Division of Behavioral Health Services
and
Arizona State Hospital

ANNUAL REPORT
FISCAL YEAR 2004

Janet Napolitano, Governor

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Submitted in Compliance with A.R.S. 36-3405 (a) (b) (c) and 36-209(e)

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ANNUAL REPORT
FISCAL YEAR 2004
For
Arizona Department of Health Services
Division of Behavioral Health Services
and
Arizona State Hospital

Submitted in Compliance with
A.R.S. 36-3405 and 36-209(e)

~Leadership for a Healthy Arizona~

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DIVISION OF BEHAVIORAL HEALTH SERVICES

VISION AND MISSION STATEMENTS

The Department of Health Services/Division of Behavioral Health has the following **VISION STATEMENT:**

Leadership for a Healthy Arizona

Further, the Division's **MISSION STATEMENT** is:

Creating partnerships for personal and community health

DESCRIPTION OF THE BEHAVIORAL HEALTH SERVICES DELIVERY SYSTEM

The Division of Behavioral Health Services shall provide leadership utilizing the following delivery system. The Arizona Department of Health Services is the State agency responsible for public health education, prevention and treatment. The Arizona Department of Health Services is comprised of six major service areas, which report to the Director of the Department. The Division of Behavioral Health Services (Division) is charged with the responsibility of overseeing publicly funded behavioral health services. By the end of fiscal year 2004, an average of 121,766 clients received behavioral health treatment services per month. During fiscal year 2004, 163,000 persons received prevention services. Expenditures totaled $796,474,800.

The publicly funded behavioral health system provides services to both federally eligible (Title XIX and Title XXI of the Social Security Act) and State-only populations. Behavioral health recipients that are served include the following:

- Prevention programs for children and adults,
- Services for children and adults with substance abuse and/or general mental health disorders,
- Services for children with serious emotional disturbance and
- Services for adults with a serious mental illness.

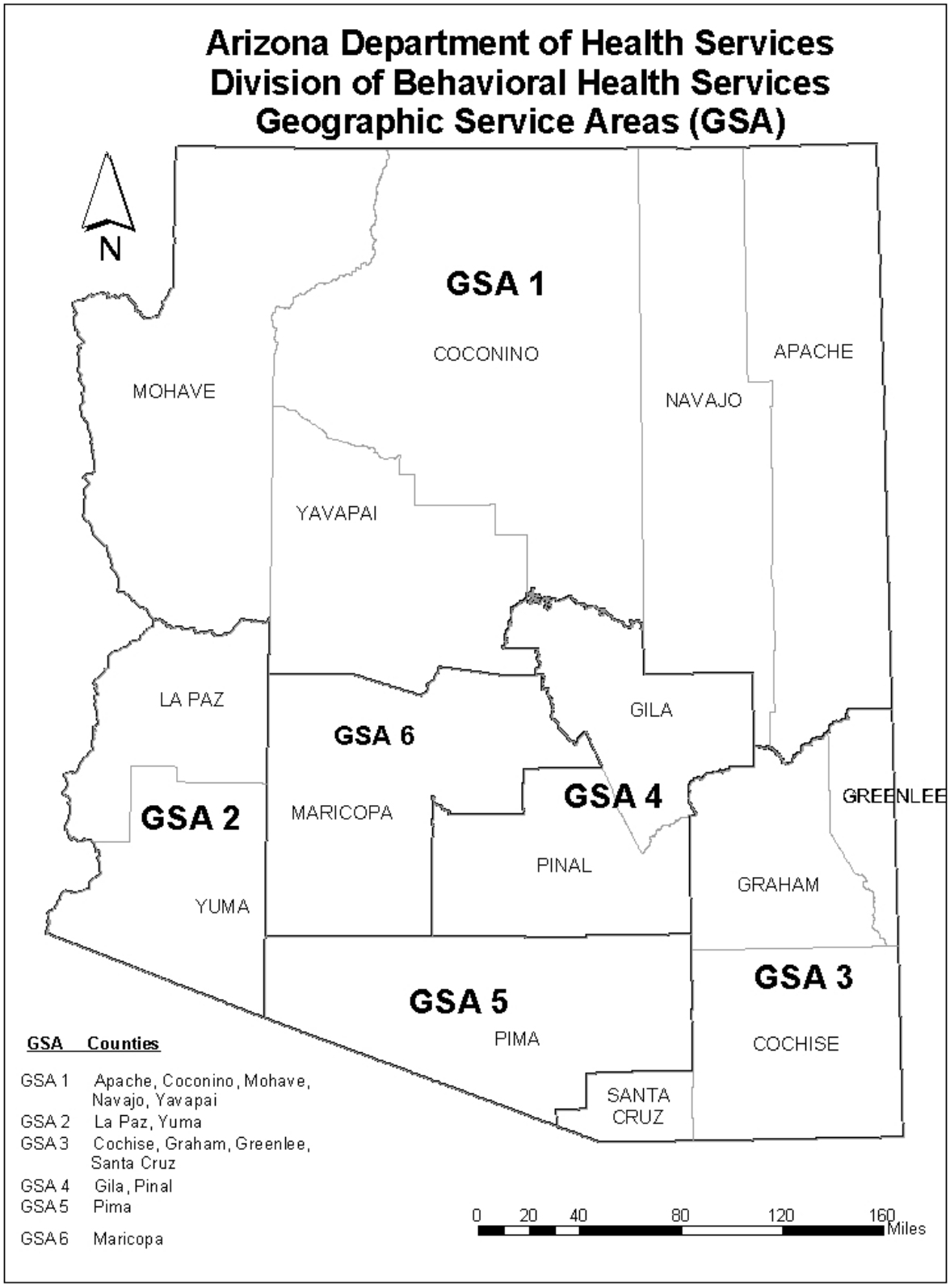
The Arizona Department of Health Services receives funding to operate the behavioral health system through a variety of sources including Title XIX Medicaid, Title XXI State Children's Health Insurance Program (KidsCare), federal block grants, state appropriations and intergovernmental agreements. Federal Title XIX and Title XXI funds may only be used for eligible persons as prescribed by the State Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS).

The State is divided into six geographic regions, called Geographic Service Areas (GSA). See the Geographic Service Areas map on the following page. The Division contracts with Regional Behavioral Health Authorities (RBHAs) who are responsible for administering delivery systems for the GSA(s). The Arizona Department of Health Services/Division of Behavioral Health Services currently contracts with five RBHAs. The five RBHAs are: Northern Arizona Regional Behavioral Health Authority, the EXCEL group, Community Partnership of Southern Arizona, Pinal Gila Behavioral Health Authority, and ValueOptions Incorporated.

Currently, four tribes have IGAs with the Division; they are Gila River, Colorado River Indian Tribe, Navajo Nation and Pascua Yaqui.

Services provided to Arizonans include medical, rehabilitation, assessment, counseling, consultation, specialized testing, professional treatment, support, crisis intervention, inpatient, residential, day programs, and prevention.

GEOGRAPHIC SERVICE AREAS



DIVISION OF BEHAVIORAL HEALTH SERVICES ORGANIZATIONAL STRUCTURE

The **Deputy Director** provides leadership and direction in accomplishing the mission of the Arizona Department of Health Services/Division of Behavioral Health Services, works as a member of the Department's Executive Management Team, and oversees the Arizona State Hospital and community behavioral health system of care delivered through the Tribal and Regional Behavioral Health Authorities. The Deputy Director leads the Core Management Team of the Division.

The **Medical Director** provides medical guidance to the Deputy Director and to all Division bureaus and offices and to the Department Director through participation in the Physician Advisory Council. Working closely with the Medical Directors of the regional behavioral health authorities, the Medical Director develops clinical practice guidelines, standards and review instruments that are used throughout the State and maintains/updates drug formularies. The Medical Director coordinates with the Medical Director of the Arizona Health Care Cost Containment System and with Arizona Health Care Cost Containment System health plans for the joint management of clients' physical and behavioral health needs.

Clinical Services provides clinical leadership, technical assistance and consultation to the Regional Behavioral Health Authorities ensuring conformance with federal and state regulations. Best practices are researched and guidelines are provided for the delivery of behavioral health services. Clinical Services is comprised of three Bureaus, Adult Services, Children's Services and Substance Abuse Treatment and Prevention.

The **Bureau for Consumer Rights** assists consumers in knowing, protecting and exercising their rights with respect to applying for and receiving behavioral health service, providing a grievance and appeal system available to consumers, contractors, and providers for the administrative resolution of disputes. The Bureau provides support to each regional Human Rights Committee through technical assistance, training, clerical support and problem solving. The Bureau is composed of the Office of Human Rights and Office for Grievance and Appeals.

Finance provides oversight and coordination of the Division of Behavioral Health Services financial and operational functions to ensure efficient, effective, and accountable operations in accordance with federal and state laws and regulations and Department policies. The functions of the Bureau include fiscal monitoring and budget, provider services, procurement and personnel services as well as receiving incident reports of financial fraud and abuse. The Bureau has provided leadership in the development of financial standards to assure a healthy balance of the fiscal viability of the system and the needs of the clients it serves.

The **Bureau of Quality Management and Evaluation** provides leadership and direction in performance improvement, policymaking, utilization review, developing outcome measurement, and coordinating the activities to monitor the clinical performance of the behavioral health system. The Bureau's mission is to support Division decision-making processes and assist in optimizing behavioral health resources by providing technical assistance and critical information related to the

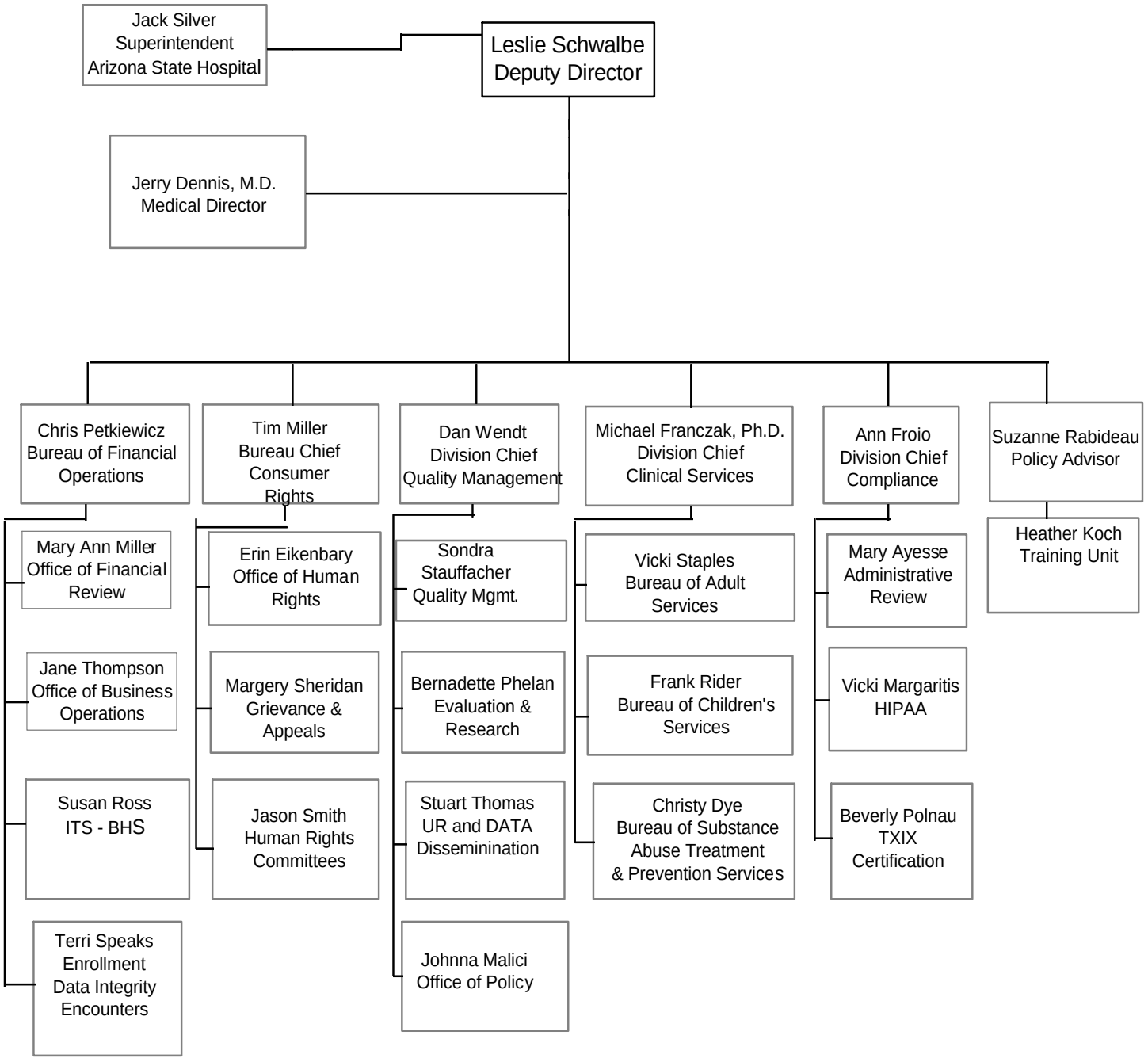
behavioral health service delivery system. It consists of the Bureau of Performance Improvement, the Bureau of Research, Grants, and Special Projects, the Policy Office, and the Office of Utilization Management and Data Dissemination.

