Tenens could fill a position resulted in high labor costs, high turnover, and a lack of continuity of care in the state hospitals. It was common for nurses to be hired by the state upon graduation, receive training and experience at the state psychiatric facilities, and then be recruited away from the by private facilities. To understand the nursing challenges, BHDDA conducted an analysis comparing the salaries, benefits, and scheduling structures of the state-operated facilities with privately run hospitals in the state. This analysis found that scheduling was a primary benefit of shifting employment from the public to the private sector. At the time, labor agreements required full-time nurses at the state hospitals work five, eight-hour shifts per week for a 40-hour week; whereas the private hospitals offered more flexibility with scheduling, with three 12-hour shifts, or four 10-hour shifts qualifying as full-time employment.

After BHDDA and labor leadership determined there was not an easy or quick path to systematize the desired schedule changes (given the complexity of contracts, membership issues and rules), the administration and legislature authorized a feasibility study to determine if privatization was a sustainable option. BHDDA prepared, but did not give, the required 280-day notice to organized labor. Before all required processes for notice were fully prepared, the state employer, labor, and BHDDA agreed to pilot scheduling changes for nurses with the intent to make permanent should the pilot prove successful. The primary changes piloted were more flexible hours for nursing staff, the allowance of nurses to "moonlight" during their off days (e.g., as nursing faculty at the state's universities, providing in-home Hospice care, etc.), and extending the amount of time Locum Tenens could hold positions at the state hospitals to six months. The state also committed to periodic reviews of staff salaries to ensure competitiveness with the private sector.

Also influencing the state's decision to not pursue privatization were issues related to other private contracts managed by the state, unrelated to the state hospitals. Prior to this time, the state had success outsourcing a variety of services to private vendors at the state hospitals, such as custodial/cleaning, and some food service. However, simultaneous to the state exploring privatizing one of the state psychiatric hospitals, two private contracts managed by the state (unrelated to the state hospitals) were publicly failing, resulting in public outcry and a growing lack of trust that private contractors could provide quality services to vulnerable populations.

Because these two contracts were failing in such a public manner, the optics of outsourcing other state operations were not ideal.

Lessons Learned and Recommendations for Alaska:

- Contracts should be written in such a way that the state has enough tools and options to terminate the agreement with vendors that are not delivering high-quality services. From Michigan's experience, vendors may initially provide excellent services, but as the vendor's leadership changes over time, quality may decrease, and the state needs to have options to bring in another entity or retake control of the service.
- Contracts with the vendor should include strong transition clauses should the vendor's contract be terminated, or the vendor ceases to reapply for the contract. The state should include transition plans for continued access to the electronic medical records of its patients; hospital staff would need to have the option to become employees of the new vendor in order to stay working at the hospital, therefore, they should not be subject to non-compete clauses; and considerations for continued facility maintenance and ownership of equipment need to be addressed in the contract.
- Michigan suggested that the state's correctional healthcare contract at that time might be useful when designing strong exit and transition language. The contract also outlines the specific performance metrics the state requires of its current contractor, Corizon Healthcare, Inc[47]. *(Note: when the contract was written, the company was known as Prison Health Services, which subsequently merged with Correctional Medical Services, becoming Corizon Helathcare, Inc.)*

Missouri

Beginning in 2006, the Missouri Department of Mental Health (DMH) began closing and transferring acute inpatient and emergency mental health services to the private sector[39]. The WICHE Project Team interviewed the individual who served as the Chief Operating Officer of the Division of Psychiatric Services during this time to better understand the rationale for shifting responsibility for these services away from the Department of Mental Health.

In 2006, before the Great Recession, Missouri was already facing budget shortfalls of $9 million. DMH evaluated its services and realized that by shifting acute inpatient services and emergency room services away from the state psychiatric hospitals to medical-surgical facilities, those services could then be reimbursed by Medicaid and would no longer be subject to the IMD exclusion rule. DMH then repurposed the acute care beds to serve as long-term care forensic beds. This resulted in a cost savings of $3 million to the state. Because the medical-surgical facilities could bill Medicaid on a per-diem rate, regardless of the type of service provided, the medical-surgical facilities also realized an increase in revenue because the actual cost of providing behavioral health beds is lower than the actual cost of providing a medical-surgical bed. When

[47] The State of Michigan's contract with Corizon Health, Inc. can be found here: https://www.michigan.gov/documents/micontractconnect/6600081_526101_7.pdf

planning for these changes, the State of Missouri informally consulted with the Missouri Hospital Association, and attorneys who specialized in Medicaid issues.

With the $3 million saved, DMH allocated $2 million to the South East region, and $1 million to the Eastern region to fill the gap in services left by the reduction of acute beds in those areas. The South East region used the funds to develop step-down, diversion programs, and crisis respite beds for individuals who might otherwise seek treatment in emergency rooms. The Eastern region used the funds as seed money to build the Psychiatric Stabilization Center.

State employees in Missouri are represented by unions; however, the unions in Missouri are not very active. Therefore, the state did not need to negotiate with the unions to outsource these services. The state did ensure the vendors gave preferential treatment when hiring to previous state employees. The state was surprised, however, when the vendor did not give any preferential treatment to state employees who smoked. For those state employees who were within two years of retirement, the state offered them the opportunity to stay on as state employees until they retired. Employees on the other side of the two-year threshold were not offered this alternative. Employees in the South East and Eastern regions of the state were able to assimilate into the existing state hospital structure because the beds were repurposed from acute care to long-term-care forensic beds controlled by the state.

DMH noted the importance of having the state either set specific standards for the types of patients the privatized facilities must admit, or that the state be the final decider on admissions. This ensures that difficult-to-treat and/or medically complex patients are not turned away.

Lessons Learned and Recommendations for Alaska

- A compelling argument for having general hospitals in Alaska to increase their acute psychiatric bed capacity is the general hospital's ability to bill Medicaid for behavioral health services on a per-diem rate that likely exceeds the cost of providing those beds. This would allow API to refocus its beds for longer-term care and forensic patients.
- It is important that the state retains authority on which patients are admitted to the psychiatric hospital, ensuring that difficult-to-treat and/or medically complex patients are not denied care.

West Virginia:

West Virginia's office of Health Facilities within the Department of Health and Human Resources (DHHR) operates the state's seven state psychiatric hospitals. Recent investigations have put the state under pressure to find solutions to operational challenges, including "under-funding, critical staff shortages and high [rates of] turnover, and underutilization" of services due to staffing

shortages[48]. Frustrations with personnel and purchasing rules within the Department of Administration have been cited as barriers to improvement[49]. The state is also facing the challenge of aging facilities. The state's Department of Health and Human resources released a report in 2012 estimating that improvements to the state hospitals would cost the state an estimated $70 million. In response to these challenges, the state is exploring the possibility of outsourcing operations, and has entered into a contract with Marshall Psychiatry to provide physician services and other certified professional services at one of the seven state hospitals.

