South Central Regional Psychiatric Hospital Advisory Panel

Agenda

March 22, 2024 1:00-3:00 PM

6th Floor Conference Room,
Sedgwick County Offices 100 N. Broadway, Suite 630
And Zoom

Join Zoom Meeting

https://us02web.zoom.us/j/83500161344?pwd=dXlNVC9vQ1VqL2VOWkd6aHVHMFpvQT09

Meeting ID: 835 0016 1344

Passcode: 443919

I. Call to Order

Scott Brunner, Deputy Secretary, Kansas Department for Aging and Disability Services

II. Approval of Minutes from February 23, 2024

Scott Brunner

III. Update on February 26 Townhall and Survey Results

Lisa Pelkey, Ph.D. Learning Tree Institute

IV. Project Updates

Scott Brunner and Tania Cole, Assistant County Manager, Sedgwick County

V. Presentations on State Psychiatric Hospital Operations and Privatization Approaches

Ted Lutterman, National Association of State Mental Health Program Directors Research Institute and Dr. Brian Hepburn, National Association of State Mental Health Program Directors
Tim Keck, President of Ancillary Services VitalCore Health Strategies
David Mica, Executive Vice President for Public Affairs, Florida Hospital Association (invited)

VI. Subpanel Preview – Dates, Meeting Structure, Key Questions and Community Members

Ryan Vaughn, Learning Tree Institute

Scott Brunner

VII. Adjourn

South Central Regional Psychiatric Hospital Advisory Panel

February 23, 2024 1:00-3:00 PM
6th Floor Conference Room,
Sedgwick County Offices 100 N. Broadway, Suite 630

Panel Members Attending

Scott Brunner, Deputy Secretary of Hospitals and Facilities, KDADS
Sarah Lopez, Sedgwick County Commissioner, 2nd District
Claudio Ferraro, Ascension Via Christi St. Joseph
Jason Gregory, Downtown Wichita
Jeff Easter, Sheriff, Sedgwick County
Joan Tammany, Director, COMCARE
LaTasha St. Arnault, President and CEO, Humankind Ministries
Mary Jones, President/CEO, Mental Health Association of South Central Kansas
Tom Stolz, County Manager, Sedgwick County
Representative Henry Helgerson, 83rd District
Senator Usha Reddi, 22nd District

Panel Member(s) not in attendance:

Marc Bennett, District Attorney, Sedgwick County
Representative KC Ohaebosim, 89th District
Representative Will Carpenter, 75th District

I. Call to Order

Chairperson Brunner called the meeting to order at 1:00 PM.

II. Approval of Minutes from December 18, 2023 and January 8, 2024

Mr. Easter moved to accept both sets of minutes, and Representative Helgerson seconded. Minutes approved.

III. Project Updates

Tania Cole, Assistant County Manager, reported that Pulse and GLMV have begun working on design starting January 19, 2024. The schematic design layout has begun, and work will begin soon for on-site planning and design. The team has toured the Osawatomie State Hospital and will visit Larned State Hospital on Tuesday (February 27). A project timeline was shared with the Panel and is attached. Construction is estimated to begin in February 2025 and be completed by August 2026.
Cole reported on conversations with the Lange Family Foundation regarding the location of the facility on their existing site. Considerations in that discussion include traffic flow and best practices in patient care. Currently, the southwest portion of the site will be utilized rather than the initially assigned

northwest portion of the site. The current design has the facility facing MacArthur, using for site circulation and access to utilities.

Chairperson Brunner reported the Governor's Office approved designing the building with expansion up to 104 beds.

The Panel had an extensive discussion regarding the technical processes involved in pricing the construction of 104 beds as the existing design phase moves forward. Items of discussion included coordination of timing with the appropriations process, existing acreage at the site, timing of use of existing funding sources, and consideration of other sites.

Several panel members expressed concern over the consideration of any other site at this time. These concerns were centered around the County's commitment to the agreed-upon process and adherence to, the intent of the creation of the Panel, and possible intersections with other members of the Legislature. Additionally, a discussion about transparency and adherence to federal ARPA funding requirements followed.

Chairperson Brunner indicated that KDADS is working on staffing models and the design process with KDADS and State Hospital staff. Panel members were invited by Chairperson Brunner to tour any existing state facility and to attend a Town Hall meeting regarding the selected site at MacArthur/Meridian being held on Monday, February 26, 2024, at South High School from 6:30 to 8:30 PM. Mr. Ferraro also welcomed the design team to tour Ascension Via Christi, St. Jospeh campus.

IV. Presentations on Workforce Development

Lynn Loveland, Dean of Health Sciences WSU Tech, presented on workforce efforts her institution has experienced and offered suggestions for the direct patient care fields. Specifically, changing the image of behavioral health care for potential new students will be needed. Facility closings and low pay are of concern to a student choosing a field of study. Several needs were identified, including the need for a career ladder in behavioral health direct service, increased compensation for faculty members at the higher education level, clinical sites for licensed mental health technicians, and apprenticeships.

Dr. William Gabrielli and Dr. Angela Mayorga May, University of Kansas School of Medicine, provided an update on the training of psychiatrists at the Kansas City location of the University. Both doctors discussed how the educational pipeline works, including funding residency positions. The logistics of using residents in the new facility and the funding required to expand resident slots were discussed. The slides of the presentation are included as part of these minutes.

Julianna Rieschick, Chief Nursing Officer at Providence Medical Center and member of the Kansas State Board of Nursing, provided information to the Panel regarding a specific area of workforce shortage, the Licensed Mental Health Technician. Rieschick referred the group to the Board of Nursing Annual Report 2023, page 11, reflecting the low number of licenses issued in this field. A pipeline could be built

between the Board and institutions of higher education to focus on this area. This kind of partnership has been successful with other health care providers. Attention to the Nurse Practice Act and partnerships to develop a curriculum could be key.

Dr. Jana Lincoln and Mark Parmley, University of Kansas School of Medicine - Wichita, presented their perspective regarding workforce development in psychiatry. They shared a historical perspective of the school and offered a perspective from a local point of view. Regarding barriers, the presenters shared that faculty recruitment and retention is difficult. At the same time, the number of individuals applying for a psychiatric residency is high, with the Wichita program oftentimes receiving up to 800 applications for six openings.

Some solutions offered were student loan repayment, increasing clinical site opportunities, increasing residency slots through increased funding, increasing understanding of the complexity of the patients in an acute care hospital, and increasing the capacity for additional full-board licensed providers within a facility.

V. Subpanel Preview

Chairperson Brunner shared the Draft Subpanel Process Updated 2.23.24. He announced the April Panel meeting would be replaced with Subpanel groups and requested names of individuals to include in the work groups. Subpanel discussion and recommendations would be brought back to the Panel for May and June meetings. Brunner encouraged the Panel to suggest who to bring in as experts for the Subpanels.

Brunner also previewed the March meeting, with the focused topic of looking at the potential of privatization of services at the new state hospital.

VI. Adjourn

Motion to adjourn by Vice Chair Lopez and seconded by Ms. Jones. The meeting adjourned at 2:55 PM.

Town Hall 2 Data Report

Published February 2024

CENTER OF COMMUNITY SUPPORTS AT GREENBUSH

GRANTS, RESEARCH AND EVALUATION

Town Hall Data Report

Prepared by
The Learning Tree Institute at Greenbush
Research & Evaluation Department

Town Hall 2 Data Report

Learning Tree Institute at Greenbush
February 2024

Learning Tree Institute at Greenbush. (February 2024). Town Hall 2 Data Report. *Learning Tree Institute at Greenbush* on behalf of the *Kansas Department for Aging and Disability Services (KDADS)*.

