

MEMORANDUM

To: Governor Sununu and Honorable Members of the Executive Council
Cc: Attorney General John Formella
Associate Attorney General Anne Edwards
From: Assistant Attorney General Mike Grandy
Date: May 3, 2022

Re: Review and analysis of concerns regarding Wellpath Recovery Solutions, LLC (“Wellpath”) contract to provide child and young adult psychiatric in-patient services at Hampstead Hospital

Executive Summary

The New Hampshire Department of Justice (“NHDOJ”) was requested by the Executive Council to conduct an independent analysis of concerns raised regarding a proposed contract with Wellpath to provide medical services to children and young adults at Hampstead Hospital.

NHDOJ reviewed allegations regarding poor quality of care and abuse against Wellpath. DOJ’s analysis does not raise any particular red flags in regards to the amount of litigation that Wellpath has faced or the quality of care that Wellpath would provide to children-patients at Hampstead Hospital.

First, the contract under consideration by G&C provides significant State oversight of compliance and operations. In addition to robust compliance policies, the contract physically mingles many State employees with contractors on-site at Hampstead. This includes several senior executive positions and a direct-provider position that would be in the treatment milieu with Wellpath providers. The intermingling of State personnel of various levels of seniority (*see, e.g. Contract at §1.1.4. ff.*) was done in order to foster an environment and culture where if irregularities occur, they will be quickly identified and corrected. Further, the contract itself has substantive mechanisms to address problem personnel, specifically including a provision (§ 5.1.16) that gives DHHS the ability to remove approval of specific contractor-employees who are misperforming or underperforming.

Second, an analysis of Wellpath itself does not suggest unusually high amounts of litigation, based on our experience in defending similarly situated state facilities, or other red flags with regard to quality of care. First, Wellpath was responsive to our questions for internal data (Wellpath provided some non-public proprietary data that we have been able to generally¹ independently verify). That data, and our own confirmatory searches to

¹ Two very important points are: First, we received some data in regards to non-correctional settings as they relate to in-patient psychiatric facilities. These data fall under the “Recovery Solutions” arm at Wellpath - the same part of Wellpath that would be providing services at Hampstead. *See* P-37 at 1.3. A comparison with involuntary admission in-patient facilities is more apt than a comparison with a county jail

validate the data, indicate a relatively low number of lawsuits regarding quality of care or alleged abuse issues at Wellpath-staffed in-patient psychiatric facilities. Second, in specific response to the Massachusetts and California reports, both the MA Department of Corrections and the San Luis Obispo County Attorney provided detailed rebuttals to the reports. In short, the issues noted at the San Luis Obispo County Jail in the USDOJ report do not raise red flags. Wellpath began operation at the facility in 2019, after the NHDOJ investigation began. Further, San Luis Obispo County indicated that healthcare improved after Wellpath began operating the healthcare at the facility.

Background

To conduct the review, our Office undertook the following actions:

1. Reviewed concerns raised by the Executive Councilors and the fact sheet submitted by the SEA, including a review of media reports regarding Wellpath, and its related corporate entities. Specifically, we did a full review of a February 9, 2022 report by the Massachusetts Disability Law Center regarding Bridgewater State Hospital; and a full review of an August 31, 2021 United States Department of Justice Investigation of conditions at the San Luis Obispo County Jail facility. We also reviewed a series of articles submitted by an Executive Councilor that raised concerns;
2. Spoke with legal counsel at the New Hampshire Department of Health and Human Services (“DHHS”) regarding the structuring of the contract, historic vetting of Wellpath, and any other salient information;
3. Spoke with Teresa Koeberlein, Group Vice President, Partnership and Government Affairs, at Wellpath;
4. Reviewed materials submitted by Koeberlein in response to our questions. Specifically, we asked for Wellpath’s internal data regarding lawsuits;
5. Discussed with Koeberlein the extent of Wellpath’s experience with facilities that are not connected to individuals who are involved in the criminal justice system;

or other correctional settings which involve a different treatment milieu. Second, all of the lawsuits referenced in the SEA document and in online media reports would be impossible to thoroughly review in a short timeframe, and, a high number of the referenced lawsuits stem from the correctional-side of Wellpath and its predecessor and related companies. However, using a variety of Westlaw search techniques, we were able to conduct comprehensive searches to ensure that the data provided to our Office by Wellpath in regards to psychiatric facilities it works in appeared to be genuine and accurate. We use the phrase “generally independently verify” only because there always remains a possibility that some minor discrepancy in numbers might exist, particularly since we developed and independently applied our own search protocols. Our conclusion is that the number of lawsuits at the psychiatric in-patient facilities in the last five years **is not concerning or high, based on our experience defending similarly situated state facilities, and accords with the data provided by Wellpath.**

6. Discussed with Koeberlein the conduct described in the Massachusetts and California reports referenced above;
7. Discussed with Koeberlein how Wellpath contracts are generally structured in other states for their facilities;
8. Reviewed the NH Wellpath contract in full with specific attention and care paid to areas of safety and oversight;
9. Sought detailed follow-up information from DHHS and Koeberlein to confirm statements and to seek more detailed information after initial review; and
10. To the extent possible, conducted Westlaw database searches of Wellpath-staffed psychiatric treatment facilities and summarized those findings in this report.