Colorado:

While the State of Colorado has not privatized either of its two state psychiatric hospitals, the state has developed private jail-based competency restoration programs, an initiative known as the RISE (Restoring Individuals Safely and Effectively) Program. The WICHE Project Team interviewed the former Deputy Director of the Office of Behavioral Health, the former director of the RISE Program who oversaw initial program implementation, and the current director of the RISE Program.

Shortly after the July 2012 Aurora theater shooting, Colorado's OBH was asked by the state legislature to develop a plan to improve the state's mental health services. Around this time, the Deputy Director of OBH was approached by a private vendor about the possibility of developing a privately-run jail-based competency restoration program in Colorado. This seemed like an interesting way to reduce pressure on the Colorado Mental Health Institute at Pueblo, the state's secure forensic hospital. Representatives from OBH traveled to California to tour a jail-based competency restoration program and presented their findings to the legislature. In July 2013, OBH was approved funding by the legislature to proceed with establishing such a program. OBH released a request for proposals, and received three bids: two from private, for-profit companies, and one from a not-for-profit community mental health center. The contract was awarded to GEO Care (now Wellpath), one of the for-profit respondents.

In 2013, OBH and Geo Care collaborated with the Arapahoe County Sheriff's Department to open a 22-bed, jail-based competency restoration program in the Arapahoe County Detention Center, located in the southeast-Denver suburbs. Initially, the vendor was providing programmatic services at this location five-days-per-week, with clinical hours from 8:00am to 4:00pm. The RISE Program, with Wellpath as the contractor, has since expanded to 114 beds across two locations: 96 beds in the original Arapahoe County Detention Center, and 18 beds in the Boulder County Jail. In addition to the daily clinical hours, the program now also offers supportive programming during evenings and weekends.

[48] Kercheval, H. (2019). Privatization may solve the problems at state hospitals. *Metro News.* http://wvmetronews.com/2019/01/08/privatization-may-solve-the-problems-at-state-hospitals/

[49] Adams, S. A. (2019). Report urges privatizing state hospitals. *The Inter-Mountain.* https://www.theintermountain.com/news/local-news/2019/01/report-urges-privatizing-state-hospitals/

OBH maintains the responsibility for evaluating individuals for admission to ensure the vendor does not turn away appropriate, but potentially difficult, patients. OBH prioritizes admission to the program for individuals residing in the jails who are in distress or experiencing a crisis. To determine inclusion and exclusion criteria for the RISE Program, OBH benefitted from other states' experiences with jail-based competency restoration programs.

To ensure program success, OBH prioritized the need to work closely with the Sheriff's Office to ensure there would be full-time deputies dedicated to the program that would not rotate to other positions.

OBH also emphasized the importance of having a presence on-site, especially at the beginning of the contract. This allowed relationships to form between OBH, the vendor, and the Sheriff's Office. Having a consistent presence on-site from OBH, both announced and unannounced, enabled the state to understand how the program was evolving, and address any issues as they arose. This consistence presence also allowed OBH to continually develop and refine their auditing process to ensure that the vendor was adhering to program fidelity.

Initially, OBH had one full-time employee dedicated to providing program and contract oversight. As the program has grown, OBH has added to its RISE management team. OBH now employs a Program Director, a Program Assistant, and three Administrative Assistants to ensure the smooth operation of the RISE Program. The Program Assistant takes the lead in facilitating patient movements and coordinates transport between the jails and Colorado Mental Health Institute in Pueblo. The three Administrative Assistants are responsible for compiling all legal and clinical documents so clinicians can conduct assessment reviews. They are also responsible for data tracking to monitor when someone is admitted to the program, how long they stay in the program, and when and why an individual is discharged. from the program.

Of note is that after the contract was awarded, OBH conducted an informal analysis comparing the cost of outsourcing the program and the cost of developing the program in-house. This initial analysis actually showed that it would be less costly for the state to operate the jail-based competency restoration program. The state decided to continuously monitor costs and outcomes to see if a change in operation would be yield significant cost savings in the future. Since the initial contract was awarded, OBH has again analyzed the cost of the program being state-run versus outsourced. Findings from this analysis now show that it would be more expensive for OBH to operate the program, primarily due to the additional state benefits they would have to offer to full-time state employees of the program.

Lessons Learned and Recommendations for Alaska:

- Prior to, and during RFP development, it is important to bring all stakeholders to the table to ensure their concerns are recognized, which will mitigate challenges once the program/privatization is implemented.

- Private contracts can be successful so long as there is transparent and ongoing communication between the state, the vendor, and other key stakeholders. For the jail-based competency restoration program, other stakeholders include the participating sheriffs' offices, the state hospital to transfer patients who needed hospital-level care, the public defenders' offices, and district attorneys. With multiple stakeholders, it can be easy for miscommunications to occur.
- To reduce the burden on API's forensic beds, the state may consider implementing jail-based competency restoration programs.
- Should Alaska privatize API, the state should retain final say as to who is admitted to the hospital to ensure that the vendor does not turn away difficult-to-treat patients.
- When developing the vendor's contract, the state should build in language and timeframes should either party wish to discontinue the relationship. This will help prevent the vendor from abruptly ceasing services and will ensure the state maintains continuity of care for its patients.

Appendix D: Legal Considerations

Legal Considerations[50]

There are a number of statutory and contractual issues that may inform the analysis of the potential operational scenarios for the Alaska Psychiatric Institute (API) proposed by the Department of Health and Social Services (Department).

1. The Department Has Legal Authority to Delegate API Staffing and Services.

Alaska's Civil Commitment Statutes (Alaska Statutes ("AS") 47.30.660 and 47.30.670 – 47.30.915) have several provisions that bear on the Department's ability to privatize API. First, AS 47.30.660 dictates that the Department must "designate, operate, and maintain treatment facilities equipped and qualified to provide inpatient and outpatient care and treatment for persons with mental disorders." AS 47.30.660(b)(4). Second, AS 47.30.760 and AS 47.30.800 require that mental health treatment be available at "state-operated" hospitals at all times for individuals who have been involuntarily committed on an inpatient basis.