Table of Contents

Introduction

On behalf of the Kansas Department for Aging and Disability Services (KDADS), the Learning Tree Institute at Greenbush (LTI) gathered qualitative data during a Town Hall 2 session in Wichita, Kansas, on February 26, 2024, from 6:30 p.m. to 8:30 p.m. In addition to in-person, the Town Hall 2 was live-streamed for individuals unable to attend. The purpose of the Town Hall 2 described on a February 5, 2024, flier indicated the topic of discussion would be to provide an opportunity for community members and additional stakeholders to learn more about the plans for a new state psychiatric facility to be built at MacArthur and Meridian. Fliers were sent to Scott Brunner, Iryna Yeromenko, and Melinda Gaul from KDADS to distribute to the Advisory Panel and their contacts; Tania Cole and Nicole Gibbs from Sedgwick County to distribute to their groups; Megan Lovely and Jim Jonas from the City of Wichita to spread on social media; and to the LTI maintained contact Sedgwick County distribution list.

To that end, two presentations were facilitated by KDADS and Sedgwick County, which provided the most recent updates on the project. Each presentation was between 10-15 minutes in length. In addition to the presentations, the community examined one aerial map which pinpointed the site for the proposed hospital.

LTI gathered feedback in two ways: a question-and-answer session and a two-question survey.

Data was collected by Lisa Pelkey, Ph.D., Statistical Analyst; Monica Murnan, Director of Community Support Services; Dawn Flores, Project Manager; Ryan Vaughn, Ed.D., Project Manager; Jenn DeLee, Program Evaluator I, and Bonnie Houk, Project Manager from LTI. This team has relative experience and expertise in qualitative and mixed-methods research.

Community Participants

The Town Hall 2 attendance was approximately 143 in person and up to 10 on live stream. Attendance was taken at the beginning of the Town Hall 2 at approximately 6:30 p.m. It was noted that a few additional community members arrived after the start time, and a few left prior to the scheduled end time. The approximate attendance total is set at n=153. No demographic information was gathered on the attendees.

To allow residents not attending to participate, an additional survey, *Citizen Feedback Extended Town Hall 2 Survey*, was available for residents to provide feedback. The data collected can be viewed in Appendix B.

Town Hall 2 Agenda

The following agenda was used during the Town Hall to ensure a smooth flow to the meeting and an opportunity for every individual to provide the level of input desired.

Questions Presented to KDADS and Sedgwick County Representatives by Attendees

Attendees wrote questions on notecards for the moderated Question and Answer session from 7:15 p.m. to 8:30 p.m. After reviewing and synthesizing the attendees' questions, the following questions were developed for the Question and Answer session. This review and synthesis ensured the moderator could move smoothly through the questions and avoid repetition. No attendee questions were omitted for content. Four attendee's note cards were not read as they contained personally identifiable information and/or did not include a question. These note cards were included in the summary in this report's Comment Analysis section. The questions, in no particular order, are provided below. Questions have been revised for grammar, spelling, and clarity. The language in brackets indicates language has been added to the question to increase readability.

1. What will be done about our loss of home or property value?
   Our hospitals can't stay properly staffed. How will this be different?

2. How can we, as a community, support this effort to be something we are proud of?

3. What are the considerations for best practices [for facilities and the building]? What does the new place [hospital] look like?

4. Will there be funds for hiring and retaining staff?

5. MacArthur is between Meridian and West Street, [which] is mostly in the county. Will that area be annexed into the city?

6. Why wasn't North Greenwich chosen with fewer homes and schools in the vicinity?

7. My house(s) are our investment. Were there any thoughts on the home owners investment? Do you think it will increase or decrease value?

8. What is the plan for the work/staff development? Including the need for a training program?

9. Meridian is a four-lane road. Why not build closer to Meridian?

10. Where will it [the hospital] be located? Is the land paid for? Will it be open 24/7? Will they accept all insurance companies? What is the budget for the upkeep of the buildings? How will they recruit qualified staff? How will the building bleed into the neighborhood to look welcoming? Is the builder from Kansas?

11. Has there been a study showing what this facility will do to homeowners around McArthur and Meridian? How much will my property be devalued? Will homeowners get an immediate warning when someone escapes from the facility? Will there be people accused of murder at this facility?

12. How can NAMI of Kansas and Wichita be involved?

13. Many general hospitals have struggled tremendously with staffing, causing patient-to-staff ratios to be stretched to unsafe levels. If the facility is understaffed, how will this be considered when admitting patients on the day-to-day?

14. What will perimeter lighting look like? [Will it be] on all night? Clear around the perimeter? What will occur to make sure the lighting does not bother people living in the area?

15. What will the discharge procedures be? Will patients be discharged directly into the community? If so, will you allow sex offenders and violent offenders into the community?

16. Why are you not talking about Riverside or Mansion Home? They are available now. The county has, in the past, gone in and remodeled to suit the needs! These two places make

sense. Is this going to be for only Sedgwick County? How does the COVID money apply to this project?

17. What was the justification for building a new hospital when another option was a hospital?

18. Party affiliations left to right, please? Explain how “COVID relief” is paying for this? How is this related to COVID?

19. What if the community rejects this now?

20. Are you concerned that we could quickly outgrow even a 100-bed hospital? People waiting for competency restoration are already over the potential 25 beds. Will there be space to expand more in the future if needed? Other counties often refer patients to Sedgwick County because there are more resources. This State Hospital will most likely increase displaced and unhoused patients. Are there any plans to improve our dire shelter situation when the winter shelter is closed?

21. Will this be the only meeting?

22. Of all the persons who are members of the planning groups, I notice no family members or patients living in recovery; our lived experiences could add a must [needed insight] to the planning process. How can this happen?

23. [Regarding security] [What will be the] security staff numbers per shift? Who will provide state vs county vs private? Why potentially no fencing? What about previous escapes from facilities? Nurse to patient ratio? Transport from hospitals to facilities due to “Banana Bus” issues? How can location be neighborhood compatible so close to homes/schools? Besides Sedgwick County, what other counties will use it?

24. If you already know that you want this facility to be a 100 bed facility, why not do it now?

25. Why are there no people from the community on the panel? In my opinion, this is a poor representation of community involvement. I would like to see family members from NAMI on this panel.

26. Is there outdoor recreation? Will we hear patients outside?

27. Why have you chosen a site that is within a densely populated area near several schools?

28. Who will be transporting individuals back to their original housing? Who will be transporting inmates? Staffing? What will happen if an inmate is released from custody while being evaluated? Will they be released from the facility or detention facility? Will inmates have a person of law enforcement beside the whole inmate at the hospital? How will walk-ins be treated? If there are walk-ins that are dropped off, will they be stranded? How will this function in comparison to ComCare?

29. Will the building inside/out be monitored by cameras? Who will provide security manpower? Protocols if a patient walks away from hospital? Will we be notified? Is there a more secure room if someone does walk away? Safety for neighborhood children (e.g., kids at bus stops, playing outside)? Traffic on MacArthur? How will an uptick in traffic keep up with the two-lane road? Do you expect them [property taxes] to go up to pay for expansions?

30. How soon for the rest of the plan [One Rise] to take off and affect the homeowners that live next to it? More accidents with increased traffic? More worries with foot traffic. Will you talk about One Rise?

31. Will this increase service demand for EMS, Fire, and Police?

32. What happens when a patient is released? What workload will this bring to fire station 12? Also EMS? As for expanding the community, who do you see wanting to build next to this hospital and why? Were neighborhoods and Churches consulted?