The **Behavioral Health Applications Team (Information Technology)** is responsible for the maintenance and development of information systems that support the Division. These systems work in coordination with the Regional Behavioral Health Authorities and the Arizona Health Care Cost Containment System to monitor and resolve Title XIX, Title XXI, and Non-Title XIX enrollment, assessments encounters (claims), and provider issues. A primary function is to develop and maintain the Client Information System application and database. This system tracks clients receiving behavioral health services in Arizona. In addition to the support of the Client Information System, the Information Technology Support team develops PC stand-alone applications to support business needs within various Division of Behavioral Health Services offices.

The **Office for Contract Compliance** is responsible to support and coordinate strategic planning for the Division, Regional Behavioral Health Authority contract and Tribal Regional Behavioral Health Authority Intergovernmental Agreement production, Title XIX Certification of Community Service Agencies, behavioral health related rule-making, mental health disaster responses, audits conducted by the Auditor General, the annual Administrative Reviews of the Regional Behavioral Health Authorities, the annual operational and financial reviews conducted by AHCCCS, mutual business activities with the Arizona State Hospital, and implementation of the Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements.

The **Policy Office** is responsible for the coordination and production of the Division's policies and procedures, the Provider Manual which contains requirements for publicly funded behavioral health providers, and the Member Handbook template which contains information that each person enrolled in the publicly funded behavioral health system is entitled to receive in accordance with federal and state rules, codes, statutes and laws. A chief goal of the Policy Office is to ensure consistency of Division information disseminated internally to staff and externally to stakeholders and contractors.

DIVISION OF BEHAVIORAL HEALTH SERVICES ORGANIZATIONAL CHART



DIVISION OF BEHARVIORAL HEALTH SERVICES FINANCIAL REPORT

The Division of Behavioral Health Services received a total of $796,474,800 in funding for the state fiscal year 2004. Administrative costs were $14,559,500. Services costs were $781,915,300. Please see the tables below for programmatic funding detail.

Table 1

Total Behavioral Health Services Funding SFY 2004		
Funding	**Amount Paid**	**Percentage**
Title XIX	$378,234,359	47.49%
Title XIX Proposition 204	$198,445,687	24.92%
Title XXI	$14,237,233	1.79%
Federal Funds	$38,369,750	4.82%
Non Title XIX/XXI Funds General Funds	$116,886,197	14.68%
County Funds	$37,254,267	4.68%
Tobacco Litigation/Settlement	$8,720,108	1.09%
Other (1)	$4,327,107	0.54%
Total	$796,474,800	100.00%

(1) Other includes PASRR, Liquor Fees, Corrections Offender Program, Crisis Counseling, Az Integrated Treatment Panel, Perinatal Substance Abuse, City of Phoenix LARC, Compulsive Gambling, Comcare Trust & Indirect.

Table 2

Administrative Funding SFY 2004		
Funding	**Amount Paid**	**Percentage**
Title XIX	$6,827,458	46.89%
Title XIX Proposition 204	$3,766,162	25.87%
Title XXI	$658,051	4.52%
Federal Funds	$1,198,186	8.23%
Non Title XIX/XXI Funds General Funds	$1,432,106	9.84%
County Funds	$125,700	0.86%
Tobacco Litigation/Settlement	$5,100	0.04%
Other (1)	$546,691	3.75%
Total	$14,559,500	100.00%

(1) Other includes PASRR, Corrections Offender Program, Crisis Counseling, Comcare Trust, & Indirect.

Table 3

Statewide Service Funding by Program SFY 2004 (Does Not Include Administrative Funding)		
Funding	**Amount Paid**	**Percentage**
Title XIX Children	$148,573,872	19.00%
Non TXIX Children	$19,500,442	2.49%
TXXI Children	$8,263,362	1.06%
TXIX SMI	$293,732,608	37.57%
Non TXIX SMI	$123,628,284	15.81%
TXXI SMI	$3,836,159	0.49%
TXIX GMH/SA	$123,779,946	15.83%
Non TXIX GMH/SA	$44,346,101	5.67%
TXXI GMH	$1,479,661	0.19%
Non TXIX Prevention	$10,636,232	1.36%
Other Programs (1)	$ 4,138,659	0.53%
Total	$781,915,300	100.00%

(1) Other includes PASRR, Corrections Offender Program, Crisis Counseling, Liquor Fees, City of Phoenix LARC, and Compulsive Gambling & Perinatal Substance Abuse.

Table 4

Statewide Service Funding by Program With TXIX Sub-Programs SFY 2004 (Does Not Include Administrative Funding)		
Funding	**Amount Paid**	**Percentage**
Title XIX Children	$138,076,166	17.66%
Title XIX Children/Proposition 204	$3,692,793	0.47%
TXIX DES/DD	$ 6,804,914	0.87%
Non TXIX Children	$19,500,442	2.49%
TXXI Children	$ 8,263,362	1.06%
TXIX SMI	$155,436,069	19.88%
TXIX SMI Proposition 204	$132,747,089	16.98%
TXIX SMI DES/DD	$5,549,450	0.71%
Non TXIX SMI	$123,628,284	15.81%
TXXI SMI	$3,836,159	0.49%
TXIX GMH/SA	$64,857,558	8.29%
TXIX GMH/SA Proposition 204	$58,922,388	7.54%
NTXIX GMH/SA	$44,346,101	5.67%
TXXI GMH	$1,479,661	0.19%
Non TXIX Prevention	$10,636,232	1.36%
Other (1)	$4,138,659	0.53%
Total	**$781,915,300**	**100.00%**

(1) Other includes PASRR, Corrections Offender Program, Crisis Counseling, Liquor Fees, City of Phoenix LARC, and Compulsive Gambling & Perinatal Substance Abuse.

DIVISION OF BEHAVIORAL HEALTH SERVICES NUMBER OF CLIENTS SERVED

As of June 30, 2004

	CHILDREN				SMI				NON-SMI							Totals Column
	T19	T21	Non-T19	Children Subtotal	T19	T21	Non-T19	SMI Subtotal	GMH T19	GMH T21	GMH Non-T19	SA T19	SA T21	SA Non-T19	Non-SMI Subtotal	RBHA Total
CPSA-3	1677	98	343	2118	466	1	261	728	1990	24	586	607	3	511	3721	6567
CPSA-5	5724	590	936	7250	2988	7	2050	5045	6540	88	2337	1915	7	1873	12760	25055
EXCEL	1123	125	183	1431	404	0	176	580	1337	17	350	563	2	625	2894	4905
NARBHA	2985	273	488	3746	1842	7	936	2785	4238	62	1146	890	2	574	6912	13443
PGBHA	1748	152	284	2184	472	3	225	700	1837	31	337	729	4	440	3378	6262
Value Options	14735	1391	3080	19206	8994	13	5617	14624	16024	264	5865	5300	18	4233	31704	65534
Statewide Total	27992	2629	5314	35935	15166	31	9265	24462	31966	486	10621	10004	36	8256	61369	121766

As of June 30, 2003

	CHILDREN				SMI				NON-SMI							Totals Column
	T19	T21	Non-T19	Children Subtotal	T19	T21	Non-T19	SMI Subtotal	GMH T19	GMH T21	GMH Non-T19	SA T19	SA T21	SA Non-T19	Non-SMI Subtotal	RBHA Total
CPSA-3	1,113	68	216	1,397	557	2	283	842	1,059	8	198	614	1	339	2,219	4,458
CPSA-5	4,257	362	802	5,421	3,367	6	2,232	5605	3,684	33	931	1,714	6	1,320	7,688	18,714
EXCEL	1,119	132	376	1,627	527	1	257	785	925	7	366	514	2	714	2,528	4,940
NARBHA	2,569	224	558	3,351	2,201	0	1,154	3355	2,038	14	495	1,246	4	890	4,687	11,393
PGBHA	1,421	112	587	2,120	409	2	257	668	1,424	12	619	633	5	533	3,226	6,014
Value Options	12,352	1,050	3,730	17,132	9,087	23	6,432	15542	9,515	129	3,693	5,858	20	4,277	23,492	56,166
Statewide Total	22,831	1,948	6,269	31,048	16,148	34	10,615	26,797	18,645	203	6,302	10,579	38	8,073	43,840	101,685

DIVISION OF BEHAVIORAL HEALTH SERVICES PROGRAMMATIC REPORT

The Division of Behavioral Health Services is responsible for the oversight of public funded behavioral health services. Further, the Division is responsible to continually improve the effectiveness and efficiency of a comprehensive system of care to meet the needs of the people of Arizona. The Division of Behavioral Health system provides for responsive, comprehensive, community-based services tailored to the individual, family, community and culture.

In order to accomplish this, the Division carries out many formal roles, responsibility and functions including, but not limited to:

- Contract development;
- Clinical and administrative guidance;
- Monitoring through formal quality management processes;
- Training and technical assistance, and
- Advocacy for behavioral health recipients.

Over the course of Fiscal Year 2004 the Division of Behavioral Health Services targeted several strategic plan goals in its 2004 Strategic Plan. This section of the report highlights these activities.

Implementing practices and principles in accordance with Jason K Agreement.

The Arizona Department of Health Services is committed to provide behavioral health services to children through a family-centered practice. The Division's Child and Family Team technical assistance document provides the assurance that all TXIX and TXXI eligible members under the age of 21 receive behavioral health services in keeping with the 12 Arizona Principles.

The Child and Family Team document is based upon a coordinated, flexible, family-driven process that:

- Explores and documents the strengths and needs of a child and family;
- Establishes and prioritizes service goals;
- Identifies the supports necessary to meet those goals;
- Describes a course of action, which is encompassed in a written plan;
- Monitors results;
- Determines the responsibilities of all team members in these efforts.