The obligation for the Department to "operate" or "maintain" mental health treatment facilities must be read in the context of the Department's general powers, as well as the State's framework for licensing specialty hospitals. Under AS 47.30.660(b)(13), the Department may enter into contracts for the provision of mental health services and "delegate upon mutual agreement to another officer or agency of it, or a political subdivision of the state, or a treatment facility[51] designated, any of the duties and powers imposed upon it by" the Civil Commitment Statutes. Additionally, though the Civil Commitment Statutes do not define what it means for a hospital to be "state-operated," a license is required to "operate" a specialty hospital such as API, and a license holder is ultimately responsible for the facility's operations. AS 47.32.020, AS 47.32.140 and AS **47.32.900(6)**. Thus, as long as the Department through its API Division holds the specialty hospital license for API, API will be state-operated under Alaska law.

[50] The purpose of this section is to provide the Department with a summary of certain legal issues and considerations. The purpose is not to provide the Department with legal advice and should not be construed as creating an attorney-client relationship between WICHE and the Department or between WICHE's counsel and the Department.

[51] Note that under AS 47.30.915 "designated treatment facility" or "treatment facility" means a hospital, clinic, institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under AS 47.30.670 -- 47.30.915 other than correctional institutions. If the Department wishes to delegate any of its statutory duties to a contractor that does not meet this definition, it may need to obtain a statutory amendment. However, the statute could also be interpreted more broadly to permit delegation to any contractor that is operating a treatment facility on behalf of the licensee.

In this context, it appears that each of the operational scenarios being considered by the Department is compatible with the Department's statutory obligations under the Civil Commitment Statutes. As discussed below, Scenarios 1, 2, and 4 contemplate that the Department's API Division would continue to hold the license to operate API. This means that the Division would be responsible for the operations of API and that API would remain a state-operated facility under Alaska law. **Additionally, the Department** has the specific statutory authority under AS 47.30.660(b) to contract with, and delegate its statutory obligations to, other entities. This authority is confirmed by State licensing regulations that expressly permit specialty hospital facilities like API to "contract with another facility or agent to perform services or provide resources to the facility." 7 Alaska Administrative Code ("AAC") 12.910(a). API can enter into a support services arrangement, provided the relationship is disclosed and complies with the minimum requirements of 7 AAC 12.910(c).

Scenario 3 contemplates creation of a separate public corporation under State supervision to operate or provide services to the facility. The Legislature would need to enact legislation to create a new public corporation. If the Department determined that its Division would retain the license to operate the facility, *see* discussion *below*, the legislation could authorize the public corporation to contract with the Division to provide staff and services necessary for operation of the facility. Alternatively, if the Department determined that the public corporation should hold the license to operate the facility, the Legislature could state expressly in its implementing statute that the facility will be considered to be "state-operated" for purposes of AS 47.30.760 and AS 47.30.800 or, alternatively, could amend AS 47.30.760 and AS 47.30.800 to make clear that mental health treatment will be at a hospital operated by the Department or the public corporation at all times for individuals who have been involuntarily committed on an inpatient basis.

2. The Department's Contemplated Contractual Relationship Could Be Structured to Comply with Alaska Licensing Rules and CMS Conditions of Participation.

The Department's RFP states that whatever scenario is proposed, the Department intends to retain (a) ownership of patient medical records and (b) ultimate control, oversight, and approval over operations through the API governing body. Absent a statutory change, the only way for the Department to achieve both objectives would be for the API to continue to hold the license to operate the facility as a Division of the Department. API would continue to be the licensee and delegate all or certain staffing and services to a private or public corporation.

This delegation could take the form of a support services agreement whereby the contractor agrees to provide the full or partial range of staff and services necessary to operate the facility. The support services agreement would need to meet the requirements of 7 AAC 12.910(c):

> (1) specify the respective functions and responsibilities of the contractor and the facility, and the frequency of onsite consultation by the contractor;

(2) identify the type and frequency of services to be furnished;

(3) specify the qualifications of the personnel providing services;

(4) require documentation that services are provided in accordance with the agreement;

(5) specify how and when communication will occur between the facility and the contractor;

(6) specify the manner in which the care or services will be controlled, coordinated, supervised, and evaluated by the facility;

(7) identify the procedures for payment for services furnished under the contract; and

(8) include the current license or registration number of the contractor, if required by state statute or regulation.

Under this type of agreement, the Department's API Division would retain the license and ultimate responsibility for the operation of the facility as the license holder. The API Division would also be the owner of all facility records, including patient records, and would have oversight responsibility through its Governing Body.

The API Governing Body would also likely need to retain the responsibility to exercise oversight authority to meet the Conditions of Participation ("COP") established by the Centers for Medicare & Medicaid Services ("CMS"). 42 C.F.R. § 482.12; CMS State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.[52] CMS COPs require the governing body to be ultimately responsible to ensure that the hospital meets all COPs. For example, the governing body duties include (a) appointing the chief executive officer to manage the hospital; (b) participating in the development of an institutional plan and budget; (c) determining which categories of practitioners are eligible for appointment to the medical staff; (d) approving medical staff bylaws; (e) exercising oversight along with the medical staff of the practitioners granted privileges at the hospital and determining which practitioners should be granted privileges; and (f) overseeing the quality of care provided at the facility. 42 C.F.R. § 482.12(a). State licensing rules contain similar governing body requirements. 7 AAC 12.630. The API Governing Body would also be responsible for ensuring that the contractor's services permit the hospital to comply with all COPs. 42 C.F.R. § 482.12(e).

4. Alternative Legal Scenarios.

[52] CMS guidelines state that in "the absence of an organized governing body, there must be written documentation that identifies the individual or individuals that are legally responsible for the conduct of the hospital operations." CMS State Operations Manual, Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, § 482.12 (Oct. 12, 2018).

a. Alternative Private Contracting Scenario1-A.

Another scenario that would likely require further statutory amendments would be to fully privatize by contracting with a private for profit or nonprofit entity that would operate the hospital under its own license subject to oversight by its own governing body. In this scenario, the Department would simply purchase the psychiatric hospital services that it needs through a contract or grant arrangement. Although the Department could still exercise a significant degree of control over the services provided in its role as grantor and licensing authority, it would not be able to own the hospital records or have the API Governing Body act as the governing board for the new licensee as contemplated by the assumptions stated in the RFP.

b. Alternative Public Corporation Scenario 3-A.