33. Why is it [the hospital] being built right next to a house and now several acres away [when an entire field was for sale and the field on the south side of MacArthur was for sale] ?

34. Is there an updated One Rise master plan showing the new selected spot of the hospital on the site?

35. Will the hospital partner with local organizations to offer mental health well-being as an outreach?

36. [How will you hire] providers, nurses, PD patrol [when they are already understaffed]? How will this facility change that [an approximately 327-day wait to be evaluated for these criminals]? How long will they [patients] be held there [hospital]?

37. What about the residential side of safety [versus the safety of staff and patients]? This takes our peace of mind away. How are you giving it back to us?

38. With forensic cases, what are the chances with prison/jail overcrowding to hold inmates here in the future? Larnard currently has high-level inmates. Will it happen here?

Representatives responded to every question with a thorough response. The responses were not collected.

Comment and Zip Code Survey

From 6:00 p.m. to 9:30 p.m., attendees were provided an opportunity to express their opinions about the project via survey. The Town Hall 2 started promptly at 6:30 p.m.; however, attendees could respond to the QR Code as early as 6:00 p.m. This opportunity was provided electronically and on paper. One attendee used paper, and 36 used an electronic survey (QR Code) for a total of 37 responses. Attendees using the electronic survey were required to submit a zip code of residence.

At the conclusion of the survey, attendees could indicate if they desired to be included on a listserv. Twenty-seven indicated they would like to be contacted for future opportunities to provide feedback. These 27 individuals were added to the LTI-maintained Sedgwick County Project Contact List.

Comment Analysis

Themes in qualitative research are recurring patterns, ideas, or concepts that emerge from the data collected during the analysis process. These themes provide a way to organize and understand the richness of qualitative data. It is essential to note themes in qualitative research are derived from an inductive process, allowing the data to guide the identification of patterns and meaning. Researchers at LTI used various methods, such as coding and thematic analysis, to analyze and interpret this qualitative data systematically.

The top five themes that emerged from the comments (n=32):

Location Concerns: There is significant discussion about the suitability of the chosen site for the facility. Some express concerns about its proximity to schools and neighborhoods and its impact on safety and aesthetics.

“My family is extremely concerned about the safety of my grandchildren, who live 1.5 miles from the proposed facility. I'm sitting in the meeting getting the impression this is being crammed down the residents' throats, and it's being built here because we are the poorer part of town compared to the other areas.”

Community Engagement: Many comments emphasize the importance of involving the community in decision-making regarding the facility's location and operation. There is a desire for transparency and inclusion of community members in planning and decision-making.

“We would love to see education given to the residents and businesses in the area to rid the fear they are feeling.”

Need and Support for Mental Health Services: There is overwhelming support for establishing the mental health facility, with many expressing gratitude for the much-needed resources and acknowledging the necessity of additional psychiatric beds and services in the community.

“I'm in favor of it. Please find a way to build 100 beds!”

Staffing and Workforce Concerns: Several comments address the importance of recruiting and retaining quality staff for the facility. There are mentions of ensuring appropriate pay and incentives to attract skilled professionals to work in the mental health field.

“This is such a big need in the community. Please move forward and ensure appropriate pay and incentives for staff retention. People are going into these fields, but they won't work for less than they are worth.”

Alternative Site Suggestions: Some participants suggested alternative locations for the facility, such as Riverside Hospital or rural areas, citing concerns about the chosen site's suitability and impact on the surrounding community.

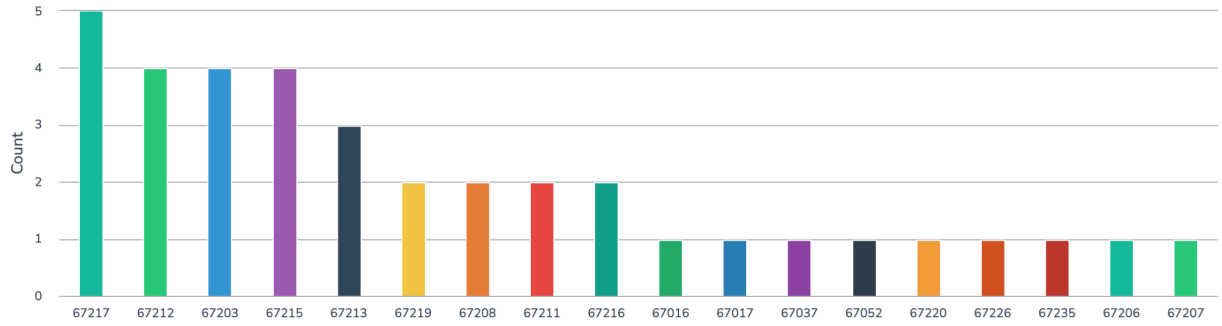
“That there are multiple closed or closing schools in Sedgwick County along with both Riverside and Halstead hospital campuses that would serve as strong potential sites. I am against any new construction for this resource, but I am for expanding opportunities and bed space for those needing such services.”

Zip Code Analysis

The attendees' self-identified zip codes are displayed in Table 1. Two attendees were not residents of Sedgwick County. The survey automatically disqualified their surveys. Most attendees were from zip codes 67217, 67203, 67215, 67212, and 67213. The zip code of the MacArthur and Meridian site is located in zip code 67217. Respondents represented eighteen zip codes.

Table 1

Table 1: Attendees Zip Codes



Colors in Table 1 are arbitrary.

Special Considerations

Qualitative research offers valuable insights into the complexities of human behavior and experiences, but it also has limitations. The following four limitations apply to this data analysis.

- Qualitative research is inherently subjective, as it involves the interpretation of data by researchers. Researchers' personal biases and perspectives may influence the analysis and interpretation of findings. (subjectivity and bias)

- One of the main criticisms of qualitative research is the challenge of generalizing findings to larger populations. Qualitative studies often involve small, non-random samples, making applying results beyond the study's specific context difficult. (generalizability)

- Qualitative studies may lack the detail needed for other researchers to replicate the study exactly. The context-specific nature of qualitative research can make it challenging for others to reproduce the same conditions and obtain similar results. (lack of replicability)