The Adolescent Substance Abuse Treatment protocol encourages the development of substance abuse interventions for children that are unique and specific to younger populations. Successful approaches for children consider the individual's developmental level, family strengths and culture, gender, coexisting disorders, and social and community factors that increase risks of substance abuse.

The **Transition to Adult Services** protocol was created to define funding, licensing requirements and contracting practices. The current service delivery systems have led to

a distinct separation between the adult and children's systems of care and to barriers to appropriate preparation for independent living and transition to adult services. This document outlines the steps needed to ensure the timely and seamless transition of children into the adult service system, and to dispel misconceptions related to the transition process.

The Division created **The Therapeutic Foster Care Home** practice improvement protocol to enable other child-servicing systems to understand the complexities of providing coordinated services within the foster care model.

Therapeutic Foster Care Services are Title XIX and Title XXI covered services available through the Arizona Department of Health Services/Division of Behavioral Health Services. This protocol outlines the clinical considerations for sound utilization of Therapeutic Foster Care services and the prior authorization criteria used by Tribal and Regional Behavioral Health Authorities who are approved by ADHS to prior authorize foster care services.

The Division of Behavioral Health Services has implemented the **Urgent Behavioral Health Response for Children Entering Foster Care** protocol. This protocol ensures timely, accessible services to all children referred to Regional Behavioral Health Authorities by Department of Economic Security and their families and caregivers. The 24-hour urgent response timeframe was developed for children removed from the home by Child Protective Services.

As a result of this protocol, the Division's Clinical subcommittee developed a paper describing the unique service needs of children placed in foster care, their families and caregivers. The committee created a plan of action to develop needed Behavioral Health provider network services that provide:

- participation of family in system design, network development needs and quality management functions;
- monitoring the use and availability of respite services;
- training sessions about the eligibility for and access to Behavioral Health services for children in the Adoption Subsidy program;
- training to Arizona Health Cost Care Containment System's Arizona Long Term Care Services program contractors about Child and Family Teams and co-sponsored a two-day Family Centered Practice conference in June.

With the plan of action, currently the Division provided services to 2,969 of children.

In addition, the funding from House Bill 2003 funds for the training and coaching programs required to educate the Child and Family Teams, Juvenile Corrections personnel working within the correctional institutional, community-parole programs, and service provider systems. All the Regional Behavioral Health Authorities are actively implementing this training and coaching program.

Improving the clinical assessment and clinical oversight processes

The Division continues to provide training and technical assistance to Tribal and Regional Behavioral Health Authorities and Provider organizations regarding the assessment tool and the role and responsibilities of the clinical liaison.

Information on Provider Network requirements have been disseminated and updates are offered through the Regional Behavioral Health Authorities Network Analysis and Development Teams.

The ADHS created the Primary Care Provider Communication Form to assure timely communication and coordination of care between the person's health providers and his/her AHCCCS health plan regarding the person's behavioral health and general medical care and treatment.

Streamline and reduce redundancy of the Division's documents

The Division has conducted training within the Division along with AHCCCS, T/RBHAs and stakeholders regarding the vision and proposal to reorganize the behavioral health system requirements into a set of concise and understandable documents. All Division documents were aligned to the requirements to reduce redundancy. Those documents include:

- Provider Manual
- Member Handbook
- Financial Reporting Guide
- ADHS Policy and Procedures

Updated documents are posted on the Arizona Department of Health Services/Division of Behavioral Health website. Each RBHA has implemented and posted/distributed geographic specific versions of the provider manual and the ADHS/DBHS Member Handbook.

Implement Corporate Compliance Program to guard against fraud and abuse

The Division has established disciplinary guidelines to enforce fraud and abuse standards. The Division has published these standards to all ADHS/DBHS employees and RBHAs. The Division has designed and implemented training to Division employees and RBHAs to detect and report possible fraud and abuse activities.

The Division has designated a Corporate Compliance Officer, who working with Corporate Compliance Committee has developed a mechanism to promptly respond to the detected fraud and abuse. The Division has established quarterly meetings with the Corporate Compliance Committee to review, educate and update members on pending and new issues.

Expanding and enhancing the statewide network of providers

The Division of Behavioral Health Services examined the current statewide network of providers, identified and addressed gaps in the network, and partnered with other agencies and organizations to improve the quality and competency of providers. Data analysis was conducted on all identified data sources and the Division of Behavioral Health Services Logic Model was utilized to determine network sufficiency and development needs for each Regional Behavioral Health Authority

The Division of Behavioral Health Services Cultural Competency Implementation Plan was revised to include 1) Education and Training, 2) Culturally Competent Services and Translation/Interpretation services and 3) Database analysis and development. The Division's Plan created an Advisory Committee that includes consumers, Regional Behavioral Health Authorities, Providers, Division staff and community stakeholders.

The Initial Behavioral Health Higher Education Partnership plan was created to encourage more individuals to work in the public behavioral health system and influence curriculum development to develop a knowledgeable, skilled and culturally competent workforce.

Assist persons with behavioral health problems in understanding, exercising and protecting their rights.

The Office of Human Rights was established within the Division of Behavioral Health Services to help people with serious mental illness (SMI) to understand, exercise and protect their rights. The Office helps resolve problems regarding behavioral health services and those in need of special assistance. The Office of Human Rights offers advocacy for services at no charge to persons receiving publicly funded behavioral health services.

The Office of Grievance and Appeals is responsible for the administration and oversight of the administrative grievance and appeals process. The Office investigates allegations of sexual abuse, physical abuse or the death of individuals with serious mental illness. The purpose of the grievance and appeals process is to resolve case specific issues and to remedy any systematic concerns that are identified.

The Office of Grievance and Appeals completed an analysis of the new Balanced Budget Act requirements and its affect on the Grievance system's complaints, appeals and notices processes. All applicable Division documents were revised to reflect compliance with the Balanced Budget Act and the 2004 AHCCCS contract.

The Grievance system policies and procedures documents have been revised and training of all Division staff and Tribal and Regional Behavioral Health Authority personnel is ongoing.

Develop a contracting process to obtain the best system for Behavioral health Services

Beginning in 2004 the Division prepared an extensive request for proposal for the contracted behavioral services for Maricopa County. The request for proposal incorporated insight from stakeholders, providers, clients and Division staff to encompass the needs of the clients.

On February 5, 2004 ValueOptions was awarded Contract No. H1432188 to provide behavioral health services in Maricopa County. The Contract Implementation Team was developed to discuss how tasks would be accomplished for determining if Value Options had met all the criteria required in the contract and the proposal. The Contract Implementation Team was comprised of key staff members from the Department of Health Services, ValueOptions, providers and stakeholders.

The Contract Implementation Team areas of review included:

- Administration - adequate structure of personnel;
- Network - standards and sufficiency of access to care;
- Service delivery - communication with stakeholders, family and incorporation of agency policies;
- Quality Management - monitoring timely and accurate data flow;
- Utilization management - prior authorization function;
- Grievance and Appeal - implementation of BBA requirements
- Information Technology - data submission testing;
- Finance - capitalization requirements, performance bond obtained, and encounter submissions;

In 2004 the Division of Behavioral Health Services issued a request for proposals for Behavioral Health Service Administration for all Geographical Service Areas, except for Maricopa County. Six organizations submitted proposals in response to this solicitation. The Division is currently in the evaluation process of these proposals. Award of contract will be completed before July 2005.

The Division worked intensively with the Navajo Nation Tribe throughout 2004 to revise an Intergovernmental Agreement.

Integration/Coordination of service delivery with the Arizona Health Care Cost Containment System health plans

The Arizona Department of Health Services/Division of Behavioral Health Services Co-Management Task Force addressed numerous issues regarding obstacles to information sharing, obtaining timely enrollment information, shared databases, accessibility and availability of Behavioral Health Clinicians to Health Plan Behavioral Health Coordinators and Primary Care Providers.

The Division developed and has implemented a standardized provider manual, member handbook and a financial reporting guide. The Regional Behavioral Health Authorities

have posted and distributed geographic specific versions of the provider manual to each subcontracted provider. Each Regional Behavioral Health Authority has established its own process to review, revise and communicate changes pertaining to their own specific version of the provider manual.

All Regional Behavioral Health Authorities have been informed on the revised Arizona Health Care Cost Containment Systems contractual requirements specific to Coordination of Care and have implemented the Provider Manual and Sample Communication Documents. Staff training was completed September 2004.

Regional Behavioral Health Authorities continue to hold quarterly regional meetings with the Health Plans including the Health Plan Medical Directors to assure identification and problem resolution at the regional level.

An annual Independent Case Review was completed in June 2004. The Division compared the Regional Behavioral Health Authorities findings with the Coordination of Care standards and provided assistance to improve outcomes.

Support the Tribal Nations in achieving their vision for a Behavioral Health System

The Division of Behavioral Health services assisted in the development of a case management model to determine what activities and deliverables the Navajo Nation would perform in its capacity as a behavioral health services provider. The Division and Arizona Health Care Cost Containment Services developed a bundled case management rate based on a time and motion study. This model was used to develop the Navajo Intergovernmental Agreement (IGA). The Navajo Clinical Operations Manual and Navajo Member Handbook were submitted to the Navajo Nation for final review.

THE ARIZONA STATE HOSPITAL

VISION AND MISSION STATEMENTS

The Arizona State Hospital has the following **VISION STATEMENT:**

> ***The Arizona State Hospital will meet the needs of our patients and other customers in collaboration with our community partners. We will continue to be a unique and valuable resource in the provision of specialized psychiatric treatment, rehabilitation, education and research. We will always strive to improve our performance.***

Further, the Hospital's **MISSION STATEMENT** is:

> ***The Mission of the Arizona State Hospital is to restore and enhance the mental health of persons requiring psychiatric services in a safe, therapeutic environment.***

DESCRIPTION OF THE ARIZONA STATE HOSPITAL

The Arizona State Hospital ("the Hospital") is located on a 93-acre campus at 24th Street and Van Buren in Phoenix, Arizona. A component of the statewide continuum of behavioral health services provided to the residents of Arizona, the Hospital is the only publicly funded, 24-hour inpatient, state-operated psychiatric hospital serving the state.

As part of the Arizona Department of Health Services, the Hospital provides direct care to the most seriously mentally ill Arizonans who are court-ordered for treatment to its 335-licensed bed facility requiring a state supported tertiary level of inpatient hospitalization and rehabilitative care. The Hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") and is a Medicare reimbursable institution.

Treatment at the Hospital is considered the "highest and most restrictive" level of care in the state, and patients are admitted as a result of an inability to appropriately care for them in a community facility, or because of their legal status. Hospital personnel continually strive to provide state-of-the-art inpatient psychiatric and forensic care. The Hospital is committed to the concept that all patients and personnel are to be treated with dignity and respect. The average monthly census for Fiscal Year 2004, for all patient populations, was 310 patients.

Authorized by A.R.S. 36-201 through 36-207, the Hospital is required to provide inpatient care and treatment to patients with mental disorders, personality disorders or emotional conditions. While providing evaluation and active treatment, the Hospital is continually cognizant of the rights and privileges of each patient, particularly the patient's right to confidentiality and privacy.

The Arizona Department of Health Services is the state agency responsible for assessing and assuring the physical and behavioral health of all Arizonans through education, intervention, prevention and delivery of services. The Hospital is one of six major service units which report to the Director of The Arizona Department of Health Services, as does its community services counterpart, the Division of Behavioral Health Services.

