API GOVERNING BODY MEETING MINUTES

LOCATION: In Person and Microsoft Teams Meeting
Alaska Psychiatric Institute, 3700 Piper Street, Room 27C, Anchorage, AK 99508
Teams Link: Passcode: 3zM2Me64
Dial in by phone: 1-907-202-7104
Phone Conference ID: 837 662 811 #

DATE: June 23, 2026

TIME: 1:30 PM to 3:00 PM

1:30PM: CALL TO ORDER

Introduction and roll call **Tracy Dompeling**

The meeting was called to order at 1:35 PM by Commissioner Dompeling.

Roll call was conducted by Jason Pickens. All voting members, two advisory board members, and non-voting members were present, establishing a quorum.

Voting Members Present:

- Tracy Dompeling, Commissioner (DFCS)
- Marian Sweet, Assistant Commissioner (DFCS)
- Kaela Watson, Vice Chair (Designee for Deputy Commissioner Member)

Non-Voting Members Present:

- Dr. Robert Lawrence, Chief Medical Officer (DOH)
- Jenn Carson, Director of Behavioral Health (DOH)
- Ken Cole, CEO, Alaska Psychiatric Institute (DFCS)

Advisory Board Present:

- Dr. Lisa Lindquist, Alaska Native Health Board
- Summer LeFebvre, Alaska Behavioral Health Association
- Travis Welch, Department of Corrections

Advisory Board Absent:

- Elizabeth King, Alaska Hospital and Healthcare Association
- Esther Pitts, Alaska Mental Health Trust
- Ann Ringstad, National Alliance on Mental Illness
- Anthony Newman, Department of Health

API Staff Present:

- Dr. Kristy Becker, Alaska Psychiatric Institute
- Karina Liranzo, Alaska Psychiatric Institute
- Erica Steeves, Alaska Psychiatric Institute
- Michelle Crow, Alaska Psychiatric Institute
- Randall Smith, Alaska Psychiatric Institute
- Jason Pickens, Alaska Psychiatric Institute

Guests:

- Abigail Gurgiole
- Krista Schooley

The Commissioner noted that Travis Welch was inadvertently excluded from the invitation list; this will be corrected for future meetings. The Commissioner also noted that Tony Newman messaged her to let her know that he had a conflict.

Two sets of minutes were reviewed and approved:

A motion to approve March 24, 2026, Governing Body Minutes was made by Marian Sweet, and seconded by Kaela Watson.

A motion to approve June 8, 2026, Special Governing Body Minutes was made by Marian Sweet, seconded by Kaela Watson.

Both passed without objection.

1:35PM: PUBLIC COMMENT

No Public Comment received.

1:40PM: NEW BUSINESS

The Commissioner asked for public comments a second time, and none were offered. She also checked to see whether Travis Welch was online. Jason verified attendees and updated the attendee list to include Travis. The Commissioner apologized to Travis for not being included in the earlier invite and thanked him for joining on short notice. She also confirmed that this will be corrected and that he will be included in all future Governing Body invitations.

Governing Body and Advisory Board Engagement **Tracy Dompeling**

Commissioner Dompeling requested this topic be added to the agenda to discuss engagement between the Governing Body and the newly formed Advisory Board. She noted that recent bylaw revisions formally separated the two groups. Although the Advisory Board currently meets at the same time as the Governing Body, it does not yet have its own structure, leadership roles such as Chair, Vice-Chair, or independent meeting process.

Commissioner Dompeling shared that she wanted to begin a conversation about how the two groups can continue engagement going forward. She encouraged Advisory Board members to consider adding Governing Body agenda items and participating actively during reports and data presentations. She also asked whether Advisory Board members had discussed among themselves what they would like their role to be and invited ideas on how to move forward.

Advisory Board Member Feedback

- Summer LeFebre shared that the Advisory Board has not yet met independently to discuss its role, though she and Dr. Lisa Lindquist have had some conversations. Summer explained that their understanding of the Board's function has historically centered on "what API needs," and that those needs look very different today than they did six to eight years ago.