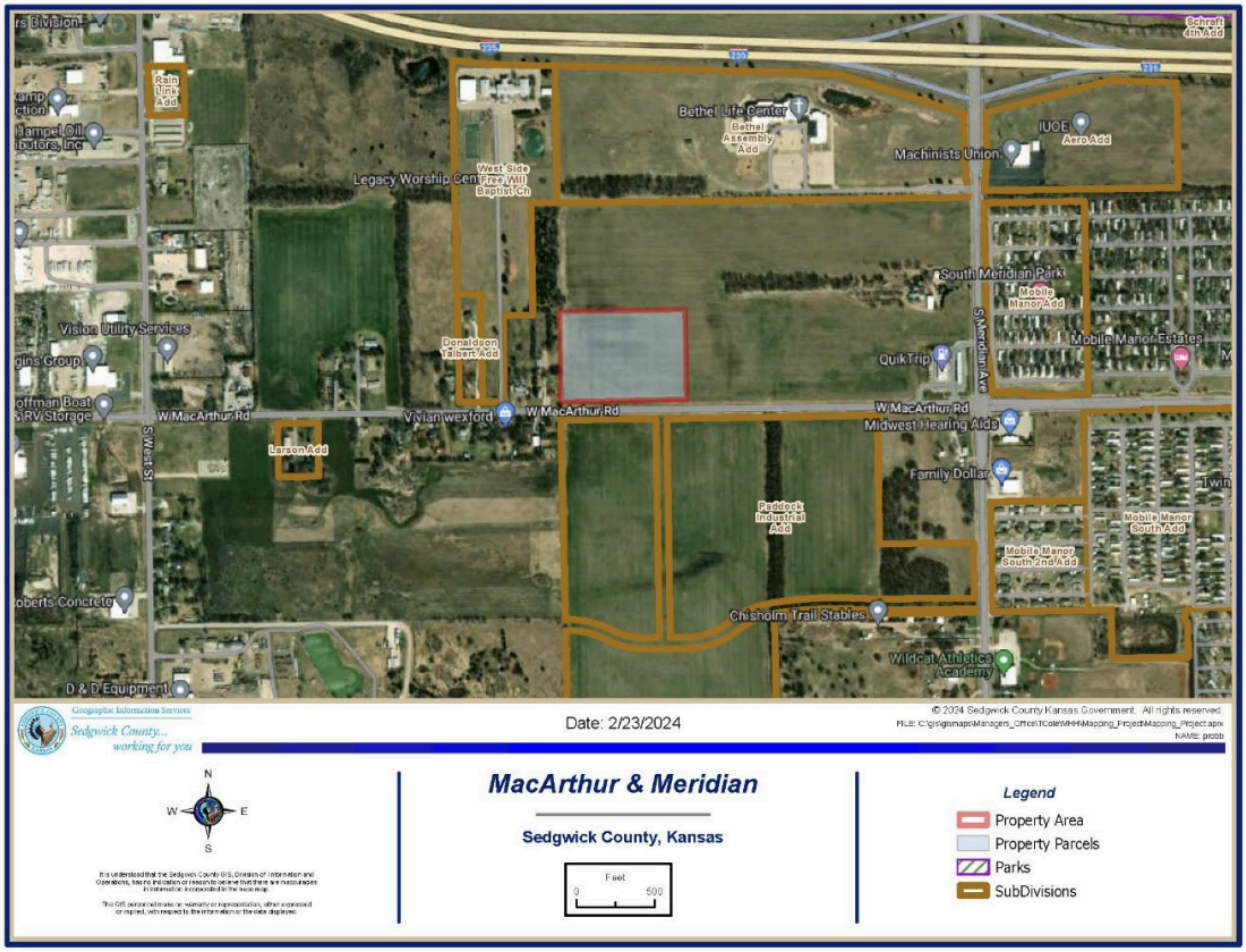
- Participants in qualitative studies may provide responses that they perceive as socially desirable or acceptable, leading to a bias in the data, especially when participants feel pressure to conform to societal norms. (potential for social desirability bias)

Summary

The comments highlight five main themes regarding the proposed mental health facility. First, significant concerns exist about the chosen site's suitability, safety, aesthetics, and proximity to schools and neighborhoods. Second, there is a strong emphasis on community engagement, with many expressing the need for transparency and inclusion in decision-making. Third, overwhelming support for establishing the facility indicates a recognized need for additional mental health services in the area. Fourth, there are concerns about staffing and workforce, with calls for appropriate pay and incentives to attract and retain skilled professionals. Lastly, alternative site suggestions are proposed, such as Riverside Hospital or rural areas, reflecting concerns about the impact of the chosen location on the community and advocating for exploring existing infrastructure to meet mental health needs.

Appendix A

Overview map of location



Appendix B

Data was collected from a *Citizen Feedback Extended Town Hall 2 Survey* from residents not attending the Town Hall 2 on February 26, 2024. This data was collected from February 28, 2024, at 9:00 a.m. through March 4, 2024, at 9:00 a.m.

Respondents (n=50) expressed the same concerns as those expressed in person at the Town Hall 2. The survey did collect a zip code from each respondent. The comments from the survey can not be generalized to the population of Sedgwick County.

Comment Analysis

The comments (n=42) on the Town Hall 2 Extended Survey regarding the new Sedgwick County hospital encompass a range of perspectives. Some express excitement and support for the much-needed facility, emphasizing its potential benefits to the community. Concerns are raised about security, location, and size, with some worrying about proximity to residential areas, schools, and the potential for increased crime. Others advocate for a purpose-built facility with proper security features and enough beds to meet demand, emphasizing the importance of accessibility, safety, and expansion possibilities. Suggestions vary regarding the hospital's location, size, and focus, with considerations for community partnerships, transportation for patients, and specialized care for different populations, such as older adults. Overall, while there is consensus on the necessity of the hospital, there are differing opinions on how best to implement it to ensure safety, effectiveness, and inclusivity for all residents.

“I think there's a great need for this facility, and I think that it will create jobs also.”

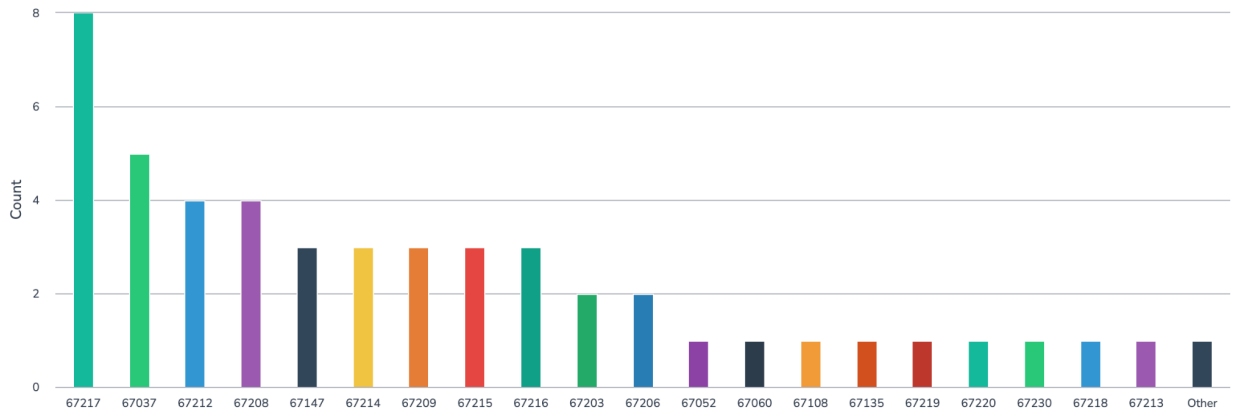
“I think it is a great place to have a facility. And as someone that would possibly work there, I appreciate it being a new building so they can make it as safe as possible for staff and residents! It is so needed and we need to offer the best which I feel like this option is best!”

Zip Code Analysis

Self-identified zip codes of attendees from the Extended Survey are displayed in Table 2. Most attendees were from zip codes 67217, 67037, 67212, and 67208. The zip code of the MacArthur and Meridian site is located in zip code 67217. Respondents represented twenty-one zip codes.

Table 2

Table 2: Attendee Zip Codes from the Extended Survey



Colors in Table 2 are arbitrary.

For questions about this report, please contact Greenbush Center of Community Supports at centerofcommunitysupports@greenbush.org or at 620-724-6281.

Sedgwick County Mental Health Hospital
Riverside Reuse vs New Analysis
March 6th, 2024

PULSE DESIGN GROUP

Riverside Facility Estimate Comparison

The Kansas Department for Aging and Disability Services (KDADS) and Sedgwick County asked Pulse Design Group to develop an estimate of the cost to renovate the Riverside Hospital for the proposed South Central Regional State Psychiatric Hospital.