Analysis

The contract provides significant State oversight with substantive mechanisms to address problem personnel and gives the State control over compliance.

1. The structure of the contract provides significant state compliance oversight. In particular, several executive positions will be physically present at the Hampstead facility to monitor operations, including staff interactions. Additionally, a clinical position will be onsite among contracted employees. This person will be involved in direct care with Wellpath providers.
2. The “cost-plus” structuring of the contract incentivizes more, rather than less, staffing. Many of the critiques of Wellpath (and other for-profit providers in this space) revolve around a lack of staffing as a means to save on costs.
3. The actual terms of the contract provide significant oversight authority to the State. By way of example, § 1.2 of the contract requires significant rules, policies, and procedures. These will need to be approved by DHHS and will likely initially take a substantially similar form to what is currently in place at Hampstead. Some of the standards and policies require national accreditation and adherence to national norms. Compliance with state statutes and rules is required in the contract as well.
4. More specifically with respect to possible problems, § 1.4.5. requires the establishment of a Review Team in cases where Wellpath feels it cannot meet treatment needs of a patient. This section helps to carve out more oversight where treatment becomes difficult for a particular patient. The Review Team would include a minimum of three DHHS or DHHS appointed members. § 1.4.5.1.2. and § 1.4.5.1.3.
5. In emergent situations that might generate the most dangerous outcomes, such as involving the use of restraints or seclusion, § 1.8 requires adherence to NH laws regarding restraint and additionally requires an explicit child-abuse reporting requirement under § 1.8.4. It is inevitable that an emergent situation will arise, but

Wellpath must adhere to NH standards as overseen and administered by the DHHS compliance team.

6. § 13.2 requires live-feed monitoring of patient care areas, and per § 13.2.3, ownership rights of the data are held by DHHS. This information will be useful in reviewing incidents and could be used by the DHHS compliance officer in reviews or to help identify the causes of any issues.
7. Finally, § 5.1.16 gives DHHS the ability to remove underperforming/misperforming personnel. With a robust compliance environment (which is a State function), this procedure is a significant tool for ensuring adequate culture and levels of care.

The number and types of lawsuits brought against Wellpath, particularly in the context of in-patient psychiatric facilities, do not appear to show an unusually high volume of litigation, based on our experience defending similarly situated state facilities, or other “red flags” regarding quality of care.

It would be impossible in a short timeframe to independently verify every lawsuit filed against Wellpath and aggregate data related to those lawsuits. Wellpath has represented litigation outcomes to DHHS that are suggestive of a normal volume of litigation and litigation outcomes in the contexts of in-patient psychiatric facilities and in correctional facilities based on our experience. NHDOJ requested Wellpath provide its data and it provided relevant information, including data that Wellpath indicated is nonpublic and confidential.

Among the data provided, Wellpath indicated that, in the last five years at psychiatric hospitals it contracts with (Bridgewater State Hospital, Columbia Regional Care Center, Montgomery County Mental Health Treatment Facility, South Florida Evaluation and Treatment Center, South Florida State Hospital, and Treasure Coast Forensic Treatment Center), Wellpath faced 26 claims at psychiatric hospitals of which 2 resulted in settlement. Wellpath indicated that both of those settlements were from 2017.

To verify the data provided by Wellpath, we did Westlaw searches for cases involving the psychiatric facilities listed above for the last five years, beginning on January 1, 2017, and further searched the results for reference to “Wellpath” and/or “Correct!”. Based on these searches, we found the following:

Bridgewater State (275 beds): 2 cases. One of the cases was dismissed. The second case ordered the transfer of a quadriplegic inmate to a non-DOC facility with specialty care for treating spinal cord injuries. Although troubling, many of the issues in that case seem to stem from MA DOC decisions rather than Wellpath medical decisions for the inmate. *See Reaves v. Dep’t of Correction*, 392 F. Supp. 3d 195 (D. Mass. 2019).

South Florida State Hospital (350 beds): No cases in the last five years appeared to involve quality of care issues, or mention Wellpath or CorrectCare. South Florida State Hospital is a civil psychiatric hospital that does not primarily cater to justice-involved patients but to those who are outside of the justice system.