- She asked for clarification on what API currently needs from an Advisory Board, including expectations for clinical, psychiatric, and peer representation.
- She stated that the ability to ask questions freely is important.
- She noted the Board's interest in supporting API's long-term strategic goals and direction - Summer also raised the issue of public support, explaining that the Board has never had a clear process for responding when API faces negative media coverage. She recalled past moments - before and during COVID-when the Board wanted to publicly support API but lacked a defined method for doing so.
- She asked for ideas from Dr. Lindquist on how the Board might address these areas moving forward.

- Dr. Lisa Lindquist agreed with Summer's points and suggested that the Advisory Board hold its own meeting to discuss engagement, define its role, and develop recommendations for meeting structure to bring back to the Governing Body.

Commissioner Dompeling offered assistance in setting up a separate Advisory Board Zoom meeting and noted that Dolly or other API staff could help coordinate it. She added that if the Advisory Board wants to respond publicly to media items in the future, API can work with the Department's Public Information Office to support that role.

Grievance Process Discussion:

Commissioner Dompeling noted that she has asked staff to review the bylaws, now that the recent revisions have gone into effect, and to also review API's grievance policy. She explained that the current grievance policy directs individuals to bring grievances to the Governing Body, which is no longer appropriate because the Governing Body is made up entirely of state employees and does not meet the definition of an impartial body.

She stated that the policy will need clarification and updating, and she expressed interest in working with the Advisory Board on revising the grievance procedure. Commissioner Dompeling added that the goal is to identify an appropriate impartial review body, and she invited Christy to contribute to that discussion, noting that API is required to have an internal impartial body for grievance review.

- Christy explained that API relies on what they refer to as an internal impartial body, which includes external organizations such as the Joint Commission, CMS, and the Disability Law Center. She noted that these groups meet with patients weekly and that patients are encouraged to contact any outside organization directly. Concerns do not need to go through API first for follow-up to occur.
- She noted that CMS has reviewed API's grievance process several times over the past year, meeting with patient advocates and examining submitted grievances to ensure proper follow-through. In one instance, a patient sent multiple grievances directly to CMS, and CMS completed a review with no findings. Christy added that during any onsite investigation, CMS routinely reviews grievance files and only provides feedback if concerns are identified; to date, no findings have been issued.
- Christy stated she would welcome additional input from others to assess whether the current grievance process meets all requirements and to identify areas for improvement.

Ken asked whether the Commissioner's concern was related to the recent bylaw changes and whether the current impartial body review process was still appropriate. The Commissioner confirmed this. Ken explained that the hospital policy identifies the Governing Body officers, the Chair, Co-Chair, and Treasurer as the three officers. He noted that all three officers are state employees and asked what should be done to correct that.

- The Commissioner noted that although the Governing Body is separate from API staff, it is still made up of state employees and may not be viewed as impartial by the community. Elizabeth added that only one grievance has escalated to the Governing Body in the past eight years and that the policy was updated at that time. She stated that API's grievance process is generally strong but now needs revision to reflect the new bylaw structure. Ken suggested that the Advisory Board may be an appropriate group to serve as the impartial body moving forward and Christie Winn supported this.

Commissioner Dompeling then asked if anyone on the line had additional comments or questions and reminded participants to use the "raise hand" feature since she could not see all attendees on the screen.

CEO Report **Ken Cole**

Operational Overview

Ken Cole provided an update on API's current operational status. He reported a census of seventy-two patients, including three available beds in the adolescent unit. He noted that five beds are currently designated as single-occupancy rooms for patients who cannot safely share a room. He emphasized that the hospital is operating at full capacity, adding that although API does not typically remain full for extended periods, this is the current situation.

Ken stated that API has twenty-four civil patients awaiting placement and six individuals waiting in the Department of Corrections (DOC), which is higher than the usual average of two to three. He explained that API receives daily updates regarding any non-criminal-charged individuals held at DOC solely because API lacks available beds. These patients are treated as immediate admission priorities.

Emerging Operational Challenges

Ken described several emerging concerns, noting that API is increasingly becoming a long-term treatment facility. He explained that he has data demonstrating this trend and stated that he would provide an overview of what has been done internally to respond, how to approach challenges within the community system, how API is working to respond overall, and provide a update on APIs electronic health record project.