Pulse Design Group is the project architect under contract with Sedgwick County for the construction project. They have developed the programmatic design and schematic for the building proposed for construction at the site selected by Sedgwick County and KDADS at Macarthur and Meridian in South Wichita.

The estimate provided to renovate the Riverside Hospital uses the requirements identified in the program design process for the regional state hospital, including:

- Current building code requirements for psychiatric hospital
- Maintaining separate treatment and support spaces for forensic and involuntary care and treatment patients.
- Best practices in building design to maintain safety for patients and staff and create therapeutic environments for patients.
- Support, treatment, and office spaces based on needs identified at the existing state hospitals
- Workflows and traffic flows for staff and patients based on best practice, security, and feedback from state hospital staff.

The estimates reflect construction, demolition, equipment, and design costs. The estimates also show phases of development starting with building or renovating for 52 beds on 2 patient units with support spaces for a total of 104 beds.

The alternative proposal to renovate Riverside Hospital for 165 beds does not include sufficient on unit treatment space, separate recreational areas, any outside recreational spaces, and medical clinic spaces within the footprint needed for the Regional State Hospital. The projected cost of $67 million is not adequate to build what's required for the Regional Hospital project.

Riverside Potential Budget

Mental Health Hospital - Sedgwick County

Riverside Reuse vs Ground Up

#23179

3/6/2024

New Facility

104 Patient Facility — 124,604 sf

Estimate Range	10% Low	Estimate ($650 psf)	10% High
Construction	72,893,340	80,992,600	89,091,860
Arch, Eng, Life Safety and Med Eq Design	6,195,934	6,884,371	7,572,808
Medical Equipment	3,077,719	3,239,704	3,401,689
Furniture, Fixtures, Art, etc...	1,275,633	1,417,371	1,559,108
IT equipment	2,186,800	2,429,778	2,672,756
Signage	364,467	404,963	445,459
Permitting/Utility Fees	218,680	242,978	267,276
Land Cost	0	0	0
Project Contingency 10%	8,001,664	8,872,739	9,743,815
Total	**94,214,237**	**97,600,133**	**114,754,770**

104 Patient Facility with 52 Beds shelled — 124,604 sf

Estimate Range	10% Low	Estimate	10% High
Construction	62,813,340	69,792,600	76,771,860
Arch, Eng, Life Safety and Med Eq Design	6,195,934	6,884,371	7,572,808
Medical Equipment	2,486,361	2,617,223	2,748,084
Furniture, Fixtures, Art, etc...	1,036,420	1,151,578	1,266,736
IT equipment	1,884,400	2,093,778	2,303,156
Signage	314,067	348,963	383,859
Permitting/Utility Fees	188,440	209,378	230,316
Land Cost	0	0	0
Project Contingency 10%	6,872,303	7,621,352	8,370,401
Total	**81,791,265**	**90,719,242**	**99,647,219**

Riverside Reuse

104 Patient Facility — 175,000 sf

Estimate Range	10% Low	Estimate	10% High
Construction	96,300,000	107,000,000	117,700,000
Arch, Eng, Life Safety and Med Eq Design	8,185,500	9,095,000	10,004,500
Medical Equipment	3,557,750	3,745,000	3,932,250
Furniture, Fixtures, Art, etc...	1,348,200	1,498,000	1,647,800
IT equipment	2,600,100	2,889,000	3,177,900
Signage	481,500	535,000	588,500
Permitting/Utility Fees	288,900	321,000	353,100
Land Cost	0	0	0
Project Contingency 10%	10,457,645	11,598,800	12,739,955
Total	**123,219,595**	**127,586,800**	**150,144,005**

104 Patient Facility with 52 Beds shelled — 175,000 sf

Estimate Range	10% Low	Estimate	10% High
Construction	80,100,000	89,000,000	97,900,000
Arch, Eng, Life Safety and Med Eq Design	6,007,500	6,675,000	7,342,500
Medical Equipment	2,705,600	2,848,000	2,990,400
Furniture, Fixtures, Art, etc...	1,121,400	1,246,000	1,370,600
IT equipment	2,162,700	2,670,000	2,643,300
Signage	400,500	445,000	489,500
Permitting/Utility Fees	240,300	267,000	293,700
Land Cost	0	0	0
Project Contingency 10%	8,673,050	9,647,600	10,568,750
Total	**101,411,050**	**112,798,600**	**123,598,750**

New Facility	
114,754,770	
Riverside Reuse	
150,144,005	
New Facility	
99,647,219	
Riverside Reuse	
123,598,750	

PULSE DESIGN GROUP

Riverside Potential Construction Budget

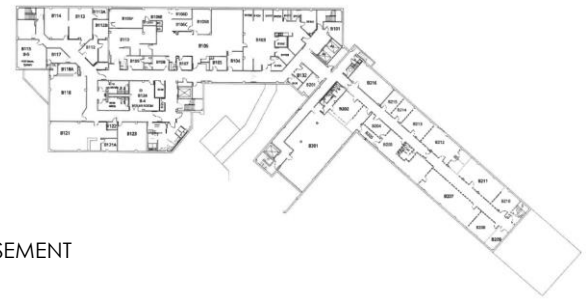
52 Bed Facility with 104 Beds of Support	
-Demolition	$4,000,000
-Envelope Upgrades	$8,000,000
-MEP Infrastructure	$19,000,000
-Building Addition	$6,000,000
-Interior Fit Out	$52,000,000
Construction Total	$89,000,000

104 Bed Facility with 104 Beds of Support	
-Demolition	$4,000,000
-Envelope Upgrades	$8,000,000
-MEP Infrastructure	$19,000,000
-Building Addition	$6,000,000
-Interior Fit Out	$70,000,000
Construction Total	$107,000,000

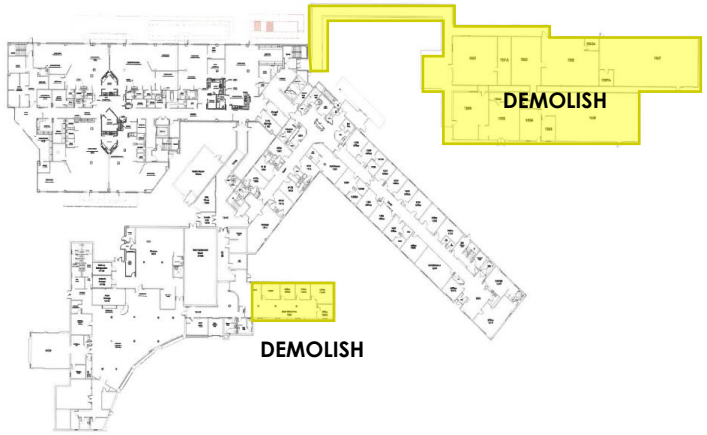
-Costs Shown are indicative of the cost to utilize the Riverside building considering the costs to make the necessary upgrades to the Exterior Envelope, Mechanical, Electrical, Plumbing (MEP), building addition, and demolition costs in addition to the costs to actually fit out the space to meet the code and clinical standards for a Behavioral Health Hospital.

-These costs are carried over to the construction cost lines on the budget comparison sheet.