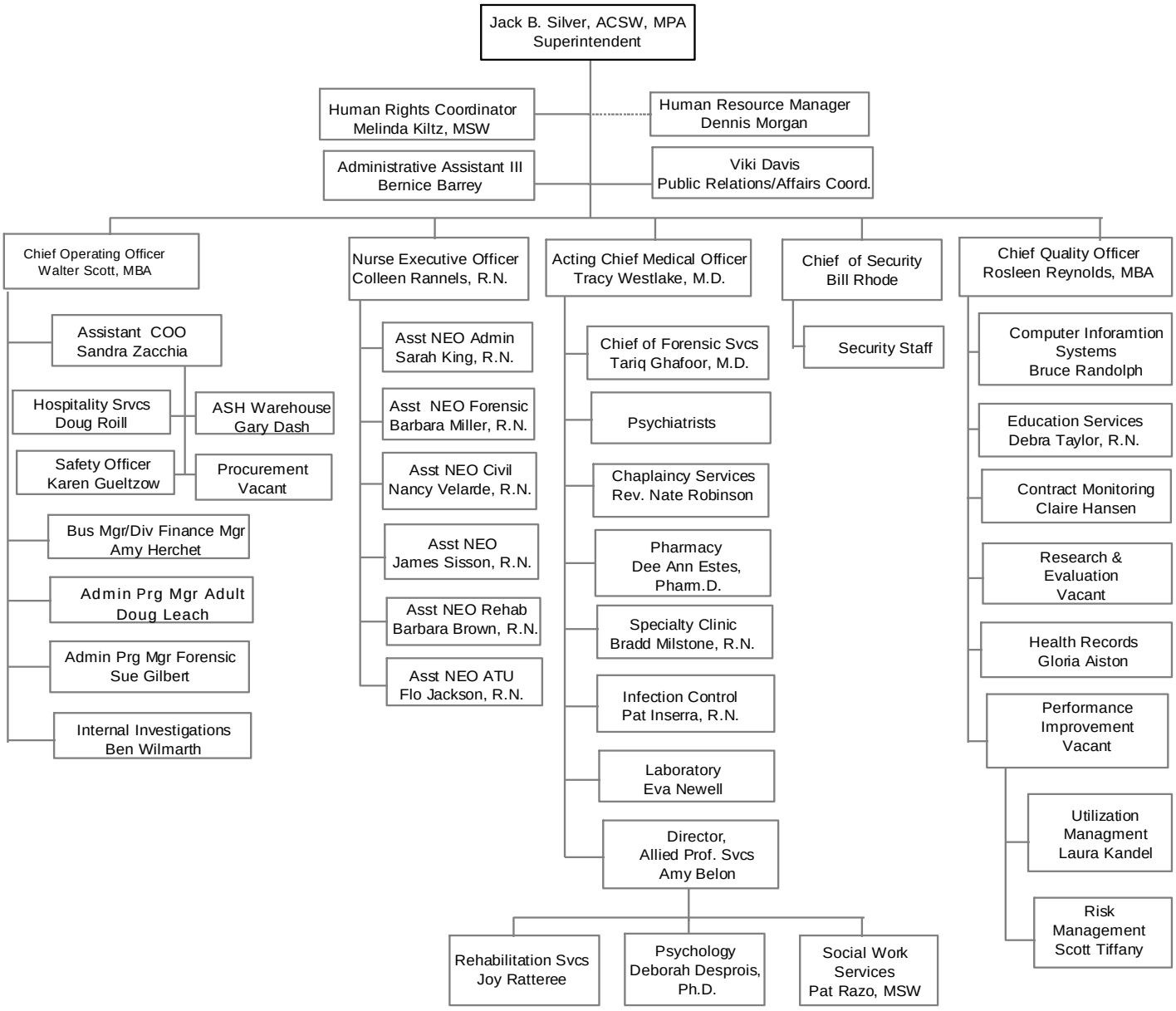
Overall guidance for Hospital leadership is provided by the **Arizona State Hospital Governing Body,** which is regulated by federal guidelines. The Deputy Director of The Arizona Department of Health Services/Division of Behavioral Health Services chairs this committee. The governing body consists of not only the Deputy Director but also a Hospital physician and a community representative.

As required in statute (A.R.S. 36-217), the **Arizona State Hospital Advisory Board** advises the Deputy Director of the Division of Behavioral Health Services and the Chief Executive Officer of the Hospital in the development, implementation, achievement and evaluation of hospital goals and communicates special hospital or patient needs directly to the Office of the Governor. The Hospital Advisory Board consists of 13 governor-appointed members.

The Hospital receives overall direction from the Chief Executive Officer (CEO) who reports to the Deputy Director of Division of Behavioral Health Services. The CEO supervises the leaders of the Hospital's four major divisions. These leaders include the Chief Medical Officer, the Chief Operating Officer, the Chief Quality Officer and the Chief Nursing Officer.

These Executive Management Team members oversee Hospital operations, establish administrative policies and procedures, and direct Hospital planning activities. Other Executive Management Team members include critical department directors, legal counsel, the public relations officer and others at the discretion of the Chief Executive Officer.

ARIZONA STATE HOSPITAL ORGANIZATIONAL CHART



ARIZONA STATE HOSPITAL FINANCIAL SUMMARY
Fiscal Year 2004
Table 5

ARIZONA STATE HOSPITAL

FINANCIAL SUMMARY
FISCAL YEAR 2003 - 2004

Funding Sources (General Operations Based on Budget Allocations): *	
Personal Services and Related Benefits - General Fund	$29,433,601
All Other Operating - General Fund/Az State Hosp Fund	12,496,195
Rental Income	726,185
Endowment Earnings	650,000
Patient Benefit Fund	30,500
Donations	18,000
Psychotropic Medications	63,500
Community Placement - General Fund	5,574,100
Community Placement - Az State Hosp Fund	1,130,700
Total Funding	$50,122,781
Expenditures: *	
Personal Services and Related Benefits	$29,576,695
Professional and Outside Services **	8,297,569
Travel (In-State)	58,218
Travel (Out-of-State)	577
Food	0
Other Operating	4,913,377
Capital Equipment ***	(43,608)
Assistance to Others	6,704,800
Total Cost of Operations	$49,507,628
Collections :	
Patient Care Collections to General Fund	$779,588
Patient Care Collections to Az State Hosp Fund - RTC	8,506,935
Patient Care Collections to Az State Hosp Fund - Title XIX	2,563,777
Non-Patient Care Collection to General Fund	2,987
Total Collections	$11,853,287

* Excludes SVP Program.

** Contract Physicians, Outside Hospitalization Costs, Outside Medical Services, and privatization of support services.

*** The negative amount in the Capital Equipment line reflects a transfer from DOA construction for the purchase of Pyxis machines resulting in a credit to expenses until the machines are paid for through the Administrative Adjustment process during FY05.

Daily Costs by Treatment Program: ****

Medical Psychiatric	$437
Adolescent Treatment	$656
Special Psychiatric Rehabilitation	$465
Psychiatric Rehabilitation	$401
Forensic - Restoration to Competency	$409
Forensic Rehabilitation	$340
Average	$401

**** Rates became effective 11/01/01.

PATIENTS SERVED AT THE ARIZONA STATE HOSPITAL

Three Population-Based Programs (Patient populations are housed separately in accordance with legal, treatment and security issues):

- CIVIL ADULT REHABILITATION PROGRAM (141 BEDS) consists of six treatment units specializing in providing services to adults who are civilly committed as a danger to self, danger to others, gravely disabled and/or persistently and acutely disabled, who have completed a mandatory 25 days of treatment in a community inpatient setting prior to admission.
- FORENSIC ADULT PROGRAM (180 BEDS TOTAL): Court-ordered commitments through a criminal process for either:
    - PRE-TRIAL RESTORATION TO COMPETENCE PROGRAM ("RTC; 60 BEDS ") consists of three treatment units providing pre-trial evaluation, treatment and restoration to competency to stand trial.
    - POST-TRIAL FORENSIC PROGRAM consists of two treatment units for those adjudicated as GUILTY EXCEPT INSANE ("GEI; 96 BEDS") who are serving determinate sentences under the jurisdiction of the Psychiatric Security Review Board (PSRB), or for those adjudicated prior to 1994 as NOT GUILTY BY REASON OF INSANITY ("NGRI; 24 BEDS").
    - COMMUNITY REINTEGRATION PROGRAM (BEDS utilized by GEI or NGRI patients, see above) consists of one treatment unit for forensic patients with an approved Conditional Release Plan approved by the PSRB for transiting into the community and for those working toward application for Conditional Release.
- ADOLESCENT TREATMENT PROGRAM: Consists of a 16-bed treatment facility which serves as the admission, assessment and treatment program for male and female juveniles, up to age 18, who are committed through civil or criminal (forensic) processes.

CENSUS MANAGEMENT

Census management is a daily challenge for the Hospital. Exceeding licensed capacity by even just one patient on one unit for one day risks federal Medicare reimbursement status, Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") accreditation, and compliance with licensure regulations.

Pursuant to Laws 2002, Chapter 161, Senate Bill 1149, on or before August 1 of each year, the Deputy Director and the Hospital collects census data by population to establish the maximum funded capacity and a percentage allocation formula for forensic and civil bed capacity (Arizona Revised Statutes §§13-3994, 13-4512, 36-202.01 and 36-503.03).

The Deputy Director notifies the Governor, the President of the Senate, the Speaker of the House of Representatives and the Chairmen of the County Board of Supervisors throughout the state of the funded capacity and allocation formula for the current fiscal

year. For FY 2003-2004, the funded capacity and allocation for the Hospital's licensed beds was as follows:

- **Civil Adult (41% licensed beds): 141 Beds**
- **Forensic Adult (54% licensed beds): 180 Beds**
  - Restoration to Competency 60 Beds
  - Guilty Except Insane 96 Beds
  - Not Guilty By Reason of Insanity 24 Beds
- **Adolescent (Civil & Forensic; 5% of licensed capacity) 16 Beds**
- **Medical Bed (reserved for infection control) 1 Bed**

- **TOTAL BEDS FY 2003-2004 338 Beds**

The law requires the Superintendent of the Hospital to establish a wait list for admission based on the date of the court order when funded capacity is reached in any population category. When funded capacity is reached, referring agencies are notified and the person is placed on the wait list until an appropriate bed becomes available. These persons remain in a community inpatient setting or a county jail psychiatric ward while on the wait list. During FY 01/02, the Hospital found it necessary to implement a wait list for the first time for Adolescent and Pre-Trial Forensic Restoration to Competency Programs. The number of persons on the RTC Wait List grew to 121 during FY 03/04, up from 11 in October 2002.

In September 2003, Maricopa County appropriated $500,000 to fund an in-house restoration to competency program in the new jail system. The Hospital has been working closely with Maricopa County in the development of their program and this collaboration has resulted in a significant drop in the number of referrals on the wait list (from 121 down to 10 in June 2004). Members of the Hospital and County clinical staffs review cases jointly to determine the most appropriate setting for treatment and care. As a result, the Hospital is receiving individuals who require a high level of specialized psychiatric treatment and are considered to be suffering from serious mental illness.