He emphasized that API is continuing to evolve into a longer-term stay hospital and shared data compiled with Dr. Becker showing a seventy-five percent increase in forensic-to-civil conversion patients from 2022 to June (rising from nineteen to forty-five) across three adult units in hospital - Katmai, Susitna, and Denali. Between 2025 and 2026, API experienced a thirty percent decrease in unique individuals served (from 477 to 332), and the average length of stay for discharged patients increased from twenty-seven days to sixty days. He noted that the trend is even more pronounced when including patients who are not discharged.

Ken noted that Dr. Becker and Erica would be providing additional insight into the complexity of these patients, including their treatment needs and the corresponding nursing responses for this population. He reported ongoing efforts within the adult units to move toward a longer-term programming model so that treatment plans and group activities better reflect patient needs.

He highlighted the limited community resources and discussed the July 1 reduction in Complex Care Support (CCS) funding. This funding had previously supported seven community-based patients on conditional release, and he noted that since the reduction, API is not currently able to discharge any patients under this funding. Dr.

Long added that the reduction is currently preventing an additional four to five complex-needs patients from being discharged.

Fiscal and System-Level Considerations

Commissioner Dompeling clarified that all funds used - regardless of department or division - originate from the general funds. She explained that these funds fluctuate with the state budget, creating volatility in service availability.

She emphasized the broader need to determine next steps and understand statewide implications for stabilization services. She expressed hope that the State may pursue more sustainable funding sources in the future for individuals who do not qualify for standard waiver services or Medicaid-supported programs. However, she acknowledged that initiatives such as the 1115 waiver involve extensive collaboration with the Department of Health and require long-term planning.

Commissioner Dompeling highlighted growing concerns about compounding system pressures, including limited stabilization beds and downstream impacts on hospitals and DOC. She emphasized the need for strategic planning and clear, data-driven communication.

She requested a condensed one-page document summarizing API's current data to concisely articulate trends and the direction the situation is heading. She thanked staff for their effort in compiling this information.

Ken expressed appreciation for the Commissioner's support and thanked her for recognizing the need for the data.

Projected Capacity Concerns

Ken projected that, if current trends persist, API may be unable to admit new patients within one to two years and raised the question of how leadership should respond if that situation arises. He emphasized the ongoing efforts of the social work staff to support patient transitions out of the hospital despite these challenges.

Ken transitioned to two related topics involving Dr. Becker and Erica. He explained that, upon his arrival, he introduced a semi-formal review process for forensic patients prior to community transition, focusing on required services and risk considerations. He noted that Dr. Becker collaborated with the team to establish a weekly review group based on that model and would be providing an overview of its work. Ken then invited Erica to discuss the nursing perspective.

Chief Clinical Officer Report **Dr. Kristy Becker**

Risk Assessment and Enhanced Transition Oversight

Dr. Becker reported that after approximately two and a half years, API has established the ability to conduct formal, psychologist-led risk assessments. Each assessment requires more than twenty hours to complete and is used to determine treatment recommendations for patients with criminal backgrounds or histories of violence. These assessments support the development of plans to ensure safe transitions into the community.

She explained that early outpatient commitments were implemented in a piecemeal manner out of necessity, helping patients who no longer needed hospital-level care but continued to present significant risk. Over time,

these commitments proved effective in supporting long-term patients through successful community transitions. As the number of outpatient commitments increased, the team recognized the need for a more structured process, which led to the opening of the outpatient clinic and Enhanced Transition Oversight Team (ETOT).

The ETOT now meets weekly to review patients with enhanced transition needs, bringing treatment teams together to evaluate discharge readiness, risk levels, benefits of transition, and required support for safe movement to the community.

Erica noted that the nursing team supervises the outpatient clinic, which has completed twenty-four appointments with no missed visits and only one rehospitalization. These successes were supported through active coordination with guardians, assisted living providers, and case managers. Dr. Long added that most patients already have established community providers for medication management, and community partners maintain ongoing communication to support continuity of care.

Erica further reported that these efforts have increased API's functional capacity by eight to ten beds, easing pressure on admissions and contributing to safer community transitions.