Columbia Regional Care Center (354 beds): The search indicates 14 cases at least including the name CorrectCare somewhere in the opinion. Of those, several were 1983 Habeas Corpus petitions that named CorrectCare as operating the CRCC but with no allegation regarding quality of care. One case alleged that CorrectCare misplaced prescription eyeglasses during a transport and was recommended for dismissal. One case, *Hunt v. South Carolina*, 2018 WL 7150756 (D.S.C. Sept. 18, 2018), *report and recommendation adopted*, 2019 WL 401412 (D.S.C. Jan. 31, 2019), involved allegations of inadequate medical care by a CorrectCare doctor, but was dismissed. The case of *Spann v. Schafer*, 2019 WL 2516555 (D.S.C. May 7, 2019), *report and recommendation adopted*, 2019 WL 2513707 (D.S.C. June 18, 2019), involves allegations of substandard care in 2016, but the case was dismissed because there was evidence that the care was potentially adequate. The allegations regarding medical care in *Spann* related to possible improper suturing of wounds that the plaintiff had had prior to his time at CRCC. The Report and Recommendation states that it is possible that this provider could have been negligent during the suturing procedure, but the merits were not reached because Mr. Spann did not properly preserve those claims.

Treasure Coast Forensic Treatment Center (224 beds): Our search indicates no cases from 2017-present alleging inadequate medical care or other issues relating to Wellpath/CorrectCare.

Maple Lane Competency Restoration Program (30 beds): We did not find any lawsuits relating to this facility. We engaged a few online searches for press about this facility, but did not find any relevant results. It appears that Washington State contracted with CorrectCare in 2016 to provide medical services at this facility. *See* <https://www.dshs.wa.gov/sites/default/files/BHSIA/WSH/Maple%20Lane%20Competency%20Restoration%20Program%20-%20letter%20for%20attorneys.pdf>

Kern County AES Center (60 beds): We did not find any lawsuits relating to this facility or quality of care issues.

Montgomery County Mental Health Treatment Facility (100 beds): We found one salient lawsuit, *Ahmadi v. Pool*, 725 F. App'x 308 (5th Cir. 2018), which involved allegations of physical, sexual, and mental abuse and improper medical care, including forced medication. The case was dismissed on summary judgment because the plaintiff failed to raise his claims within two years of being discharged from the facility and thus was barred by the statute of limitations. This case did not reach the merits of the claims.

MA DOC's Response to the Disability Law Center's Report on Bridgewater State Hospital

The Disability Law Center's (DLC) Report² and the MA DOC response³ to the Report contain several points of interest. In the DLC Report, several areas of concern are only tangentially, if at all, related to Wellpath. Those areas include issues of mold remediation and physical deterioration of Bridgewater State Hospital (pages 6-16 of the Report); and discharge process and underutilization of county facilities (pages 35-40 of the Report). The primary issue and set of allegations against Wellpath stems from the use of "Restraint and Seclusion" practices and "Emergency Treatment Orders"⁴ ("ETOs"). In short, DLC asserted illegal use of techniques during emergent/psychiatrically emergent circumstances. MA DOC denied that the use of seclusion and restraint in the manner applied at BSH was illegal (MA DOC response at 3) and indicated that, since 2015, total seclusion hours at BSH had declined from 39,319 hours in 2015 to 1,229 hours in 2021. Similarly, MA DOC noted 706 hours of restraint in 2015 and 363 hours in 2021. *Id.* MA DOC agreed that use of seclusion and restraint should be limited to the maximum extent possible and further agreed to implement a more robust monitoring program to help reduce the use of seclusion, restraint, and ETOs and to promote de-escalation techniques.

Conclusion

Based on our review, Wellpath does not appear to have an unusual amount of litigation or pose any substantial risk of inadequate care. Additionally, the contract contains many strong compliance provisions that give the State significant, meaningful oversight, including embedded executive and treatment positions, if issues do arise. The media reports and the concerns regarding Wellpath sound troubling, but a deeper analysis of more analogous treatment milieus indicates that Wellpath does not pose any unusually high risk of litigation or substantial risk to the future children and young adult patients at Hampstead Hospital.

² Available here: <https://www.dlc-ma.org/wp-content/uploads/2022/02/DLC-BSH-January-2022-Public-Report-2.9.2022.pdf>

³ Available here: <https://www.dlc-ma.org/wp-content/uploads/2022/02/DLC-BSH-January-2022-Public-Report-2.9.2022.pdf>

⁴ An ETO in Massachusetts is ordered by a provider during an emergent psychiatric crisis and could involve the use of medication. In certain circumstances, it could also involve the use of seclusion and/or restraint to help administer the medication, or to allow for the time needed for the medication to take effect. An ETO is ordered "in the moment" by the provider. DHHS will approve all policies in place at Hampstead, and would have embedded state employees who could observe and track the use of any analogous procedures at Hampstead for personal safety emergencies. *See He-M 305 et. seq.* governing "Personal Safety Emergencies" which also require adherence to RSA 126-U (limiting use of restraint and seclusion of children in treatment settings).