Population Shift

Since October 1999, the Hospital has experienced an overall population shift and now serves more forensic than civil patients:

	October 1999	FY 2003-2004	Increase or Decrease
Civil (Adult) Beds	51%	42%	-9%
Forensic Beds	44%	53%	+9%
Adolescent Beds	5%	5%	0%

End of Month Census

The Hospital began FY 2003/2004 with a patient census of 324 and ended the fiscal year on June 30th with a census of 304, a decrease of 20 patients. During the year, 417 patients were admitted and 432 patients were discharged. The average daily census for the fiscal year was 311.9 patients. These patients accounted for a total of 114,413 patient days*, an increase of 522 days compared to the previous fiscal year. The patient end of month census covering July 2002 through June 2004 is depicted in

EXHIBIT # 1 (A)

End of Month Census, FY02/03 through FY 03/04

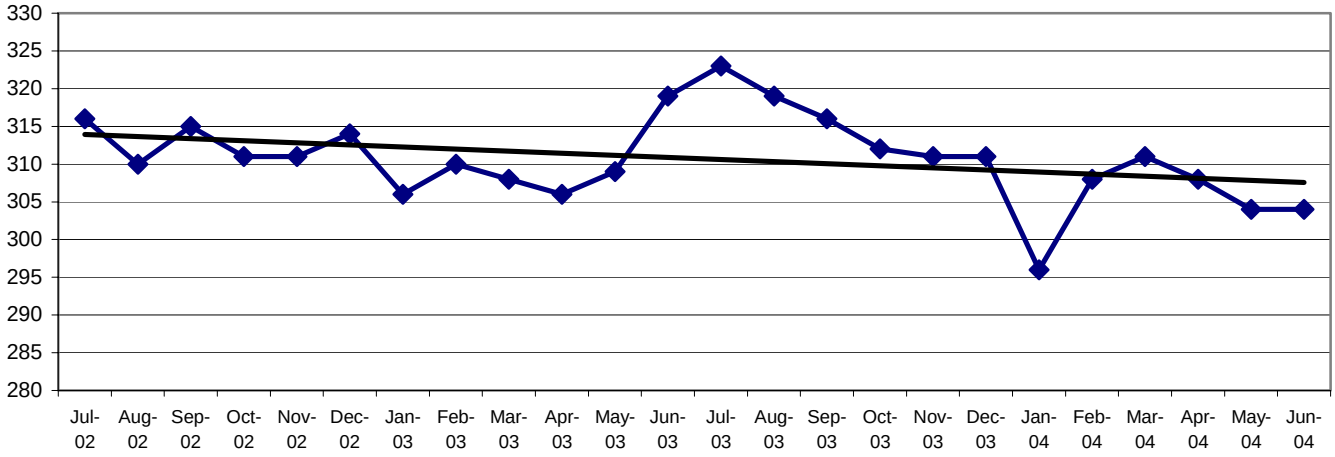


EXHIBIT # 1 (B)

End of Month Census FY 02/03 through FY 03/04							
Fiscal Year 2002-2003				**Fiscal Year 2003-2004**			
July	316	January	306	July	324	January	296
August	310	February	310	August	319	February	308
September	315	March	308	September	316	March	311
October	311	April	306	October	312	April	308
November	311	May	309	November	311	May	304
December	314	June	319	December	311	June	304

*Patient days are defined as a patient assigned to a unit, i.e. occupies a bed on that unit. The patient can be on pass and the bed day will be counted as “occupied” for that day.

EXHIBIT #2

Monthly Admissions and Discharges

FY 03/04	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Admits	39	37	34	36	31	37	34	35	31	31	29	43	**417**
Discharges	35	41	37	40	32	37	49	23	28	34	33	43	**432**

FY 02/03 Data:
Beginning Census as of July 1, 2002: 314
Ending Census as of June 30, 2003: 319
Admissions 7/1/02 – 6/30/03: 447
Discharge 7/1/02- 6/30/03: 440
Average Daily Census FY 02/03: 313.7
Number of Patient Days: 113,891

FY 03/04 Data:
Beginning Census as of July 1, 2003: 324
Ending Census as of June 30, 2004: 304
Admissions 7/1/03 – 6/30/04: 417
Discharges 7/1/03 – 6/30/04: 432
Average Daily Census FY 03/04: 311.9
Number of Patient Days: 114,413

Admission Statistics

The Hospital admitted 417 patients this fiscal year. Individuals admitted to the Hospital for the first time accounted for 286, or 68.5%, of all admissions during FY 03/04. Admissions by diagnostic grouping indicated that patients diagnosed with schizophrenic disorders accounted for 29.7% (n=124) of all admissions during FY 03/04, which is a 23.1% decrease from 38.6% during the previous fiscal year. During FY 03/04, patients diagnosed with affective psychoses (15.6%) and other non-organic psychoses (14.8%) comprise the major diagnostic groupings for patient admissions to the Hospital.

Patients were discharged to the community to the following placements:

Patients Discharged during FY03-04

Living Arrangements after Discharge	Adult	Adolescent	Total	Overall %
AWOL	2	0	2	0.5
Correctional Facility	279	17	296	68.5
Family	13	3	16	3.7
Foster Home	0	1	1	0.2
Group Home	52	1	53	12.3
Independent Living	5	0	5	1.2
None	4	0	4	0.9
Nursing Home	4	0	4	0.9
Other	4	0	4	0.9
Psych Health Facility (PHF)	6	0	6	1.4
Residential SAP/SMI-Dual Diagnosis	5	0	5	1.2
RTC 24-hour (not PHF)	13	9	22	5.1
RTC Semi-Supervised (not PHF)	1	0	1	0.2
Sponsored Based Housing	10	0	10	2.3
Unknown	3	0	3	0.7
Total	**401**	**31**	**432**	**100.00%**

ARIZONA STATE HOSPITAL – STATE FISCALYEAR 2003 - 2004
ADOLESCENT ADMISSION AND DISCHARGES

Forensic SMI Admissions		Civil SMI Admissions				
Title 13 – 4512	Title 8-242.01	Title 8 – 242.01	Voluntary	Title 14-5312	Title 36 -540	Total
RTC (tried as adult)	RTC	Civil Unspecified		With Mental Health Powers	Court Ordered Treatment	
1	**7**	**22**	**3**	**0**	**0**	**33**
Forensic SMI Discharges		**Civil SMI Discharges**				**Total**
Title 13 – 4512	Title 8-242.01	Title 8 – 242.01	Voluntary	Title 14-5312	Title 36 -540	
RTC (tried as adult)	RTC	Civil Unspecified		With Mental Health Powers	Court Ordered Treatment	
2	**7**	**20**	**2**	**0**	**0**	**31**

ARIZONA STATE HOSPITAL – STATE FISCALYEAR 2003 - 2004
ADULT ADMISSION AND DISCHARGES

Forensic SMI Admissions					**Civil SMI Admissions**			Total Admissions
Title 13 –4512	Title 13-3994	Title 13-3994	Title 13-3994	Title 13-45.07	Title 14-5312	Title 36 - 540	Voluntary	
RTC	GEI (dangerous)	GEI (non-dangerous; 75 day)	NGRI	Observation	With Mental Health Powers	Court Ordered Treatment		
267	**16**	**10**	**1**	**3**	**8**	**77**	**2**	**384**
Forensic SMI Discharges					**Civil SMI Discharges**			Total Discharges
Title 13 –4512	Title 13-3994	Title 13-3994	Title 13-3994	Title 13-45.07	Title 14-5312	Title 36 - 540	Voluntary	
RTC	GEI (dangerous)	GEI (non-dangerous; 75 day)	NGRI	Observation	With Mental Health Powers	Court Ordered Treatment		
272	**23**	**9**	**2**	**3**	**13**	**68**	**11**	**401**

SUMMARY OF ADMISSIONS AND DISCHARGES FY 2003 - 2004

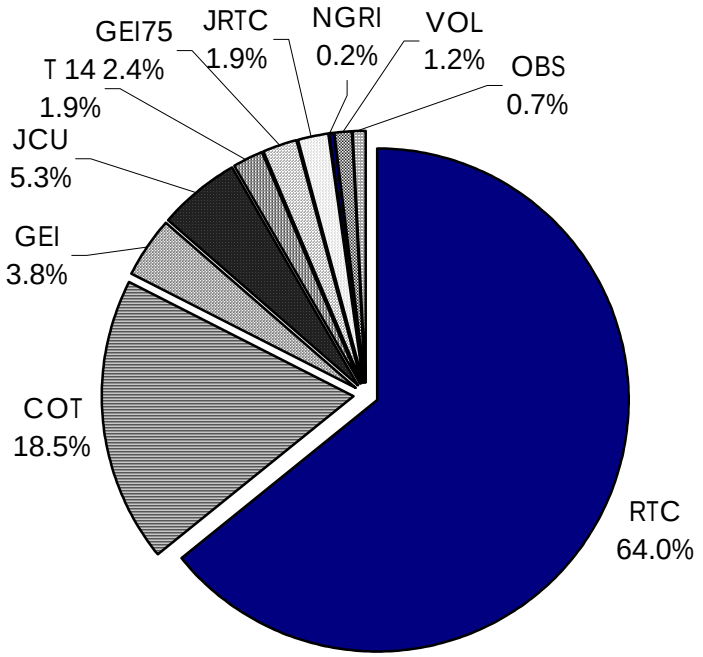
	Total Admissions	Total Discharges
Adolescents:		
Forensic	8	9
Civil	25	22
Subtotal	**33**	**31**
Adult:		
Forensic	296	309
Civil	88	92
Subtotal	**384**	**401**
Total for FY 03 - 04	**417**	**432**

Admission Averages

The average monthly admission rate for FY 03/04 was 35 patients, ranging from a low of 29 admissions in May 2004 to a high of 43 admissions in June 2004. This was a 5.4% decrease from the FY 02/03 average monthly admission rate of 37 patients.

EXHIBIT #3

Legal Status At Admission FY 03/04



Legal Status At Admission FY 03/04

Code	Legal Status	Admits	Percentage
RTC	Title 13 - 45.12 Restoration to Competency	267	64.0%
COT	Title 36 - 450 Court Ordered Treatment	77	18.5%
GEI	Title 13 Guilty Except Insane	16	3.8%
JCU	Title 8 - Juvenile Commitment - Unspecified	22	5.3%
T 14	Title 14 with Mental Health Powers	8	1.9%
GEI 75	Title 13 Guilty Except Insane 75 day	10	2.4%
JRTC	Title 8 - Juvenile Commitment - Restoration to Competency	8	1.9%
NGRI	Title 13 - 3994 Not Responsible for Criminal Conduct by Reason of Insanity	1	0.2%
VOL	Voluntary	5	1.2%
OBS	Title 13 - 45.07 Observation	3	0.7%
	Total FY 2003-2004 Admissions	**417**	**100.0%**

EXHIBIT #4

Admissions by County FY 03/04

County of Admission	Total	Percentage
Apache	1	0.2%
Cochise	7	1.7%
Coconino	7	1.7%
Gila	1	0.2%
Graham	0	-
Greenlee	1	0.2%
LaPaz	0	-
Maricopa	228	54.7%
Mohave	10	2.4%
Navajo	5	1.2%
Pima	109	26.1%
Pinal	16	3.8%
Santa Cruz	5	1.2%
Yavapai	14	3.4%
Yuma	13	3.2%
Total Admissions FY 03/04	**417**	**100.0%**

Admission by County
Maricopa County had the highest number of admissions during FY03/04 with 227 patients or 54.4% of all statewide admissions. Admissions from Maricopa County decreased by 24.1% from the previous year's total of 299 admissions. Pima County accounted for 109 or 26.1% of the total admissions. This was an increase of 55.7% from last fiscal year's 70 Pima County admissions. The remaining thirteen counties accounted for 82 or 19.6% of the state admissions during the period July 2003 to June 2004.