Questions and Discussion

Dr. Lawrence thanked the Commissioner and the team for the presentation and stated that the recent monthly KPI report provided helpful context. He expressed concern that API appears to be shifting toward operating as a long-term state facility. He asked how many current patients fall under the enhanced or complex care category. Citing Dr. Becker's earlier comment regarding seven patients already supported in the community through Complex Care Support funds, he requested estimates of the number of patients who typically require community placement annually, and how many of the current census of nearly eighty individuals meet criteria for enhanced or complex care needs.

Patient Population Overview

Dr. Becker thanked Dr. Lawrence for his question and responded by outlining two main patient groups. API currently serves several former forensic patients, as well as patients in Gero-Psych and IDD categories. These include individuals with dementia, serious age-related medical comorbidities, intellectual and developmental disabilities, or autism spectrum disorder. Some patients also have criminal backgrounds, creating overlaps among groups.

She reported that approximately fifteen current patients would benefit from transitional oversight such as outpatient commitment, placement in a skilled nursing facility, or residence in specialized homes for autism or IDD. For patients meeting ALI or IDD waiver criteria, funding is typically not the primary barrier.

Dr. Becker emphasized that the population facing the greatest challenges consists of individuals with severe and persistent mental illness who also have significant legal involvement and present ongoing risk to the community. This risk limits viable discharge options. Other patient groups may also experience placement delays, but they generally have more alternatives compared to patients with both serious mental illness and criminal justice involvement.

Questions and Clarifications

Dr. Lawrence asked about API's responsibilities once individuals transition into the community. He requested clarification about the hospital's oversight obligations, including staff workload, fiscal implications, and the degree of responsibility API maintains for ensuring patient safety and access to care post-discharge.

Dr. Becker explained that outpatient commitment statutes define the process. Under these statutes, patients placed in the community remain under API's custodial authority. API retains legal responsibility for oversight, safety, and continuity of care. Much of the clinical oversight is carried out by Dr. Long, who accepts these patients in community settings. The executive team also maintains responsibility for community safety and patient wellbeing under outpatient commitment.

Operational Impact

Dr. Becker noted historical bed loss of approximately six to seven beds per year and explained that the outpatient commitment model helps mitigate this effect. However, it generates a significant burden on staff.

The outpatient cohort effectively functions as an additional small unit for the hospital. Although daily in-person monitoring is not provided, API staff maintain regular communication, conduct clinic visits, and provide monitoring through a coordinated provider, social worker, and nursing team. API also responds promptly to community concerns, including situations requiring a patient's return to the hospital.

She emphasized that the model creates substantial workload and is at risk of exceeding the hospital's capacity due to the lack of a formal structure, dedicated staffing, or an established funding mechanism. It was implemented as a temporary solution to meet a critical need but does not have a long-term operational framework. Dr. Becker noted that Dr. Long may have additional comments on this topic.

Dr. Long provided an overview of how current patient needs are affecting staff workload. He noted that medically complex and elderly patients require significantly more hands-on nursing care than in previous years, including assistance with activities of daily living, feeding, showering, and management of multiple medical comorbidities. He stated that these demands align more closely with nursing-home-level care and have increased the need for medical staff rather than behavioral health professionals.

In contrast, Dr. Long explained that the forensic conversion patients referenced by Dr. Becker are clinically stable, consistently take their medications, participate in their groups, and are easier to care for from both nursing and medical perspectives. These patients no longer require inpatient psychiatric care but remain hospitalized due to the lack of appropriate community placements.

Commissioner Dompeling requested clarification from Dr. Long regarding payer coverage. She asked whether the patients being discussed were those for whom Medicaid or another payer source would not reimburse continued hospitalization. Dr. Long confirmed this, explaining that many of these patients no longer meet inpatient criteria and should be stepped down, but that transitioning them is difficult. He described step-down placement as "stepping off a cliff," emphasizing the challenges in moving patients from 24-hour supervision at API into lower-intensity community settings.

Dr. Becker added that some patients have recently completed outpatient commitment after demonstrating strong adherence to treatment, stability, and medication compliance. She noted that several of these individuals have significant alleged criminal histories, which complicates community placement, as their backgrounds may be concerning to providers and the public.