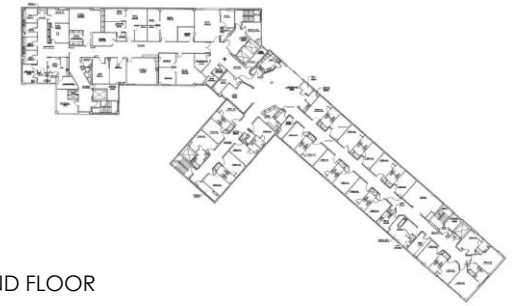
Riverside – Existing



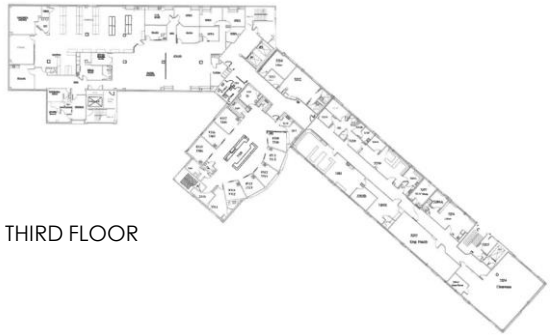
BASEMENT



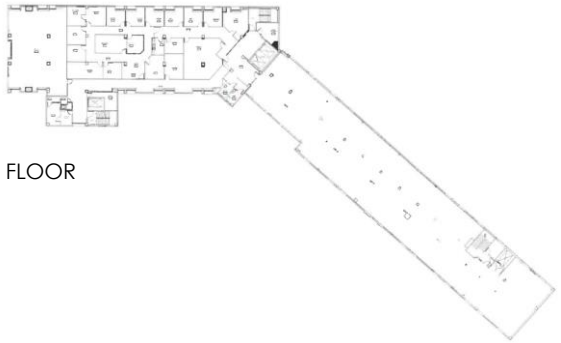
FIRST FLOOR



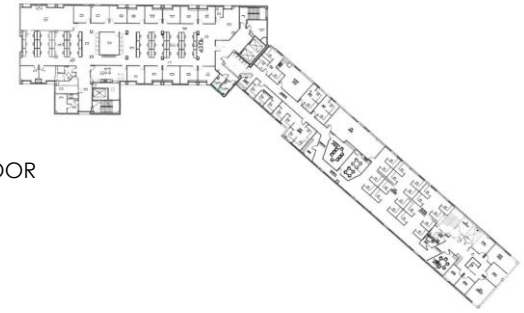
SECOND FLOOR



THIRD FLOOR

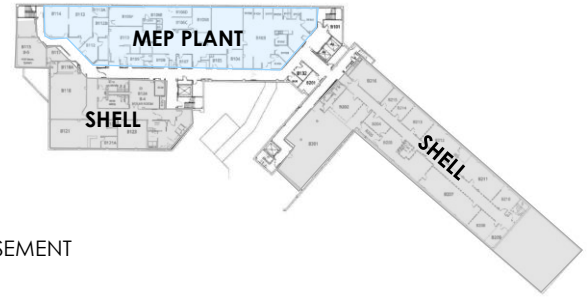


FOURTH FLOOR

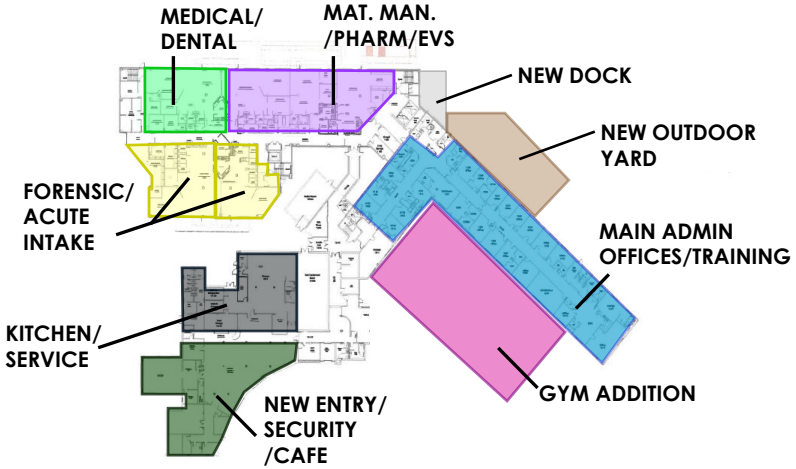


FIFTH FLOOR

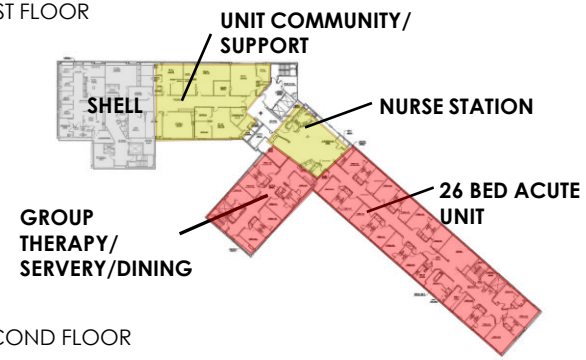
Riverside – Potential Reuse



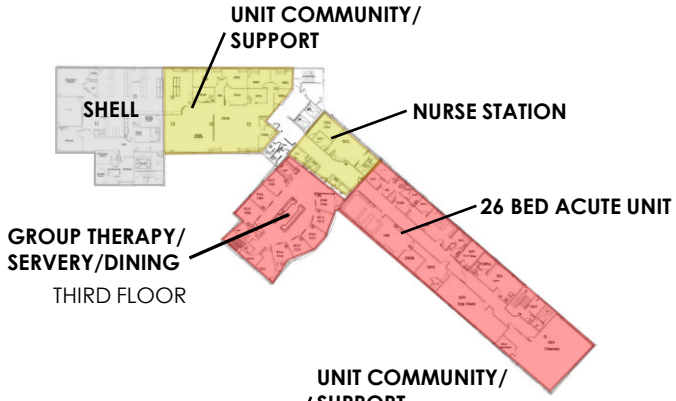
BASEMENT



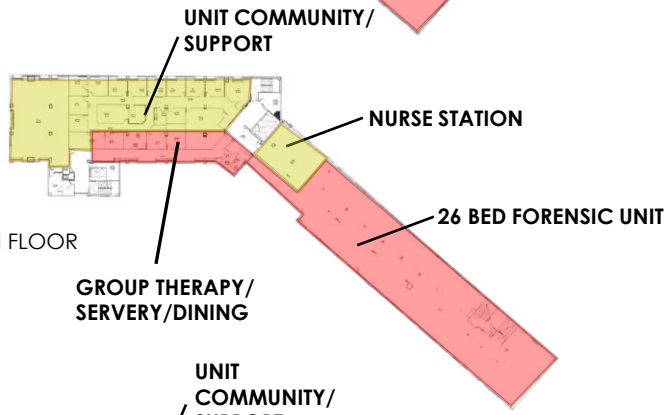
FIRST FLOOR



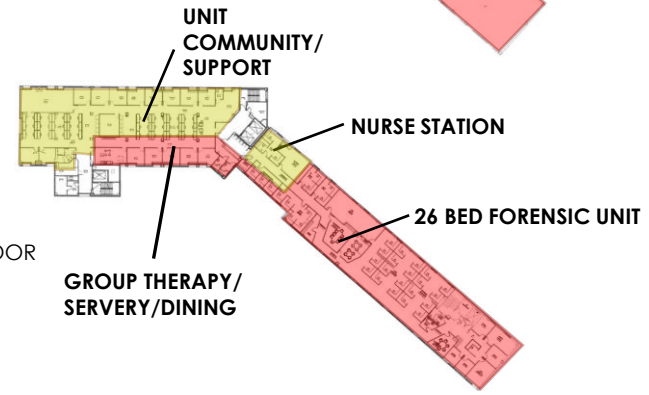
SECOND FLOOR



THIRD FLOOR



FOURTH FLOOR



FIFTH FLOOR

Riverside Facility Challenges

1) The existing facility was built long before the newer codes and substantially more than 50% of the building will be renovated. This means the existing building code does not apply and the entire facility will need to be brought up to new building standards.
   a. This will entail substantial upgrades / replacement of exterior envelope to meet modern energy codes and ensure all new patient rooms have windows as required for daylighting and safety.
   b. The entire building will have to be upgraded even if we are not utilizing it for program space and it is ultimately shelled.
   c. The Mechanical, Electrical, & Plumbing (MEP) infrastructure needs full replacement to meet codes and is beyond age regardless. 3 of the 5 elevators will need complete modernization. Evidence of Asbestos –Friable, Non-Friable Category I and II in the building.
   d. There was a dump at this site from 1935 to 1960. City of Wichita Environmental Department Records indicating reports of methane gas venting in the hospital from the ground to the roof to help prevent gas from entering the building. Prior conversations with former Director of Wichita Environmental Department indicated hospital has encountered parking lot settling problems and methane odors.
   e. CMS requires separate clinical treatment and activity spaces for licensure / reimbursement so additional circulation and elevators will be needed to keep functions separate.