Recidivism
Recidivism is defined as the readmission of a patient who was discharged from the Hospital within 180 days prior to the subsequent admission. The FY 03/04 recidivism rate was 5.8% (n=24). Readmission rates for prior fiscal years vary from a low of 4.4% in FY 99/00 to a high of 9.2% in FY 98/99. In total, there were 73 readmissions during FY 03/04 with an average community stay of 312 days before the subsequent admission in the Hospital.

Discharge Statistics
The Hospital discharged 432 patients during this fiscal year.

EXHIBIT #5

Discharge Length of Stay FY 03/04

Length of Stay	*Non-Forensic*		Forensic		Total	
	Patients	**%**	**Patients**	**%**	**Patients**	**%**
Less Than 90 days	13	11.4	211	66.4	224	51.9
90 to 180 days	24	21.1	78	24.5	102	23.6
181 to 365 days	34	29.8	8	2.5	42	9.7
366 to 1095 days	33	28.9	13	4.1	46	10.6
1096 to 2190 days	7	6.1	7	2.2	14	3.3
2191 to 3650 days	2	1.8	1	0.3	3	0.7
Over 3651 days	1	0.9	0	-	1	0.2
Total	**114**	**100%**	**318**	**100%**	**432**	**100%**

EXHIBIT #6

Mean Discharge Length of Stay FY 03/04

Length of Stay	Total Patients Discharged	Mean
Less than one year	368	93.9
More than 1 year but less than 3 years	46	715.2
More than 3 years but less than 6 years	14	1601.5
More than 6 years but less than 10 years	3	2567.7
More than 10 years	1	3655
Mean Discharge Length of Stay Total	**432**	**234.3**

Note: The mean discharge length of stay is the average number of days of hospitalization per patient during FY 03/04.

Adult Discharges

Of the 432 patients discharged during this fiscal year, 401 or 92.8% were adults. Overall, the average length of stay for this age group was 243.4 days. During FY 03/04, 92 non-forensic patients had an average length of stay of 559 days: 68 patients were discharged from the Title 36 Court Ordered Treatment program with an average length of stay of 564.6 days; 13 patients under Title 14 with Mental Health Powers were discharged in an average of 668.2 days; and 11 Voluntary patients were discharged in an average of 402.3 days. (Exhibit #7) During the same time period, 309 forensic patients were discharged with an average length of stay of 149.2 days: 272 patients were discharged from the Title 13 Restoration to Competency program with an average length of stay of 73.1 days; 23 Title 13 Guilty Except Insane patients were discharged in an average of 1043 days; 9 Title 13 Guilty Except Insane – 75 Day patients were discharged in an average of 46.5 days; and 2 patients were discharged from the Title 13 Not Responsible for Criminal Conduct by Reason of Insanity treatment in an average of 831 days.

Adolescent Discharges

Of the 432 patients discharged during FY 03/04, 31 or 7.2% were adolescents. Overall, the average length of stay for this age group was 117 days. The 22 non-forensic patients stayed an average of 135 days during FY 03/04: 20 patients were discharged from Title 8 Juvenile Commitment after an average of 140 days and 2 Voluntary patients were discharged in 84 days. The 9 forensic patients – 7 Title 8 Juvenile Restoration to Competency and 2 Title 13 Restoration to Competency – were discharged this fiscal year after an average of 73 days.

Discharge Averages
The average monthly discharge rate for FY 03/04 was 36 patients, ranging from a low of 23 discharges in February to a high of 49 discharges in January (Exhibit #2). This was a 7.7% decrease from the FY 02/03 average monthly discharge rate of 39 patients.

EXHIBIT #7

Average Length of Stay by Legal Status FY 03/04

Legal Status	Number of Patients	Average Length of Stay
Title 13-45.07 Observation	3	44.7
Title 13 - 3994 Not Responsible for Criminal Conduct by Reason of Insanity (NGRI)	2	831.0
Title 13 - 45.12 Restoration to Competency (RTC)	272	73.1
Title 13 Guilty Except Insane (GEI)	23	1043.3
Title 13 Guilty Except Insane 75 day (GEI-75)	9	46.6
Title 14 with Mental Health Powers	13	668.23
Title 36 - 450 Court Ordered Treatment (COT)	68	564.6
Title 8 - Juvenile Commitment - Restoration to Competency (JTRC)	9	73.1
Title 8 - Juvenile Commitment – Unspecified (JCU)	22	134.9
Voluntary	11	402.27
Total FY 2003-2004 Discharges and Average Length of Stay	**432**	**234.3**

The number of non-forensic patients discharged during FY 03/04 with a length of stay less than 365 days was 71 or 62.3%, which is 12.6% lower than last fiscal year. This data continues to support the premise that the Hospital, the ADHS/Division of Behavioral Health Services and the Regional Behavioral Health Authorities are committed to the concept that non-forensic patients are to be admitted to the Hospital for intensive treatments and shorter durations rather than for extended hospitalization periods.

During FY 03/04, 18 patients were discharged with a length of stay of greater than 3 years, including 4 patients hospitalized for over 6 years. These patients require extensive treatment and discharge planning coordination between the Hospital and the community providers, who will provide follow-up services.

2003 / 2004
Arizona Department of Health Services - Arizona State Hospital Patient Populations
Seriously Mentally Ill (SMI) Admission & Discharge Criteria

Civil (Adult): A.R.S. 36-540 Court Ordered Treatment	Admission: Petition is filed in Superior Court alleging person is suffering from a mental disorder and is • a danger to self, • a danger to others, • persistently and acutely disabled and/or • gravely disabled. Person receives a court-ordered evaluation & if committed, undergoes mandatory local treatment in the community for 25 days. At a civil hearing, the judge can order up to six months of inpatient treatment. The hospital can grant exceptions for earlier admission.
	Discharge: After treatment goals are achieved and discharge plans are finalized, the patient is released to outpatient treatment.
Civil - Adult: A.R.S. 14-5312 et.seq (formerly 36-547.04) Placed by a Guardian	Admission: A person's guardian may request their Ward's admission to the Hospital's Medical Director and provide documentation from the patient's psychiatrist justifying the reason for admission. These patients have been admitted for treatment to the Hospital through the consent of a guardian who has been given authority by a judge to consent to the patient (the guardian's ward) receiving inpatient mental health treatment.
	Discharge: The psychiatrist determines that the person is stabilized or the patient achieves his treatment goals. The person is placed in a community setting upon receiving permission from the guardian.
Forensic - Adult: A.R.S. 13-4512 Restoration to Competency (RTC)	Admission: • These patients have been charged with a crime, found incompetent to stand trial, and committed to the Hospital for a period of treatment to attempt to restore them to competency. • The court orders the patient to receive treatment at the Hospital for RTC services • If the Hospital determines that the patient is not restorable to competency, the patient may be civilly committed.
	Discharge: When the psychiatrist determines that the patient is competent to stand trial, the person is returned to the county jail and the courts for disposition of the case. If the psychiatrist determines that the patient is not restorable, the person is returned to court for disposition of the case and may be civilly ordered to the Hospital. Maximum length of commitment as RTC is 22 months.

Forensic - Adult **A.R.S. 13-4507** **Observation of competency to stand trial**	Admission: These patients have been charged with a crime and committed to the Hospital for a determination of whether they are competent to stand trial. The Hospital also receives defendants for examination for purposes of the insanity defense.
	Discharge: Upon determination of competency to stand trial, the patient
Forensic - Adult: **A.R.S. 13-3994** **Not Guilty by Reason of Insanity (NGRI)**	Admission: • A person declared NGRI for a crime committed prior to 01/02/94 and found by a criminal court judge to have been insane at the time of the offense. • The person is committed by the court to the Hospital for an indefinite period of treatment at the Hospital and the Superior Court judge retains jurisdiction over the patient. NGRI patients retain this classification for their entire life and can be readmitted to the Hospital as necessary.
	Discharge: The patient petitions the court to grant release. The release may be unconditional or conditional
Forensic (Adult): **A.R.S. Title 13** **Guilty Except Insane (GEI)**	Admission: A person declared GEI (at the time of the crime), for a crime committed after 01/02/94, serves a period of commitment at the Hospital under the authority of the Psychiatric Security Review Board (PSRB). For non-dangerous crimes, the judge sentences the defendant to a term of treatment at the Arizona State Hospital and sets a court hearing within 75 days to determine if the patient should be released or civilly committed. For serious crimes (death, physical injury or threat of the same), the judge sentences the defendant to treatment at the Hospital for the presumptive term for the crime and transfers jurisdiction over the patient to the Psychiatric Security Review Board.
	Discharge: If the crime did not result in death, physical injury or threat of the same, the court holds a hearing to determine whether the patient is mentally impaired and dangerous. If not, the patient is released. If the crime resulted in death, physical injury of threat of the same, the Psychiatric Review Board (PSRB) controls the patient release.
Forensic (Adult Female): **A.R.S. Title 13** **Transfer of Prisoner**	Admission: The Department of Corrections files a petition for a female prison inmate to receive treatment at the Hospital. If, during the court hearing, the judge agrees, the inmate is sent to the Hospital. Applies only to female patients.
	Discharge: Inmates can be transferred back to the DOC facility when their prison sentence expires or their psychiatric condition stabilizes.
Forensic (Adult): **A.R.S. Title 13** **Death Row Inmate** Restore to competency	Admission: Inmate who suffers from a mental disability which makes him/her incompetent to be executed. The Medical Director is charged with the responsibility to treat the inmate in order to restore him/her to competency.
	Discharge: Inmate must understand that he/she has been convicted of the crime, that the sentence is death and that they will be executed.

Civil - Adolescent: A.R.S. 8-242.01 Commitment	Admission: • A Parent (through the Superior Court) or custodian (as a ward of the state through Juvenile Courts) applies to the Hospital to have the child committed. • The Hospital Medical Director evaluates the child and makes a determination
	Discharge: The patient achieves treatment goals as determined by the treatment team.
Forensic -Adolescent: A.R.S. 8-242.01 Juvenile Restoration to Competency Commitment	Admission: These patients are juveniles who have been ordered by a juvenile judge to undergo treatment for restoration to competency or who have been found by a juvenile judge to need inpatient mental health treatment and the judge approves admission to the Hospital.
	Discharge: The patient achieves his/her treatment goals and the psychiatrist determines that the juvenile has been returned to competency.
Department of Health Services - Arizona Community Protection and Treatment Program Admission & Discharge Criteria for Sexually Violent Persons as of February 9, 2001	
Sexually Violent Persons (SVPs) A.R.S. 36 - Chapter 37	Admission: A competent professional evaluates certain inmates for SVP status near the end of their prison term(s). Based on the evaluation results, the county attorney may file a request for a Probable Cause Petition with the court. If the court determines probable cause exists, the inmate may be ordered for detention to the ACPTC program pending a trial (a pre-trial detainee), admitted for treatment or less restrictive treatment.
	Discharge: The patient must successfully pass a variety of psychological examinations and tests to indicate that he/she no longer poses a threat to the community. If no threat is posed, the ADHS Director or the Arizona State Hospital Chief Executive Officer may release the patient to a less restrictive setting (LRA) or to the community with supervision.

ARIZONA STATE HOSPITAL PROGRAMMATIC REPORT

The mission of the clinical members of the Hospital staff is to provide safe and effective psychiatric and medical care to our patients. These patients suffer from serious psychiatric, neurological and medical illnesses. These illnesses hamper patient's ability to care for them selves safely in the community because they are a danger to themselves or to others.