Summer asked whether API is effectively providing a medically monitored, intensive outpatient level of coordination and whether staff are also mentoring assisted living facilities to help them manage these patients.

Dr. Long responded that the team serves as a point of support for community providers, ensuring they can reach out with concerns or questions. He noted an increase in communication from assisted living facilities in recent months, particularly regarding medication management.

Dr. Becker explained that support varies based on patient needs and often includes providing clinical information and risk assessments. She stated that API is transparent with receiving providers regarding both adjudicated and unadjudicated alleged criminal histories of incompetent-to-proceed defendants. She also highlighted the role of state funding in establishing oversight expectations, such as mandated one-to-one staffing. She noted that providers receiving this funding must document compliance in monthly billing. While this support historically allowed accountability and oversight, recent reductions in funding have limited the state's ability to enforce these requirements, making it harder to safely transition higher-risk patients.

Dr. Long added that mentoring and training efforts are particularly intensive for patients with severe autism, often requiring months of site visits, staff familiarization, and coordinated planning. He noted that despite the challenges, several high-acuity patients - some previously requiring two-to-one staffing - have successfully transitioned into the community.

Commissioner Dompeling concluded the discussion by noting the need for continued dialogue and monitoring of these issues. Due to time constraints, she moved the meeting to the next agenda item.

Ken reported that the department, with the Commissioner's support, has decided not to proceed with the current electronic health record (EHR) vendor. He stated that the contract termination process is underway. The department is pursuing funding through the Rural Health Transformation Grant to support implementation of a different system, and if awarded, API would likely upgrade its existing Meditech platform. Ken noted that the department received notification two to three weeks ago that it had advanced to the second round of consideration for this grant.

Ken recognized Christy Winn for her work in preparing the required narrative and documentation, which will undergo internal review before submission to the Department of Health. He explained that the decision to discontinue the Netsmart product was based on concerns that the system would not meet operational needs, would not support patient or staff safety, and was not progressing despite significant time and financial investment.

The Commissioner thanked staff for their extensive efforts to make the previous system work and emphasized her support for the decision to discontinue it.

Chief Quality Officer Report **Christy Winn**

a. Performance Indicator Report

Christy presented the KPI dashboard update and acknowledged the work of Research Analyst Andre Alexander, who has significantly advanced the dashboard's development. She noted that external organizations using NRI and WIPSHA data have begun referencing API's dashboard due to its usefulness. The dashboard continues to be refined, and Christy encouraged members to contact her directly with data-related questions.

She explained that since January, three major data themes have emerged. First, a small group of five to six high-acuity patients is driving a disproportionate share of seclusions, restraints, medication-related incidents,

and workplace violence. Second, approximately 80% of brief manual holds are associated with court-ordered medication needs, often when patients refuse PO medication. Third, patient grievances appear largely tied to inconsistent expectations and communication differences among staff rather than concerns about clinical care.

Christy reviewed operational strengths and ongoing concerns, noting that census levels have remained steady in the 70s, with 421 admissions and 412 discharges since January. Seclusion hours have decreased from 25 hours in January to 10 hours in May, demonstrating meaningful improvement. Workplace violence incidents have remained stable, with 80% requiring no first aid, 15% requiring minor first aid, and 6% requiring external medical care. These incidents generally involve a small number of known patients for whom individualized behavior and safety plans are developed prior to admission.

She also reported an increase in self-harm events on the adolescent unit, primarily involving two patients who are being supported through individualized behavior plans. Since January, 178 brief manual holds have occurred, with more than 70% connected to court-ordered medication administration. Regarding grievances, Christy stated that 57 submissions have been reviewed, 83% were resolved the same day, and none exceeded seven days. Most concerns centered on inconsistent expectations - such as room access hours - and communication issues among staff. Patient Advocacy staff are working with unit teams to reinforce consistency.

Commissioner Dompeling asked whether the accrediting body provides any comparison data for hospitals. She noted that while the KPIs presented are useful indicators that hospitals generally review, she wanted to know whether API has any benchmarks showing how it compares to other facilities - specifically, whether API is higher in certain areas or lower in others.