Forming a new public corporation under Scenario 3 would provide the Legislature the opportunity to create a governance model specific to API, rather than retaining the Department oversight and governing body structure that currently exists. Enacting legislation would detail the purpose, powers, size, and composition of the governing board, and would be tailored to best support API's unique operations. API's governing board would focus its governance and oversight exclusively on API and its mission, operations, and outcomes. As a governing board, it would have management authority to approve the budget and would select and oversee API's CEO. Board composition would be defined by statute and could include professionals with private sector experience and expertise in health, finance, and operations. A separate governing board may facilitate more consistent leadership of API and minimize political turmoil. Under this scenario, the Department's responsibility would be as regulator, rather than as licensee and contractor.

5. Additional Significant Contractual Considerations.

The following is a summary of some of the most significant legal issues the Department should consider if it determines to move forward with contracting some or all of the work under Scenarios 1, 2, 3 or 4.

a. Labor Issues.

API is subject to the State's collective bargaining agreements ("CBAs") covering API's employees, including supervisors. This memorandum addresses the legal impact on API's labor relations that results from each of the four proposed scenarios. In sum:

- **Under Scenario 1 or 1-A**, contracting with a private third party that would assume responsibility for API management and operations would result in dissolution of API's supervisory bargaining unit, because supervisors are precluded from organizing under federal labor law that governs private employers. As for nonsupervisory bargaining units, the third party – the "successor" employer – would assume the terms and conditions of existing nonsupervisory bargaining agreements if it promises

continued employment to a majority of the existing bargaining unit employees. If the successor employer makes no such commitments, but nonetheless builds a majority of workforce with bargaining unit members, it would likely be required to recognize the union as the exclusive bargaining representative of the employees. In that case, however, the successor employer would be entitled to establish the initial terms and conditions of employment, subject to subsequent bargaining.

- **Under Scenario 2**, where the State continues to operate API, API's labor obligations would not change.

- **Under Scenario 3 or 3-A**, where API staff and management are transferred to a public corporation, the public corporation's employees would remain employees of the State. Accordingly, Alaska State labor law would apply, permitting API's supervisors to remain unionized. Whether the public corporation would be required to adopt the existing CBAs or recognize the unions is, like the private third party in Scenario 1, largely dependent on whether it promises employment to or otherwise hires a majority of its workforce from the predecessor.

- **Under Scenario 4**, where only a portion of API's workforce is transferred to a private employer, the same analysis applies to the components of hospital services/operations that become private as are considered in Scenario 1.

Under any scenario in which the new employer adopts, or the State maintains, the terms and conditions of the existing CBAs, the employer could attempt to bargain a supplemental CBA that appropriately addresses the unique workforce issues that arise in a psychiatric hospital setting. This could be done at any time, including but not limited to upon expiration of the current CBAs.

Under Scenarios 1, 1-A, 3, 3-A, and 4, where the State transfers management of at least some part of the workforce to another employer, existing CBAs require the State to provide the unions 30 days' notice and the option to submit an alternative plan before releasing any bids. *See* CBA between the State of Alaska and the Alaska Public Employees Association (supervisory unit), Art. 6.01 C.1; CBA between State of Alaska and the Alaska State Employees Association, American Federation of State, County, and Municipal Employees, Local 52, Art. 13.01. The State is not obligated to adopt the union's plan. If the State's action displaces bargaining unit members, the State must make a good-faith effort to place those employees elsewhere in State government, with the following order of priority: (1) within the division; (2) within the department; or (3) within State service generally.

Finally, under Scenarios 3, 3-A, and 2, where API's employees remain public, the State has the option to enact legislation that exempts certain public employees (such as API supervisors) from its State labor laws, thereby eliminating their eligibility to participate in union activities and reducing the number of unionized employees at API. This of course would provoke intense lobbying and pressure from Alaska's unions in opposition and likely generate significant media attention.

b. Immunity and Indemnification.

In contracting with a private for profit or nonprofit contractor (Scenarios 1 and 4), the State should consider that absent a legislative change the contractor will not enjoy the same protections from civil action currently provided to API under state law. Currently, under Alaska State law, state employees who are acting within the scope of their employment cannot be sued directly. Instead, the State is substituted as the defendant party to the civil action upon certification by the attorney general that the employee was "acting within the scope of the employee's office or employment at the time of the incident out of which the claim arose." AS 09.50.253(c). Employees of a private contractor would not have this same protection and therefore would need to be protected by insurance policies as contemplated by the RFP. In addition, the qualified immunity protections that are currently available to the State under AS 09.50.250 would not apply to a private contractor but likely would still apply to the extent a litigant were to sue the State for its actions or inactions in overseeing operations assuming the Department retains its status as licensee.

In contracting with a private contractor to perform any functions, the State will want to be very clear which functions it is delegating to the private contractor and which it is retaining for itself, if any, as this division of responsibilities will also define liabilities. In addition, any contract should specify the duty of the private contractor to indemnify, hold harmless, and defend the Department against claims from any third parties. The contract should also specify robust insurance requirements.

The same considerations will apply to Scenario 3 or 3-A. However, in establishing the public corporation, the Legislature will likely determine the extent to which the public corporation and its board and employees can be held liable in a civil action and the protections to be afforded to them. For example, the legislation establishing the Alaska Mental Health Trust Authority states that the authority

> (2) may sue and be sued;
>
> (3) may retain the services of independent counsel when, in the judgment of the authority's board of trustees, independent counsel is needed; [and]
>
> (4) shall insure or indemnify and protect the board, a member of the board, or an agent or employee of the authority against financial loss and expense, including reasonable legal fees and costs, arising out of a claim, demand, suit, or judgment by reason of alleged negligence, alleged violation of civil rights, or alleged wrongful act resulting in death or bodily injury to a person or accidental damage to or destruction of property if the board member, agent, or employee, at the time of the occurrence, was

> acting under the direction of the authority within the course or scope of the duties of the board member, agent, or employee[.]

AS 47.30.011(c). Similarly, the statute establishing the Alaska Railroad Corporation states that the corporation may sue and be sued and permits but does not require the corporation *to* defend and indemnify board members and employees and purchase insurance. AS 42.40.250, 42.40.310. Any legislation forming a public corporation to operate or contract with API would need to address these issues as well.

c. Incorporation of Regulatory Compliance Requirements.