Civil adult patients are committed here if they have not responded well following 25 days in a community hospital setting. Forensic patients are court-ordered for pre- or post-trial treatment. Many are homeless, or cannot be treated in a specialized home setting with outpatient services. Many of our patients are the most dangerous (to themselves or others) in the community, with histories of self-mutilation, assault or arson. We treat people who suffer from complicated illnesses fraught with psychiatric, physical and social problems. Some have family members who are involved and invested in their treatment, while others have lost contact with family and friends.

Because of this mission, we strive for clinical excellence and humanitarian concern. The guidelines for our practice are to make careful and precise diagnostic formulations, to use the most current interpersonal and pharmacological treatments and to create an effective rehabilitative environment to aid our patients in their recovery.

ARIZONA STATE HOSPITAL CLINICAL SERVICES OVERVIEW

METHODS OF TREATMENT: Interdisciplinary Clinical Team Approach

The Interdisciplinary Clinical Team consists of a qualified (board certified or board eligible) psychiatrist, a board certified family practice physician (or certified physician assistant), a registered nurse, a social worker, rehabilitation professionals, a nutritionist and a psychologist The Interdisciplinary Clinical Team assesses and evaluates each patient upon admission to the Hospital, at periodic intervals, and at any time during the course of hospitalization, based upon the condition of the patient.

The patient's acuity level and the patient's legal status at the time of admission provide the interdisciplinary clinical team guidance in determining the patient's least restrictive and most appropriate level of placement within the Hospital.

TREATMENT PLANNING

Comprehensive Assessments are updated annually, as necessary, and each patient receives a comprehensive admission assessment. The Interdisciplinary Clinical Team meets to identify the patient's needs for ongoing treatment and rehabilitation. Psychiatric, medical and nursing assessments are completed within 24 hours of admission. Social work and rehabilitation assessments are completed within 10 days.

Comprehensive assessments include, but are not limited to, information about the presenting problem and prior treatment, medical history / current medical condition; risk assessment; cultural, religious and spiritual issues; linguistic needs; and family / social history. The information is used to evaluate and plan for the psychiatric, psychological, medical, rehabilitation and psychosocial treatment needs of the patient during hospitalization.

Individualized Treatment and Discharge Plan (ITDP)
Upon completion of the comprehensive assessment, an Individualized Treatment and Discharge Plan is developed for the patient. The plan addresses the patient's identified assets and strengths, evaluation and treatment needs, barriers and supports/services needed for the patient to meet the treatment goals.

The ITDP seeks to address the patient's biological, psychological, spiritual, cultural, linguistic and socio-economic needs. The patient's psychiatrist, who provides leadership for the Interdisciplinary Clinical Team coordinates the patient's care and ensures there is a well-defined plan in place that may include these components:

- A full medical and psychiatric assessment of each new patient and at least annually re-written, with monthly clinical team reviews;
- Medically necessary care for any medical condition, either acute or chronic;
- Pharmacotherapy;
- Psychotherapy (individual and group);
- Behavioral / cognitive therapy;
- Full range of psychiatric rehabilitative therapy;
- Family evaluation and therapy education process;
- Recreational therapy;
- Educational therapy (medication, coping skills, GED);
- Nutritional Assessment.

STAFFING
Staffing patterns vary depending on the acuity of the treatment program and the needs of the individual patient. Each unit is staffed with Registered Nurses, Clinical Nurse Specialists, Licensed Practical Nurses, Mental Health Program Specialists, Social Workers, Rehabilitation Specialists, Psychologists, Psychiatrists, Medical Physicians (or Physician Assistants) and Clerical Staff.

The Hospital provides translation services for patients who do not read or understand English. Social workers have the primary responsibility for identifying the resources that are necessary to address the special needs of patients (including sign and other interpreter services) upon admission to the Hospital.

Psychiatric Rehabilitation is the foundation for service delivery used at the Arizona State Hospital. We try to ensure that everything we do with, or on behalf, of a patient is consistent with the Psychiatric Rehabilitation approach. The reason we use Psychiatric Rehabilitation as our framework is because there is equal importance to the:

- Management of the symptoms associated with mental illness
- Development of skills to cope with the demands of life; and,
- Development or strengthening social support networks

Psychiatric Rehabilitation moves us away from just focusing on symptoms to looking at how patients function in the world (their environment). Psychiatric Rehabilitation emphasizes the importance of believing in hope. Since many professionals do not have the ability to predict who will do well and who won't, we use this approach because it stresses building on people's strengths and abilities rather than emphasizing their illness.

When new employees are hired by the Hospital, they are oriented to Psychiatric Rehabilitation during their first week on the job. There are 17 key principles or concepts that describe this approach. They are as follows:

1. **Supportive Care Model**
   Services must be custom-tailored to the individual. This means that treatment must be very flexible and indefinite.
2. **Emphasis on Skill Building**
   The core of rehabilitation is increasing competency and mastery through learning and relearning skills. There are many skill areas that are focused on depending on the person's needs. Some examples include social interaction, improved vocational skills and coping with the demands encountered in everyday life.
3. **Emphasize Strengths**
   Emphasis is placed on current strengths and abilities and not exclusively on reducing symptoms or focusing on past problems.
4. **Instilling Hope**
   Hope is the belief in the potential to change and grow of even the most severely disabled individual.
5. **Staff Act as Consultants and Teachers**
   The role of staff is to partner with patients with the goal being to create an environment free from authoritarian barriers. Positive relationships are more likely to facilitate growth and change.
6. **Promote Empowerment**
   Choice, decision-making and personal control are essential to maximizing independence and empowering patients to accept responsibility for facilitating their own recovery.
7. **Establishment of High, Yet Realistic, Expectations**
   Every patient admitted to the hospital is involved in the development of an individualized treatment plan that addresses their issues and needs. In developing the plan, achievable goals are established by the patient. As patients progress in treatment, these goals are modified and expectations are increased.
8. **Focus on Personal Responsibility and Responsible Behavior**
   Taking responsibility and being responsible for their own behavior, including their own recovery process, is strongly emphasized in the teaching process. Assuming responsibility is a stepping-stone to making behavioral changes that lead to personal growth.

9. **Action-Oriented, Not Insight-Oriented**
   The focus of treatment planning is on changing behaviors that have not been helpful to the patient. In order to have meaning, the patient must be an active partner in the process.
10. **Focus on the Here and Now**
    Childhood or past issues are not always important to understanding why a person behaves in a certain way. It is important to focus on current behaviors and current problems.
11. **Provide a Level of Structure According to the Needs of the Individual**
    Treatment planning is individualized, based on the unique needs of the patient. Everyone will respond differently to treatment, and, therefore, show progress at different rates. The treatment plan should consider the level of structure the patient needs, based on their condition.
12. **Support Individual's Attempts at Growth and Initiative**
    Positive support is more helpful to promote a person's growth than is negative feedback. It is our responsibility to find out, through good observation, what positive supports increase the patient's progress in treatment, and then implement these supports.
13. **Holistic Approach**
    The mind, body and spirit are connected and all must be in balance in order for a person to function at their optimal level. We strive to provide patients with information and opportunities to learn how to live a healthy lifestyle in all of these areas.
14. **Relationships are the Core Tools of Rehabilitation**
    Research show that the quality of the relationship between a patient and their care/support provider is critical in minimizing the need for hospitalization. When relationships are effective, patients feel safe, feel better about themselves, and are more likely to take risks and try things that may improve their life.
15. **Promote Opportunities for "Normalization" through Interaction with the Larger Community**
    As patients experience fewer psychiatric symptoms, we provide opportunities for them to re-engage with their community. We offer opportunities for community outings to keep that connection alive.
16. **Provide Support and Education to Families and Involve Them in the Rehabilitation Process**
    Family members experience a great deal of stress in caring for their loved ones, day in and day out. If they have the information and tools necessary to help their loved ones, family members will feel supported in carrying out their roles, and will intervene in a timely and appropriate manner when additional support and services are needed.

Essential Tools for Personal Growth Include Peer Networking, Social Involvement, Group Processes and Interdependence

Group processes, or group therapy, is used to help patients share ideas and problem-solve situations experienced by other who have "walked in the same shoes." In addition, groups help patients learn, practice and build skills in interpersonal communication. Peer support is a powerful tool that contributes to

the recovery process by providing patients with the opportunity to see that others lead productive and meaningful lives despite their condition.

THE ARIZONA STATE HOSPITAL - CONDITION OF EXISTING BUILDINGS AND EQUIPMENT

The $80 million appropriated in 2000 for the renovation, demolition and construction of the new 16-bed Adolescent Treatment Facility (opened July 2002), the new Adult Civil 200-Bed Facility (opened January 2003), and hospital infrastructure, has gone a long way to mitigate 40 years of neglect. These new facilities have done a great deal to improve the environment of care for patients and staff at the Arizona State Hospital campus.

To remain within budget, many items of new construction were postponed or eliminated, while trying to achieve the greatest improvement with the funds provided.

RESULTS OF CANCELING THE FORENSIC PROJECT

The state budget crisis resulted in the final phases of funding ($10.5 million) being withdrawn for the renovation of the Wicks and Juniper Units to serve the Forensic Program in October 2002. Today, the costs to complete this project have risen to over $25 million dollars, due to inflation.

The Juniper and Wick units were never built to house forensic and both wings suffer from decades of use and deteriorating infrastructure.

The following projects were considered but not included due to funding constraints and remain unfunded:

1. Relocate Chapel (move the building closer to patients);
2. Enlarge the Laboratory in Granada and create a separate entry for X-ray;
3. Renovate Dietary Building (especially equipment and plumbing);
4. Renovate Pharmacy in General Services Building;
5. Renovate or replace entire Wick/Juniper complex for a new Forensic Hospital;
6. Renovate Kitchen / Dining Areas of Wick / Juniper Complex;
7. Provide a Day Care Center for children of employees;
8. Stabilization of **Old Main Administration Building** (one of the oldest buildings in the state, it is listed on the National Historic Register - Restoration would come later). The Old Main Administration Building is in a seriously deteriorating condition, and at the very minimum, a new roof membrane is needed to prevent further water damage.

Un-addressed Master Plan deficiencies include the correction of structural, mechanical, plumbing and electrical deficiencies in existing buildings on campus. Items not addressed in the current master plan include:

The Old Main Administration Building includes the need for seismic bracing, replacing the hot water systems and upgrading the rest rooms to conform to ADA requirements.

The Commissary / Dietary Building needs upgrading for ADA compliance, a fire alarm system, seismic upgrade, new interior wiring, among other requirements.

The Training and Education Building is also not ADA compliant, nor braced for seismic activity, and will require new wiring, an air handling system, ductwork, central air compressor, and new lighting.

The General Services Building is ADA accessible from the exterior, however the interior needs ADA improvements, including upgrading the elevator, seismic bracing needed, clean or replace ductwork, properly exhaust toilets, properly vent sump pump in the basement and install smoke detectors.

The Paint and Garage Shop is currently used to store batteries, battery charging and spray painting, which is dangerous, and must be relocated to separate buildings or rooms designed to code. Wood trusses need to be fire proofed, rest rooms must be ADA compliant, a ventilation system in the work area is needed, requires fire sprinkler coverage, pressure reducing stations, new sand and oil interceptor at vehicle maintenance area, install new receptacle wiring and wiring to power tools with proper disconnects.