Christy responded that API's data is reported to CMS through NRI, and the hospital is compared with other state psychiatric hospitals that are similar in type. She added that some of the comparison hospitals are larger because API operates as an 80-bed facility.

In response to Commissioner Dompeling' s questions, Christy confirmed that API's data is reported to CMS through NRI and is benchmarked against other state psychiatric hospitals, including 13-14 Western state facilities of similar scale. She noted that although API previously had one of the highest numbers of seclusion events, it had one of the lowest durations spent in seclusion. Since January, continued efforts have reduced seclusion hours by half.

Christy reported that API also compares its data with Western State Psychiatric Hospitals. She explained that this comparison is conducted annually, with results typically returned in October or November. After API completes its review, the data is then shared with other hospitals to support broader benchmarking. She noted that she will be glad to share that data when received.

Christy asked if there were any questions, and none were raised.

Chief Clinical Officer Report **Dr. Kristy Becker**

Dr. Becker stated that her primary report was already provided at the beginning of meeting. She added that her team is actively working on new group development, with several initiatives already underway for longer-term patient populations.

She explained that the team has expanded portions of the CBTP (Cognitive Behavioral Therapy for Psychosis) training into longer-term protocols. One example is a new "Social Skills for Schizophrenia" group, a 16-week closed program designed for individuals living with psychosis long term to improve social engagement and frustration tolerance. Historically, API did not have patients who remained long enough to support such a program, but the changing patient population now allows for these expanded protocols.

Dr. Becker also reported on the pro bono family's group, which began last fall as a long-term project she had hoped to implement. With the support of an intern, Olivia, who is completing her post-doctoral transition this week, the program delivered two iterations over 28 weeks. The group is designed for families of patients-without requiring patient participation or permission and provides a space for them to discuss the challenges of supporting a loved one with a psychiatric condition requiring hospital or near hospital level care.

One group was held in person, though winter conditions made attendance difficult, and the second iteration was delivered online using CAD-10 screens. This allowed multiple family members or friends to join from the same household or separate locations, with a maximum of ten screens to keep the group appropriately scaled. Olivia's final session is scheduled for tomorrow night, after which the program will pause and resume in the fall once new interns are trained. Dr. Becker noted the group has been highly beneficial for families and for the community, offering support where few resources currently exist.

Dr. Becker then shared staffing updates. The department's long-time paralegal, Melissa Luce, recently completed her law degree and accepted a position with the Attorney General's Office. Dr. Becker expressed pride in her advancement but noted that the transition has left the legal team strained. The new ILINKS / NeoGov hiring processes have added complexity, but she is actively working through them and has candidates under consideration. She hopes to have additional support in that department soon.

Dr. Becker concluded by stating she had no additional updates beyond what had already been discussed. Appreciation was expressed for the family support initiatives, and she acknowledged that the family groups involve significant emotional processing but have been positive overall.

Commissioner Dompeling asked if there were any questions for Dr. Becker, and none were raised.

Chief Nursing Officer Report **Erica Steeves**

Erica provided an overview of current nursing operations, highlighting both staffing challenges and ongoing transitions within the department. The most significant update is the resignation of the Infection Control Nurse, Jen, who also oversaw Employee Health. Recruitment efforts for this position are underway, supported by a strong onboarding plan that includes both in state and out-of-state resources. Erica noted that Jen left extensive guidance and improved processes, which will help maintain continuity during the transition.

Recent staffing challenges include high call-outs, including a weekend where all but one staff member on a major unit called out. Units have been operating with one core staff and supplemented by overtime and float staff.

Additional Nursing Operational Updates

- The Nursing Office continues to manage staffing, but unexpected call-outs, often 5 to 8 per shift - create operational and safety challenges.

- Use of travel nurses exists but is less as we have brought on travelers with the intent to go live with Netsmart, so as those contracts end, we will continue to evaluate the use of travelers. Some travelers will still be needed, but fewer than before.
- Recruitment for nurses and psychiatric nursing assistants remains positive; good candidates are applying.
- Anticipated future turnover may occur as new crisis centers open with significantly higher pay for behavioral health technicians. Consistent scheduling may help retain some staff despite wage differences.
- Long-term salary considerations will likely need review.