2) Meeting operational needs will be a struggle and will require more staff. KDADS estimates 7 to 10% more staff on each patient unit based on the unit configuration compared to building from scratch.
   a. Units on differing floors removes the ability to cross staff units and space.
   b. The unit support spaces won't fit on the unit without an addition. They are shown off unit in a location that is less safe due to staff and patient overlap.
   c. Elevators present an opportunity for patient attacks on staff and added staff will be needed during patient transport.
   d. The existing facility does not have any courtyard spaces so outdoor activity would have to be created using only fencing at the back of the facility. This would require tearing down the outbuildings.
   e. The tearing down of the outbuildings would also be required to create a true dock for material delivery.

3) The current floor to floor distance is very low which will mean more hardened spaces to prevent patient access.

4) The building does not have a space to house the 2 gyms required so those would need to be an addition to the structure.
   a. This would require a small portion of the existing building to be demolished and rework of the site.

State Estimate - Reusing Riverside Hospital		Riverside Renovation Proposal	
104 Bed Facility with 104 Beds of Support		165 Bed Renovation, New lobby and shared gym addition of 10,000 square feet	
-Demolition	$4,000,000		
-Envelope Upgrades	$8,000,000		
-MEP Infrastructure	$19,000,000		
-Building Addition	$6,000,000		
-Interior Fit Out	$70,000,000		
Construction Total	$107,000,000	Construction Total	$62,350,000
-Architectural Design	$9,095,000	-Architectural Design	$4,650,000
-Medical Equipment	$3,745,000		
-Furniture, Fixtures	$1,498,000		
-IT Equipment	$2,889,000		
-Signage	$535,000		
-Permitting/Utility Fees	$321,000		
-Land Cost	$7,500,000	-Land/Building Cost	$7,500,000
-Project Contingency 10%	$11,598,800		
Total	$135,086,000	Total	$74,500,000

Mental Health Hospital - Sedgwick County

Project Option Estimates with Escalation

#23179

Option 1

2/29/2024

104 Patient Facility			124,604 sf			Initial Total
Estimate Range	10% Low	Estimate ($650 psf)	10% High			**94,214,237**
Construction	72,893,340	80,992,600	89,091,860			**to**
Arch, Eng, Life Safety and Med Eq Design	6,195,934	6,884,371	7,572,808			**114,754,770**
Medical Equipment	3,077,719	3,239,704	3,401,689			
Furniture, Fixtures, Art, etc...	1,275,633	1,417,371	1,559,108			High Total in 5 years
IT equipment	2,186,800	2,429,778	2,672,756			
Signage	364,467	404,963	445,459			**114,754,770**
Permitting/Utility Fees	218,680	242,978	267,276			
Land Cost	0	0	0			
Project Contingency 10%	8,001,664	8,872,739	9,743,815			
Total	**94,214,237**	**97,600,133**	**114,754,770**			

Project Complete Initially

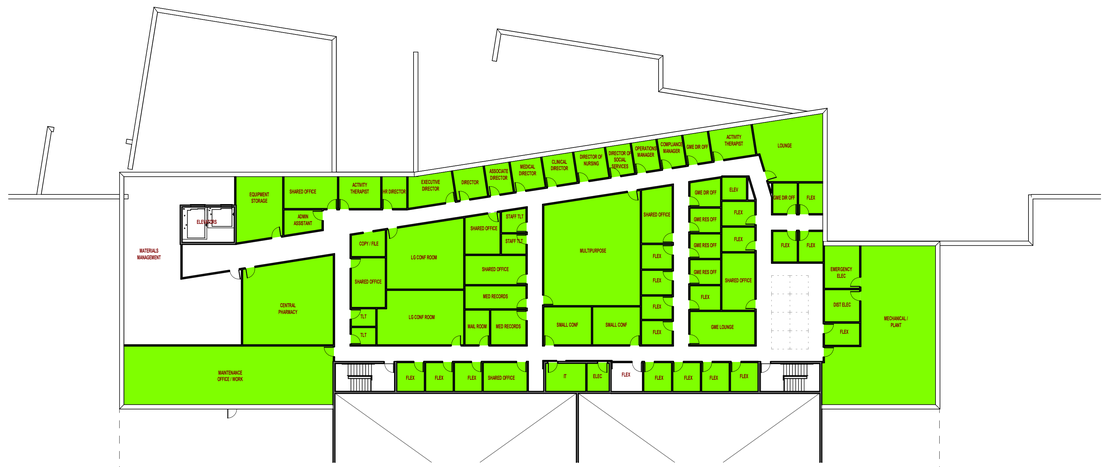
Option 2

104 Patient Facility with 52 Beds shelled			124,604 sf		52 bed fit out 5 years later			32,000 sf		Initial Total
Estimate Range	10% Low	Estimate	10% High		Estimate Range	10% Low	Estimate	10% High		**81,791,265**
Construction	62,813,340	69,792,600	76,771,860		Construction	24,480,000	27,200,000	29,920,000		**to**
Arch, Eng, Life Safety and Med Eq Design	6,195,934	6,884,371	7,572,808		Arch, Eng, Life Safety and Med Eq Design	1,836,000	2,040,000	2,244,000		**99,647,219**
Medical Equipment	2,486,361	2,617,223	2,748,084		Medical Equipment	969,000	1,020,000	1,071,000		
Furniture, Fixtures, Art, etc...	1,036,420	1,151,578	1,266,736		Furniture, Fixtures, Art, etc...	403,920	448,800	493,680		High Total in 5 years
IT equipment	1,884,400	2,093,778	2,303,156		IT equipment	734,400	816,000	897,600		
Signage	314,067	348,963	383,859		Signage	122,400	136,000	149,600		**137,775,023**
Permitting/Utility Fees	188,440	209,378	230,316		Permitting/Utility Fees	73,440	81,600	89,760		
Land Cost	0	0	0		Land Cost	0	0	0		
Project Contingency 10%	6,872,303	7,621,352	8,370,401		Project Contingency 10%	2,678,316	2,970,240	3,262,164		
Total	**81,791,265**	**90,719,242**	**99,647,219**		Total	**31,297,476**	**34,712,640**	**38,127,804**		