Finally, any contract with a private for profit or nonprofit entity or a public corporation would need to allocate responsibility between the Department and the contractor for compliance with multiple regulatory systems. The following is an initial list of the laws that govern those regulatory systems and that may need to be addressed in any agreement between the Department and a contractor:

State laws

- Laws governing voluntary admission for treatment (AS 47.30.670 – 47.30.695)
- Laws governing involuntary admission for treatment (AS 47.30.700 – 47.30.815)
- Patient rights (AS 47.30.817 – 47.30.865)
- Patient transportation rights (AS 47.30.870)
- Provision for personal needs upon discharge (AS 47.30.890)
- Disposition of unclaimed/personal property (AS 47.30.895 – 47.30.900)
- Payment of patient expenses (AS 47.30.910)
- Licensing laws and regulations (AS 47.32.010 – AS 47.32.900)
- Hospital records retention (AS 18.20.085)
- Mental health patient's right to select staff; duties of hospital staff (AS 18.20.095)
- Overtime limitations for nurses (AS 18.20.400 – 18.20.499)
- Patient records; medical review organizations (AS 18.34.005 – 18.23.070)

Federal laws

- CMS Conditions of Participation and Conditions for Coverage for Hospitals, 42 C.F.R. § 482, including 42 C.F.R. § 482.60 (Special Provisions applying to psychiatric hospitals)
- Privacy, Security, Breach Notification, and Enforcement rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 at 45 C.F.R. Parts 160 and 164
- Confidentiality of Drug and Alcohol Program records, if applicable (42 U.S.C. § 290dd-2(g); 42 C.F.R. Part 2)
- Emergency Medical Treatment and Labor Act, if applicable (42 U.S.C. § 1395dd)
- Medicaid/Medicare Overpayment Report and Return Law (42 U.S.C. § 1320a-7k(d))

- Exclusion Statute (42 U.S.C. § 1320a-7)
- Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
- Physician Self-Referral Law (42 U.S.C. § 1395nn)
- Civil Money Penalty Statutes (42 U.S.C. § 1320a-7a)
- False Claims Act (31 U.S.C. §§ 3729-3733)
- Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. § 263a)
- Controlled Substances Act (21 U.S.C. §§ 801 – 971)

Appendix E: Lawsuit Summaries

***Olmstead* Cases in the U.S.**

Title II of the Americans with Disabilities Act (ADA), commonly referred to as the Integration Mandate or *Olmstead*, mandates that individuals with disabilities are entitled to receive services and live in the most integrated settings appropriate for their care. Entities that receive public funding can be found in violation of *Olmstead* by failing to provide services in the most appropriate, most integrated setting. While initial Olmstead cases focused on clients residing in psychiatric hospitals, many of the recent Olmstead cases have focused on whether states are providing an adequate array of community-based services to individuals at risk of institutionalization to avoid unnecessary hospitalization.

An analysis of API's outcome measures shows that, compared to the national averages, API has high utilization and adult readmission rates, and short median lengths of stay. These indicators support the idea that Alaska uses its state hospital to provide short-term, acute care services, which may also reflect a limited availability of community-based behavioral health and crisis services. In addition to a lack of community-based services, these data may also indicate a lack of alternative, short-term psychiatric inpatient capacity in general hospitals and private psychiatric hospitals in the state, forcing API to serve more acute patients. Such a high reliance on state hospital psychiatric beds at API to provide short-term, acute care and crisis services may lead to individuals who require hospital-level of care languishing in other, less appropriate settings, such as emergency departments or jails and prisons, as they await for hospital beds to become available at API. This issue may be exacerbated by API's current difficulties where they are operating at less than half their licensed bed capacity.

High rates of readmission at API may also indicate improper and inadequate discharge planning at API or inadequate working with community-based behavioral health services to provide timely community-based follow-up for discharged patients. Poor discharge planning, and the lack of availability of appropriate services, either in the community or the state hospital, may put Alaska at a high risk of an *Olmstead* violation. Lessons from other states that have faced *Olmstead* violations may be helpful to the State of Alaska as it works to improve its behavioral health service delivery system, and can give the State an idea of what the potential financial impact of an *Olmstead* lawsuit might be.

Olmstead Expenses

Proactively improving Alaska's behavioral health system can reduce the state's risk of an *Olmstead* violation, which will allow DHSS to allocate resources toward system improvement rather than toward court fees and penalties. The WICHE Team reviewed settlement agreements on www.ada.gov, reviewed newspaper articles, and reached out to a handful of states that have faced *Olmstead* lawsuits in an attempt to determine costs to related to *Olmstead* litigation and Settlement compliance. Potential fees associated with an *Olmstead* violation include:

- **Plaintiffs' fees**: In some instances, the state may be responsible for covering both their own legal expenses, as well as any expenses incurred by the Plaintiffs. Many states use a combination of private attorneys and the State Attorney General's office to defend themselves and these legal fees can be quite high.
- **Court Reviewer/Monitor fees**: An independent reviewer is a neutral third party who is responsible for monitoring compliance to a Settlement Agreement or Consent Decree.

- **Penalties for inaction**: In some instances, the court may require states to pay penalties for non-compliance (e.g., a fee per-person, per-day until that person is transitioned to the community).
- **Cost of system improvement/Consent decree implementation**: These expenses reflect the investment the state is required to make to its system. For instance, these expenses may cover the cost of transitioning individuals out of inpatient settings into the community, expanding the availability of community-based and crisis services, and establishing trust funds for vouchers that support independent living.

The table on the following page provides a snapshot of some of the known expenses states have faced when found in violation of the *Olmstead* mandate. It is important to note that this is not a comprehensive list of expenses, and expenses range considerably based on a variety of factors (size of state, how well the state's community system was operating at the time of a lawsuit, whether/how long the state contested the lawsuit before reaching a Settlement Agreement or being found in violation, etc.). Due to the political nature of *Olmstead* lawsuits, states are reluctant to publicize their actual costs; it is also difficult to accurately quantify and isolate expenses associated with staff time, as staff in various state offices are dedicated *Olmstead* compliance (including the state mental health authority, the Attorney General's Office, etc.). Due to the lack of financial information available related to court costs, all *Olmstead* cases were reviewed, regardless of priority settings and populations identified in the lawsuits.