A question was raised regarding the structure of API's on-call and float pools.

- On-call positions exist for Psychiatric Nurse levels 1, 2 and 3, plus PNAs.
- Currently about two on-call nurses and 10 to 12 on-call PNAs. On-call staff are asked to work three shifts per month and are called as needed.
- A full-time float pool is used to cover short notice call offs.
- Per-diem pay is the same hourly rate as full-time (no increased rate for lack of benefits), making per-diem work less competitive compared to other hospitals.

Ken provided positive recognition for the smoothness and efficiency of staffing and scheduling operations compared with other state hospitals. Erica acknowledged the feedback and stated she will pass the appreciation on to Deanna for her effective work in managing schedules.

Chief Medical Officer Report **Dr. Robert Long**

Dr. Long reported ongoing concerns regarding staffing consistency within the medical team. Two psychiatrists, Dr. Paulie and Dr. Sawyer, are expected to join the staff in the fall, which should significantly improve continuity of care and reduce the reliance on locum providers. The long-term goal remains to decrease locum usage and improve the stability and quality of psychiatric coverage.

He also noted upcoming changes within the medical officer team. One of the long-serving medical providers will be retiring next month after 18 years of service, and recruitment for a replacement is underway. Dr. Long emphasized the essential role of the medical providers, who manage complex medical and behavioral health needs of patients who often remain in care for extended periods.

A follow-up question was raised regarding the increasing number of medical appointments required for patients. The inquiry centered on understanding how much time and resources these external medical visits are consuming, and whether longitudinal data is available.

Erica provided additional context, noting that API has begun tracking outside medical consults and appointments. In April, there were over 100 external visits for various routine and specialty medical needs. Staff highlighted the operational challenges of coordinating these appointments, especially when individual scheduling and occasional rescheduling are required. Despite this, most visits continue to be related to dental and eye care.

To explore cost-effective approaches, discussions have begun with Grants and Contracts (Patricia Latimer) about what other facilities use for on-site or contracted medical services. Contacts have been provided to identify possible models that reduce external scheduling demands. Reference was also made to practices used in smaller

correctional facilities that might offer useful insights. Erica concluded Dr. Long's report by addressing the follow-up question before moving on to the next agenda item.

Commissioner Dompeling then apologized to Karina Liranzo for having been inadvertently skipped on the agenda.

Chief Finance Officer Report **Karina Liranzo**

Karina provided an update on expenditure reviews, financial performance, and revenue cycle operations. She reported that the Business Office experienced significant staffing losses in February but successfully rebuilt the team, returning to full staffing by the end of April.

Year-over-year expenditure data shows a decrease from 52 million last fiscal year to approximately 50 million this year, reflecting a reduction of about 1.5 million. She noted that this figure could change based on any late-year purchases but emphasized that achieving this reduction has been a significant accomplishment for the team.

Revenue performance has improved. Karina highlighted the hard work of the billing and accounts payable teams, noting that the department saw four different audits in one month, all of which were passed. A corrective action plan was submitted for minor suggestions in one audit, and no further follow-up has been requested. Overall, collections are officially up $2.2 million compared to last year.

The Business Office is working closely with Meridian to identify coverage options for patients who arrive decertified, with the goal of maintaining billable status whenever possible. They are also improving tracking of uncompensated care to support upcoming cost reporting requirements. Process efficiency continues to be strengthened through new video-based training resources in a centralized Teams channel, reducing single points of failure and improving staff access to procedural guidance.

Karina concluded her report without further updates. Commissioner Dompeling asked if there were any questions, and none were raised.

2:30PM: OLD BUSINESS

None

3:05PM: PUBLIC COMMENT

A family member provided a public comment expressing appreciation for the care their family member received while at the facility. Commissioner Dompeling and API staff acknowledged the comment and expressed gratitude for the feedback.

ADJOURNMENT:

A motion to adjourn was made by Marian Sweet and seconded by Kaela Watson. The meeting was adjourned at 3:08 PM.

NEXT MEETING:

The next meeting is scheduled for Tuesday, September 29, from 1:30 PM to 3:00 PM.