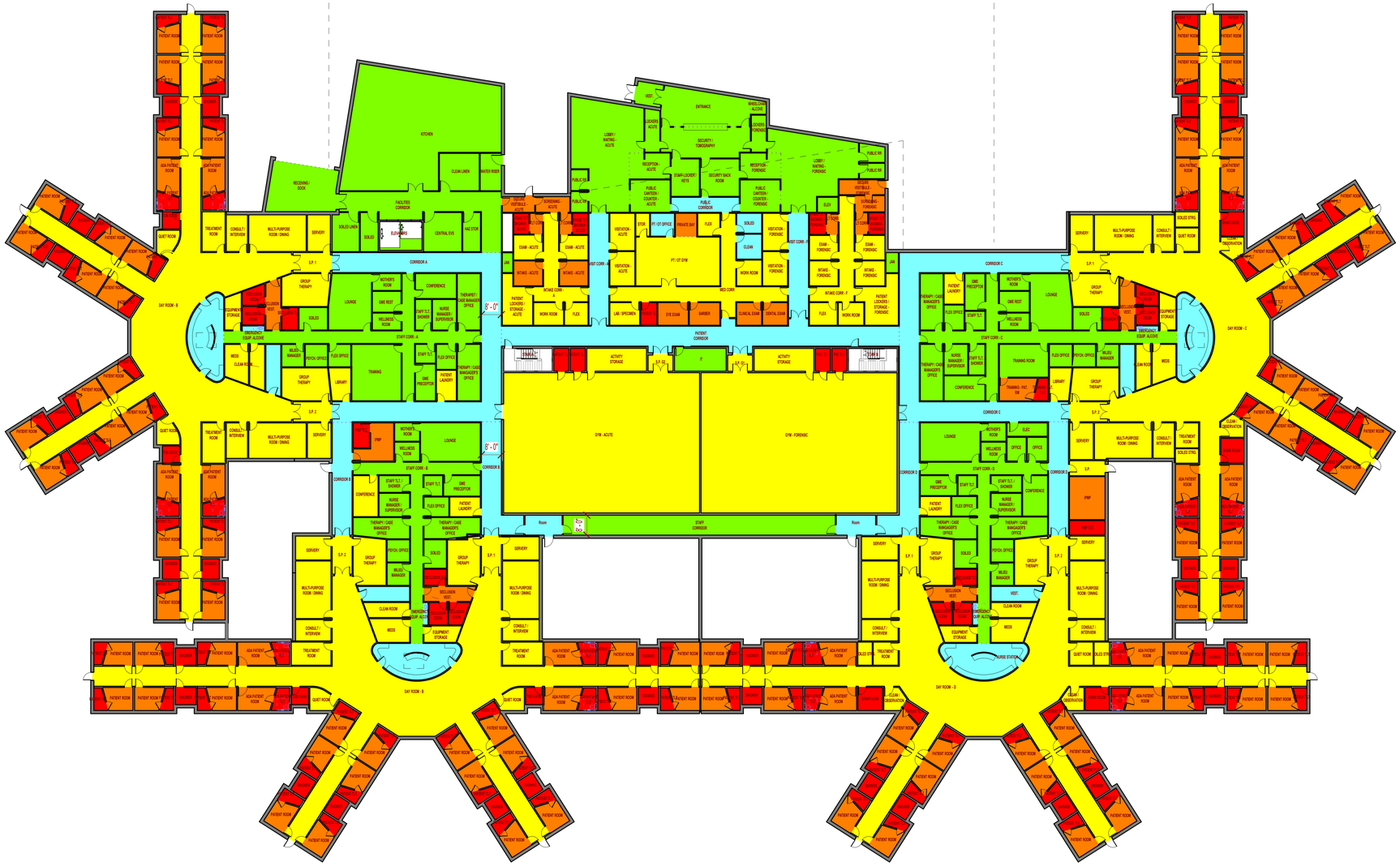
Option 3

52 Patient Facility with no future Shell			92,604 sf		52 bed expansion & fit out 5 years later			32,000 sf		Initial Total
Estimate Range	10% Low	Estimate ($650 psf)	10% High		Estimate Range	5% Low	Estimate	5% High		**71,393,097**
Construction	54,173,340	60,192,600	66,211,860		Construction	38,880,000	43,200,000	47,520,000		**to**
Arch, Eng, Life Safety and Med Eq Design	6,195,934	6,884,371	7,572,808		Arch, Eng, Life Safety and Med Eq Design	2,916,000	3,240,000	3,564,000		**86,982,347**
Medical Equipment	2,144,361	2,257,223	2,370,084		Medical Equipment	1,539,000	1,620,000	1,701,000		
Furniture, Fixtures, Art, etc...	893,860	993,178	1,092,496		Furniture, Fixtures, Art, etc...	641,520	712,800	784,080		High Total in 5 years
IT equipment	1,625,200	1,805,778	1,986,356		IT equipment	1,166,400	1,296,000	1,425,600		
Signage	270,867	300,963	331,059		Signage	194,400	216,000	237,600		**147,538,271**
Permitting/Utility Fees	162,520	180,578	198,636		Permitting/Utility Fees	116,640	129,600	142,560		
Land Cost	0	0	0		Land Cost	0	0	0		
Project Contingency 10%	5,927,015	6,573,032	7,219,049		Project Contingency 10%	4,253,796	4,717,440	5,181,084		
Total	**71,393,097**	**79,187,722**	**86,982,347**		Total	**49,707,756**	**55,131,840**	**60,555,924**		

PULSE DESIGN GROUP

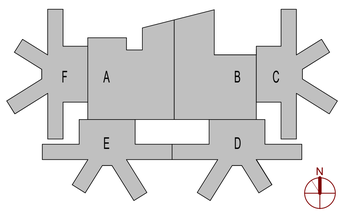


E1 LEVEL 2 - OVERALL PLAN SECURITY PLAN
NTS



A1 LEVEL 1 - OVERALL SECURITY PLAN
NTS

KEY PLAN



PULSE+ DESIGN GROUP
4622 Pennsylvania Ave. Suite 1050
Kansas City, MO 64112
pulsedesigngroup.com
Ph: (913)438-2005
Fx: (913)438-2660

CONSULTANT LOGO SPOT.

INTERNAL NOTE:
CONSULTANT LOGOS DO NOTGET PLACED ON
AE / IN / GI / QH SHEETS.

KGS# 12245

SOUTH CENTRAL KS REGIONAL PSYCHIATRIC HOSPITAL
KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
PROJECT STATUS
WICHITA, KANSAS

DATE: 03/15/2024
PROJECT #: 23179

#	REVISION	DATE

3" = 1' - 0" 0" 3" 6" 1'
1 1/2" = 1' - 0" 0" 3" 6" 1' 2'
3/4" = 1' - 0" 0" 6" 1' 2' 4'
1/4" = 1' - 0" 0" 1' 2' 4' 8' 16'
1/8" = 1' - 0" 0" 2' 4' 8' 16' 32'
1/16" = 1' - 0" 0" 4' 8' 16' 32' 64'

z2AE1-101
SCMHH PLANS

3/21/2024 11:18:06 AM

WICHE

Western Interstate Commission for Higher Education

Behavioral Health Program

ALASKA

ARIZONA

CALIFORNIA

COLORADO

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

GUAM

HAWAI'I

IDAHO

MONTANA

NEVADA

NEW MEXICO

NORTH DAKOTA

OREGON

SOUTH DAKOTA

UTAH

WASHINGTON

WYOMING

www.wiche.edu/mentalhealth

API Privatization Feasibility Study

Prepared for the
Alaska Department of Health and Social Services

March 2020

WICHE
Western Interstate Commission for Higher Education
Behavioral Health Program

Since 1987
NRI
Analytics Improving Behavioral Health℠

STOEL RIVES LLP

Table of Contents

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.

---

[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.