Table 1: State Olmstead Expenses

State	Plaintiffs' Fees	Court Reviewer/ Monitor Fees	Penalties	System Improvements/ Consent Decree Implementation	Other Comments
Georgia: *U.S. v. Georgia* (2010)	None[53]	Up to $250,000/year $2,750,000 to date, FY10 to FY20 (budgeted)	Unknown	Unknown	Lawsuit filed by the DOJ in 2008; initial Settlement Agreement reached in 2010, and extended in 2016. Case is currently ongoing. Georgia and the DOJ each agreed to pay their own legal fees. Settlement is ongoing.
Illinois: *Williams v. Quinn* (2012)[54]	$2,229,515 (to date, FY12-20)	Average $188,079/year $1,504,632 to date (actual)	Unknown	Average Budget $40,240,930/year $362,168,367 to date **Does not include Court Monitor Fees*	From FY13 to FY19, $94,875,928 of the implementation budget was returned to State Treasury. As of FY19, State also drew down $32 million in Federal Medicaid Match for services. Settlement is ongoing.
Illinois: *Colbert v. Quinn* (2015)[55]	$1,200,000	Average $182,617/year $1,095,702 to date (actual)	Unknown	Average Budget $28,069,900/year $168,419,398 to date	From FY15 to FY19, $44,307,356 of the implementation budget was returned to State Treasury. As of FY19, State also drew down $19 million in Federal Medicaid Match for services. Settlement is ongoing.
New Hampshire: *Amanda D. v. Hassan* (2012)	$2,426,800 total	$175,000/year $1,225,000 to date (budgeted)	None[56]	$30 million	Lawsuit brought by The Disability Rights Center in 2012, Settlement Agreement reached December 2013, to cover improvements to New Hampshire's mental health systems over the course of six years.[57] Settlement is currently ongoing.

[53] https://dch.georgia.gov/document/document/department-justice-settlement-agreement/download
[54] Email correspondence with Court Monitor
[55] Email correspondence with Court Monitor
[56] https://www.ada.gov/olmstead/documents/nh-final-settlement.pdf
[57] https://www.justice.gov/crt/case/amanda-d-v-hassan-united-states-v-state-new-hampshire

State	Plaintiffs' Fees	Court Reviewer/ Monitor Fees	Penalties	System Improvements/ Consent Decree Implementation	Other Comments
New Jersey: *Disability Rights NJ v. Velez* (2005)	Approximately $800,000 total for the Bazelon Center (actual)[58]	$25,000/year plus expenses $200,000 total, plus expenses FY09 to FY17 (budgeted)	Unknown	$104 million in services and rental assistance, plus $200 million special needs housing trust fund.[59]	Lawsuit began in 2005. Settlement agreement reached in 2009, concluded in 2017. In addition to costs listed here, NJ was responsible for paying DRNJ between $88,000 and $94,000 per year to cover expenses associated with reaching compliance. If mediation was required, New Jersey was responsible for any associated fees.[60]
New York: *U.S. v. New York* (2013)[61]	Up to $225,000/year	$350,000/year	Unknown	Unknown	Settlement Agreement filed in 2014, amended in 2017. Settlement is ongoing.
North Carolina: *U.S. v. North Carolina* (2012)[62]	None	$250,000/year $1,750,000 total for the length of the Settlement Agreement (budgeted)	Unknown	Unknown	Entered into eight-year Settlement Agreement in 2012; extended for one more year in 2017. Settlement Agreement will conclude on July 1, 2021. The U.S. and North Carolina each agreed to pay their own attorneys' and court fees.
Oregon: *Lane et al v. Brown et al* (2012)[63]	Up to $90,000/year	$250,000/year	Unknown. Financial penalties to be determined by both parties if the state fails to meet certain goals set forth in the Settlement Agreement.	Unknown	Settlement agreement reached in 2015 and is currently ongoing; expected to conclude in 2022.

[58] Email correspondence with the Bazelon Center for Mental Health Law.
[59] http://www.tacinc.org/blog/2017-access-blog-posts/march-2017-two-olmstead-settlements-resolved/
[60] https://www.clearinghouse.net/chDocs/public/PB-NJ-0004-0009.pdf
[61] https://www.ada.gov/olmstead/documents/141-1%20SUPPLEMENT%20(002).pdf
[62] https://www.ada.gov/olmstead/olmstead_cases_list2.htm
[63] https://www.ada.gov/olmstead/documents/lane_sa.pdf

State	Plaintiffs' Fees	Court Reviewer/ Monitor Fees	Penalties	System Improvements/ Consent Decree Implementation	Other Comments
Virginia: *U.S. v. Commonwealth of Virginia* (2012)	None	Up to $300,000/year	Unknown	$800,000 housing fund for housing assistance.	Settlement Agreement reached in 2012, set to conclude in 2020. The U.S. and Virginia each agreed to pay their own legal fees. There may be other funds allocated toward system improvement.
Washington: *Trueblood et al v. DSHS* (2014)	Unknown	Unknown	DSHS found in contempt in October 2017. Judge issued penalties of $750 per person, per day for individuals waiting beyond 14 days to receive competency evaluations. As of 2018, state fined $83.4 million.[64]	$3 million to expand funding for mental health programs for law enforcement; $1,200 per person for six months for high utilizers (number of people unknown). Other investment totals unknown.[65]	In 2015, a federal court found DSHS was violating defendants' rights by taking too long to evaluate competency. An initial Settlement Agreement was reached in 2015. To resolve issues with compliance, the Trueblood Implementation Plan was developed and submitted in 2019.
West Virginia Department of Health and Human Resources (2014)[66]	None	Unknown	Unknown	Unknown	Investigation initiated in 2014. Settlement agreement reached in 2019 and is currently ongoing. Settlement Agreement calls for $125,000/year for technical assistance activities to reach compliance. The U.S. and West Virginia will each bear the costs of their own legal fees.

[64] https://www.seattletimes.com/seattle-news/judge-oks-settlement-in-case-against-washington-state-over-delays-in-mental-competency-services/
[65] https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2019Trueblood/679_1_ExhibitA_FinalPlan.pdf
[66] https://www.ada.gov/olmstead/documents/wv_agreement.pdf

Should Alaska continue operating API as it has in the past, the State is exposing itself to a potential *Olmstead* lawsuit. If faced with an *Olmstead* violation, and a Settlement Agreement is reached, Alaska will – at minimum – be required to pay for the cost of an independent court monitor once a settlement agreement or consent decree is reached. Based on other states' experiences, this expense may range between $175,000 to $300,000 per year. The total amount allocated to a court monitor will depend upon the length of the Settlement Agreement.

Depending on who the litigating party is, Alaska may also be faced with covering the cost of the Plaintiff's legal expenses. Based on prior *Olmstead* lawsuits, if the U.S. brings the charges, then the Department of Justice will likely bear its own legal costs. However, if an individual party represented by a private attorney (e.g., state Protection and Advocacy Attorney) files suit, the state may then be liable to cover the Plaintiff's legal fees as well as its own. Based on other states' experiences, this can range from $800,000 (New Jersey) to more than $2.2 million (and counting; Illinois).

Systems improvements required by *Olmstead* Settlement Agreements also require a significant investment by the state. Our research shows that states have invested between $30 million (New Hampshire) and $362 million (Illinois) to make the improvements required under *Olmstead* Settlement Agreements. The smallest amount identified, from a small state that wishes to remain anonymous, is $20 million for the expansion of community-based programs. These investments cover the cost of transitioning individuals out of institutional settings into the community, and the cost of services and supports required to ensure a successful transition. Illinois has budgeted more than $362 million over seven years to improve its system based on the findings of *Williams v. Quinn*.