The **Engineering Building (the old Laundry Building)** is recommended for complete demolition and replacement, but in lieu of replacement, the following deficiencies need correction:

- Replace the roof, stucco exterior finish, interior plaster walls and partitions, install new flooring, modify building and toilet to conform to ADA requirements, replace exterior decaying timber fascia and soffit at eves;
- Seismic bracing for exterior masonry walls;
- Install new air conditioning units with outside air provisions and new duct work;
- Replace steel piping with copper, install new toilets an install properly vented piping
- Total replacement of electrical system, new wiring, light fixtures, branch circuit wiring, additional receptacles and replace old ones, replace branch circuit panels and upgrade with proper fault current protection

The Maintenance Shop needs a new roof, ADA upgrades, seismic bracing, a new air handling unit, implosion doors on the duct vacuum system, new ductwork, a fire damper, fire sprinkler heads, ADA compliant plumbing fixtures, new electrical service, panels and light fixtures.

The Warehouse needs to be ADA compliant, new roof by 2008, exit and emergency lights, seismic bracing, new ductwork, new evaporative coolers, new air handling system, smoke detectors, fire sprinkler heads for proper coverage, new fire sprinkler piping, new electrical service and panels.

Other Building Concerns

The modular buildings on campus are of combustible construction and are an inefficient use of the site that need to be replaced with conventional construction buildings. The Department of Corrections Motor Pool area and buildings need to be relocated off site. Almost all existing buildings require asbestos containment / removal. The landscaping needs to be revised campus wide, including the entire irrigation system. The Psychiatric Security Review Board, which oversees the Guilty Except Insane patients, needs permanent accommodations.

ARIZONA STATE HOSPTICAL RECOMMENDATIONS FOR IMPROVEMENT
Issues for FY 2004 / 2005

RESTORATION TO COMPETENCY PROGRAM FUNDING ISSUES

Prior to 1995, the counties and cities provided restoration to competency services for those pretrial detainees who were deemed incompetent to stand trial. In 1995, the law changed and the Arizona State Hospital began offering restoration services. An unintended consequence of the statutory change was that the counties and cities began court-ordering defendants exclusively to the state hospital because the state paid for the services and counties/cities discontinued the use of any other programs.

In 2002, session law was enacted that required the counties to pay between 50% - 86% of RTC costs. In 2003, session law required Maricopa County to pay 100% of the RTC costs (because it constituted over 75% of the referrals to the program) and other counties to pay 86% of the RTC costs. This session law expires at the end of FY 2004/2005, at which time the state will be required to pay all restoration to competency costs, unless the session law is extended or made permanent. The general fund appropriation for the Hospital will have to be increased by $5 million if the law lapses.

Forensic Hospital Renovation

The existing forensic buildings barely meet security, life-safety or therapeutic hospital standards which subsequently impacts public safety, patient and employee safety and our availability to provide services, especially for patients who are considered to require an equivalent to a level 5 Department of Corrections environment.

Due to the state's recent budget crisis, the $10.5 million designated for the final phase (as part of the $80 million appropriated in Laws 2000, Chapter 1, HB 2019) for this forensic renovation project was withdrawn in October 2002. The five vacant Juniper units (which formerly held the Hospital's adult civil and adolescent patients) were scheduled for renovation in FY 2003 to serve as part of the Forensic Treatment

Program. As of June 2004, this Forensic Project will now cost over $25 million dollars to complete.

The same buildings that were found in 1997 by the Auditor General to be seriously deficient exist today. Built in the 1950's, the existing forensic Hospital consists of the Juniper, Wick and Granada Building Units which were never designed to house criminal patients. The Wick Units, which house the current forensic populations, underwent a forensic $2 million upgrade in the 1990's to make them secure, but the five Juniper Units were left in their original condition to serve civil patients.

Without renovation, the Juniper Units are unsuitable to house forensic / criminal patients, due to lack of appropriate security measures, and will result in an inability to open additional forensic beds / treatment units.

COMPENSATION: RECRUITMENT AND RETENTION ISSUES

Nursing – **Difficulty in Recruiting New Nurses:** Nationally, there is an acknowledged serious nursing shortage. But within the state of Arizona, current compensation of critical direct care nursing positions at the Arizona State Hospital is non-competitive with both the private sector and other public agencies. Although the legislature appropriated a $2000 raise for RNs during the 46th Legislative Session, local markets have accelerated their recruitment strategies to include hiring bonuses of up to $5000 per year and pay scales that are higher than the state hospital can offer.

Nursing – Difficulty in Retaining Qualified Staff: Turnover data reflects a significant amount of employees in these positions are attracted to higher wage comparable positions at other facilities. This has lead to significant recruitment and retention problems making it difficult to meet the needs of the patients, including safety, security, active treatment, and a therapeutic environment and to meet national / state regulatory standards. Two years ago, the Hospital had a 15% vacancy rate in its' RN staff; this fiscal year, we are averaging a 39% vacancy rate: there are 127 authorized RN positions, but the Hospital has only 84 positions filled (4 of these are on long term disability).

Rehabilitation, Social Work, Psychology, and Psychiatry – Compensation is non-competitive with the private sector and other governmental agencies. This has lead to increased staff vacancies and high turnover in direct care positions.

Finance – Several key finance positions cannot be filled due to low grade/pay as compared to equivalent positions in the market, these positions need to be re-classed. Overall the workload and complexity has increased for the Finance Office due the statutory requirement to bill counties for 86% - 100% of the costs for the Restoration to Competency Program.

Security – Compensation is non-competitive with both the private sector and other governmental agencies. Significant turnover has lead to recruitment and retention problems.

Hepatitis C

Hepatitis C viral infection is now of epidemic proportions in the USA. Infectious rates are relatively higher in populations of incarcerated individuals and IV drug abusers. Untreated Hepatitis C infection results in severe medical morbidity and mortality. Current statistics show that approximately 20% of the Arizona State Hospital's patients are Hepatitis C positive. Approximately one-half of these require on going treatment at any one time. With the current level of funding, the Hospital can only afford to treat 10% of the Hepatitis C positive patients.

OPEN AN ADDITIONAL CIVIL UNIT

The State of Arizona already has the lowest number of civil beds per capita in the nation. Due to population growth of the state, at some point in the future we will not be able to meet the demand for civil beds unless an additional unit is opened. The state needs to make plans to open an additional civil unit on the top floor Desert Sage as the population grows.

Drug Costs

The so-called newer generation atypical psychotropic medications, while much more expensive than their predecessors, have played a key role in enabling the Hospital to evolve from a warehousing institution of the 1950's (with over 1500 patients) to being a true treatment facility in the year 2002 (with only 335 licensed beds), with patients returning to the community within 6 - 8 months to lead more normal lives. It was not until the 1990's that this dramatic breakthrough in psychiatry came about.

Pharmacy drug costs are increasing at an alarming rate. Literature projects that there will continue to be a 20-22% increase in drug costs each year, an estimated increase of $578,000 this year alone. While the costs of the newer generation medications is high, it must be weighed against the costs of keeping people in confinement, which in the past, often meant decades of hospitalization - not to mention the human costs of diminished capacity to lead normal lives. A body of evidence is developing to show that people who are prescribed these "atypical" medications are more likely to take them, that they can engage in more meaningful and productive activity, and that they ultimately place fewer demands on the system than those remaining on the older drugs.

GUILTY EXCEPT INSANE, MISSING 4TH DISPOSITON

Formerly known as "Not Guilty by Reason of Insanity", the law in Arizona changed in 1994 to "Guilty Except Insane" and defendants sentenced under the statute were given determinate sentences to the Hospital and are under the jurisdiction of the Psychiatric Security Review Board. The law prescribes PSRB actions that must be taken when a GEI patient is:

1. No longer mentally ill, and not dangerous (RELEASED)
2. Mentally ill, and still dangerous (REMAINS CONFINED)

3. Mentally ill, and no longer dangerous (CONDITIONALLY RELEASED)

But, for the following category of GEIs, the statute is silent and the PSRB has no mechanism or authority to oversee the defendant in the community, nor the statutory ability to assign responsibility to any other agency (as is the case in other states), for example, to the department of corrections parole board:

4. No longer mentally ill, but still dangerous (STATUTE IS SILENT) - and therefore, the defendant remains at the Hospital, even though there is no treatment we can provide, because the PSRB is concerned about the public's safety. There is no mechanism through which to release this person (possible parole authority). These patients tend to be manipulative and disruptive to current programs and to the vulnerable seriously mentally ill patients under our care.

This is not to imply the person was not mentally ill at one time, but the person exhibits no current symptoms of mental illness. Some of these individuals may not have met the statutory criteria for admission, but the Hospital continues to work with the courts and the counties to ensure that those involved in the commitment process are currently aware of the admission criteria (which does not include sociopathic behavior or primarily substance abusers). This emphasis on education has gone a long way in the past year to encourage admissions where the Hospital can play a key role in treatment. But it has not addressed what to do with those who are no longer mentally ill, but still dangerous. The PSRB is reluctant to act without statutory guidance, out of concern for the public's welfare.

Precious bed space and resources are spent on persons who do not require psychiatric care. The Hospital agrees with the PSRB that a solution to this dilemma needs to be decided by policy makers upon review of the current GEI laws.

The GEI population has been the Hospital's fastest growing population during the past several years, which is complicated by the determinate sentences involved. The average lengths of stay for GEI patients was over 1000 days this past fiscal year, versus 180 - 270 days for civil patients. These patients are here a much longer duration, and the trend appears to be rising. Keeping people confined at the Hospital who do not require our services at the current time (at an average cost of $401 per day) is problematic. The challenge, however, is to draft a law that is constitutional. The Hospital is working with representatives from the counties and the courts to come up with a constitutional solution.

DIETARY, ENGINEERING, AND GROUNDS KEEPING

Some equipment used by support services is outdated and inefficient to meet the needs of the hospital. It is difficult to find replacement parts for some pieces of equipment. By updating and adding various equipment used by Dietary, Engineering and Grounds Keeping the increased efficiency will free up manpower time allowing workers to get more projects complete better meeting licensure and accreditation environmental and safety requirements.

ENVIRONMENT OF CARE ISSUES

Throughout the Hospital planning process for the new Hospital, interim life safety measures have been implemented. Proactive risk assessments have been conducted, including hazard surveillance and insuring that infection control measures meet the AIA standards.

In conjunction with local community hospitals and community wide organizations, the Hospital is involved in "Emergency Management Planning" to develop bioterrorism plans and a "Business Continuity Disaster Recovery Plan". The Hospital needs to have a viable evacuation plan in place and be prepared to assist other local agencies should the need arise. At this time, the Hospital lacks a hospital-wide public address system and the necessary radio controlled devices in order to respond in such an emergency.

FUNDED BED CAPACITY WAIT LIST; NEED FOR PERMANENT LAW

In 1998, serious overcrowding (66 patients on two units licensed for 44 beds) in the Restoration to Competency Program forced the Hospital to temporarily close admissions to the Hospital due to staff shortages and serious safety issues (increased assaults). This led to the passage of session law that allows the Hospital to implement a wait list when funded capacity is reached in the RTC, GEI, Adolescent and Civil Treatment Programs, but the legislation is due to expire in June 2006. It should be made permanent in statute.

Wait lists played a key role in the Hospital regaining Medicare reimbursement status in June 2000. Wait lists have been a critical census management tool that allows an orderly admission process to the Hospital, and exceeding licensed capacity on even one day, on just one unit, for even just one hour, can jeopardize our accreditation and Medicare reimbursement status because we are subject to unannounced surveys at any time. Wait lists help keep the Hospital in incompliance with both federal and state regulatory standards.

The patients treated at the Hospital are admitted because they are a danger to themselves or a danger to others (or are persistently and acutely or gravely disabled), the Hospital should not admit more patients than it has beds for. This is an issue of safety for both patients and staff and an issue of being able to provide active treatment to the patients sent to us.

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