While not common, states may also be required to pay penalties for non-compliance. Washington State accrued $83.4 million in fines for non-compliance under its *Trueblood* Settlement Agreement.

The variation in amounts spent by states for legal fees is dependent upon multiple factors, including the length of time a state spends in litigation, whether the case is settled quickly or goes to trial, and the strength of the state's negotiating position. In addition, the amount spent to make improvements to the behavioral health system is also dependent upon the quality and amount of infrastructure the state already has in place. To summarize what Alaska may expect in terms of expenses should it be faced with an *Olmstead* lawsuit for the quality of care provided at API, the range of typical legal expenses identified through the WICHE Project Team's research are listed in the table below.

Expense	Minimum	Maximum	Comments
Plaintiff's Fees	$0	$2.4 million	Amount dependent on filing party. If DOJ files suit, the U.S. bears the cost of its own legal fees.
Independent Reviewer/ Court Monitor	$25,000 plus expenses *annually*	$350,000 *annually*	Total dependent upon length of Settlement Agreement/time to remedy. Shortest identified is five years.
Total	$125,000+	$4,150,000	Assuming the ***least*** amount of time to reach compliance (5 years). Does not account for any potential penalties for delayed compliance or failure to comply, or for any of the expenses associated with system improvements.

Olmstead Cases Relevant to Alaska

To identify relevant *Olmstead* cases, the WICHE Project Team searched the internet and other sources[67] for *Olmstead* cases related to adults with mental illnesses filed after 2010. The WICHE Project Team narrowed down the list of cases to those focused on the inappropriate placement of individuals with a mental illness in a state hospital, cases that identified a need for improved discharged planning to ensure an individual's success in the community, and cases that involved sending individuals out-of-state for treatment. Researchers excluded *Olmstead* cases that solely focused on providing services to individuals with developmental and physical disabilities hospital, and also excluded institutional settings other than the state hospitals (i.e., nursing facilities and residential treatment programs). Cases that may provide valuable insight to the State of Alaska are listed below. In addition to the information provided here, the State of Alaska may find it beneficial to reach out to the state mental health authorities in Delaware, New Jersey, and Mississippi for valuable lessons learned, and estimates on state expenditures settling and/or fighting *Olmstead* investigations.

[67] SAMHSA Docket

Summary of Recent *Olmstead* Cases and Lessons for Alaska

State and Case	Description of Violation and Settlement	Lessons for Alaska
Delaware *U.S. v. Delaware (2011)*	State found in violation of *Olmstead* due to a lack of community-based services, especially crisis services. As part of Settlement, Delaware had to establish: 11 ACT Teams, 4 intensive case management (ICM) teams, 25 targeted case managers, 650 housing vouchers/subsidies, supported employment services for 1,100 people, supported education services for 1,100 people, and family/peer support services for 1,000 people. Also had to establish a statewide quality management system.	Expand community-based crisis services to ensure that individuals receiving treatment at API require hospital-level care, which will also reduce the waitlist for people needing services at API if they can effectively receive treatment in the community. Alaska may also consider establishing a quality management system to determine how effective the community services are at meeting the needs of its citizens.
Georgia: *U.S. v. Georgia (2010)*	State found in violation of *Olmstead* by keeping individuals unnecessarily segregated in the state psychiatric hospitals. As part of the Settlement, Georgia had to: serve 9,000 individuals with SPMI who are frequently institutionalized or at risk of institutionalization in the community; develop 22 ACT teams, 8 community support teams, 14 ICM teams, 45 case management service providers, 6 crisis service centers, 3 crisis stabilization programs, and an unspecified number of community-based psychiatric beds, mobile crisis teams, crisis apartments, crisis hotline, supported housing, supported employment, and peer support services. Also had to establish a statewide quality management system. Settlement Agreement extended in 2016 to expand capacity of community-based services for individuals with IDD and mental illness.	Expand community-based services to ensure that individuals can receive short-term, acute-care services in the community. This will prevent individuals from being inappropriately segregated in the state hospital and will reduce burdens on emergency rooms and homeless shelters. This will also free-up beds at API to provide more intensive services to individuals who need hospital-level care.
Mississippi: *U.S. v. Mississippi (2016)*	A lack of behavioral health services in the community leads to unnecessary institutionalization of individuals with mental illness in the state's four state psychiatric hospitals. After a four-week trial in the summer of 2019, the U.S. District Court found Mississippi in violation of *Olmstead.* The State and the Court are working together to find solutions to improving Mississippi's behavioral health system. Mississippi was aware of the DOJs concern in 2011 and did not make adequate steps	Expand community-based mental health and crisis services in Alaska to prevent unnecessary institutionalization of individuals at API. Alaska could work to get ahead of any investigations by the DOJ by making necessary improvements to the community now.

	to improve the system; therefore, the state went through a costly trial and was still found in violation of *Olmstead.*	
New Hampshire *DOJ Findings Letter to New Hampshire (2011)*	A drastic decline in community-based acute and crisis services may result in individuals unnecessarily institutionalized, and even ending up in settings not designed to provide mental health care, such as jails and prisons.	A lack of available beds at API may result in individuals ending up in even less desirable settings not designed to provide mental health care services (e.g., jails and correctional facilities). Expand crisis services in the community to prevent individuals from ending up in institutionalized settings, including jails, correctional facilities, and the state hospital.
New Hampshire *Amanda D. v. Hassan (2012)*	New Hampshire failed to provide community-based mental health services, resulting in individuals unnecessarily institutionalized in the state hospital. Settlement Agreement reached in 2013 requiring the state to expand supported housing to include 450 scattered-site units; expand ACT teams to serve 1,500 individuals; expand supported employment programs; and provide new mobile crisis services.	Expand community-based services to meet the needs of individuals to eliminate their need for crisis services and acute care at API.
South Carolina *A.W. v. Magill (2017)*	A lack of community services provided by the state results in individuals unnecessarily languishing in Werber Bryan State Hospital	Expanded community services will prevent individuals in Alaska from becoming unnecessarily institutionalized at API.

Delaware: *U.S. v. Delaware (2011)*

On July 6, 2011, the Division of Substance Abuse and Mental Health filed in District Court a complaint and simultaneous Settlement Agreement resolving its investigation into whether persons with mental illness residing in the Delaware Psychiatric Center are being provided appropriate services while at the Center, and whether residents could be served in more integrated settings appropriate to their needs. Pursuant to the Agreement, Delaware will create a comprehensive community crisis system to serve as the front door to the state's mental health system, including a crisis hotline, mobile crisis teams able to reach someone within one hour, two walk-in crisis centers, and short-term crisis stabilization units. The agreement also commits the state to providing intensive community-based treatment through the development of 11 Assertive Community Treatment (ACT) teams, 4 intensive case management (ICM) teams, and 25 targeted case managers. Delaware will also offer at least 650 housing vouchers or subsidies to allow individuals to obtain stable, integrated housing. The state will also develop evidence-based supported employment services for 1,100 people, and family/peer support services to 1,000 people. The Settlement Agreement also requires Delaware to establish a statewide quality management system reflecting qualitative and quantitative measures.[68]

Georgia: *U.S. v. Georgia (2010)*

On October 19, 2010, the DOJ entered into a comprehensive Settlement Agreement with the Sate of Georgia resolving the U.S.'s complaint alleging that individuals with mental illness and developmental disabilities confined in state hospitals were unnecessarily institutionalized in violation of the ADA. The agreement requires Georgia to expand community services so that individuals can receive supports in the most integrated setting appropriate to their needs. Specifically, for individuals with mental illness, the agreement provides that Georgia will serve in the community 9,000 individuals with serious and persistent mental illness who are currently served in state hospitals, frequently readmitted to state hospitals, frequently seen in emergency rooms, chronically homeless, and/or being released from jails or prisons. Services will be provided through a combination of 22 ACT teams, 8 community support teams, 14 ICM teams, 45 case management service providers, 6 crisis service centers, 3 additional crisis stabilization programs, community-based psychiatric beds, mobile crisis teams, crisis apartments, a crisis hotline, supported housing, supported employment, and peer support services. The agreement also provides for a statewide quality management system for community services.

Mississippi: *U.S. v. Mississippi (2016)*

On December 22, 2011, the ODJ sent a letter to Mississippi's Governor finding the state's developmental disabilities and mental health systems out of compliance with the ADA's integration mandate. It refers to Mississippi as a "broken system" whose reliance on institutional care "harms residents" and "incurs unnecessary expense" for the state. The DOJ instructed the Governor to make remedial measures or face litigation, among the remedial measures:

- Divert new admissions from state facilities by offering comprehensive supports in the community
- Offer intensive community services across the state, including ACT, crisis services, case management, peer support, supportive housing, supported employment, and transportation services to enable individuals with SMI to remain successfully in the community.
- Institute a quality assurance system to ensure the safety of those individuals who are in the community or return to the community with supports. Professionals should regularly review and

[68] SAMHSA Docket

assess the safety, treatment, and services provided by the state and by community providers. After each review, the state should require that providers implement plans for correcting any deficiencies identified by the process.

However, on August 11, 2016, the DOJ filed a complaint against the State of Mississippi, alleging that the state violates both *Olmstead* and the Civil Rights of Institutionalized Persons Act (CRIPA) by failing to provide adults with mental illness with necessary community-based mental health services, which results in individuals seeking treatment at one of the state's four state psychiatric hospitals. Such inappropriate placement subjects adults with mental illness to needless trauma, especially during a crisis.[69] On September 3, 2019, the U.S. District Court ruled that Mississippi was in violation of *Olmstead.* The State and the Court are currently developing a comprehensive action plan to improve the behavioral health system in Mississippi.[70]

New Hampshire: *DOJ Findings Letter to New Hampshire (2011)*
The letter suggests that the State of New Hampshire fails to provide services to individuals with mental illness in the most integrated setting appropriate to their needs, which has led to the needless and prolonged institutionalization of individuals with disabilities, and has placed them at increased risk of unnecessary institutionalization. This lack of community-based crisis services also results in a greater likelihood that some individuals will end up in even less desirable settings not designed to provide mental health care, such as the state corrections system and county jails. The letter finds that acute care/crisis alternatives to institutional care have diminished drastically in recent years, and that there is a lack of safe, affordable, and stable community housing for persons with mental illness.

New Hampshire: *Amanda D. v. Hassan (2012)*
Plaintiffs alleged that the State of New Hampshire failed to provide mental health services in the community, in direct violation of the ADA, and therefore people with mental illness who need services are forced to seek treatment at the state hospital and other institutionalized settings. The DOJ intervened after an investigation and reached a Settlement Agreement with the State of New Hampshire. New Hampshire was required to expand its supported housing to include a minimum of 450 scattered-site supported housing units, expand ACT teams to provide services to 1,500 people, expand supported employment programs, and provide new mobile crisis services.

South Carolina: *A.W. v. Magill (2017)*
The South Carolina P&A and private attorneys filed a class action lawsuit against the South Carolina Department of Mental Health and its Commissioner on behalf of individuals with mental illness who are forced to reside in the Werber Bryan State Hospital for longer than necessary because they are unable to access appropriate community mental health supports. Plaintiffs allege that the state is in violation of the ADA for unjustifiably isolating and segregating individuals at Bryan Hospital; failing to consistently provide adequate integrated services in the community; overly and inappropriately relying on segregated residential facilities for outpatient treatment; failing to develop and maintain a working *Olmstead* plan; employing policies that create arbitrary barriers to effective discharge to the community; and charging

[69] https://www.justice.gov/opa/pr/justice-department-sues-mississippi-discriminating-against-adults-mental-illness
[70] https://www.ada.gov/olmstead/documents/decision_miss.pdf

the Plaintiffs fees of $500+ per day for unnecessary and unjustified hospitalization, creating a perpetual burden of debt. The case is currently pending in the U.S. District Court.[71]

[71] http://www.bazelon.org/awvmagill/

Appendix F: List of Peer Hospitals

State	Hospital Name	Number of Beds
AK	Alaska Psychiatric Institute	80
AZ	Palo Verde Behavioral Health	84
AZ	Quail Run Behavioral Health	102
AZ	Banner Behavioral Health Hospital	104
CA	Aurora Behavioral Healthcare-Santa Rosa, LLC	95
CA	John Muir Behavioral Health Center	73
CA	Loma Linda University Behavioral Med Ctr	89
CO	Colorado Mental Health Institute at Ft Logan	94
CO	Centennial Peaks Hospital	83
CO	Clear View Behavioral Health	92
HI	Kahi Mohala	88
ID	State Hospital South	106
ND	North Dakota State Hospital	103
NV	Dini-Townsend Hospital at NNMH	70
OR	Cedar Hills Hospital	89
WY	Wyoming State Hospital	73