Arizona Department of Health Services
Division of Behavioral Health Services
and
Arizona State Hospital

ANNUAL REPORT
FISCAL YEAR 2005

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

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~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 is charged with the responsibility of overseeing publicly funded behavioral health services. By the end of fiscal year 2005, an average of 130,205 clients received behavioral health services. During fiscal year 2005, approximately 200,000 persons received prevention services. Expenditures totaled $920,821,670.

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 funded 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).

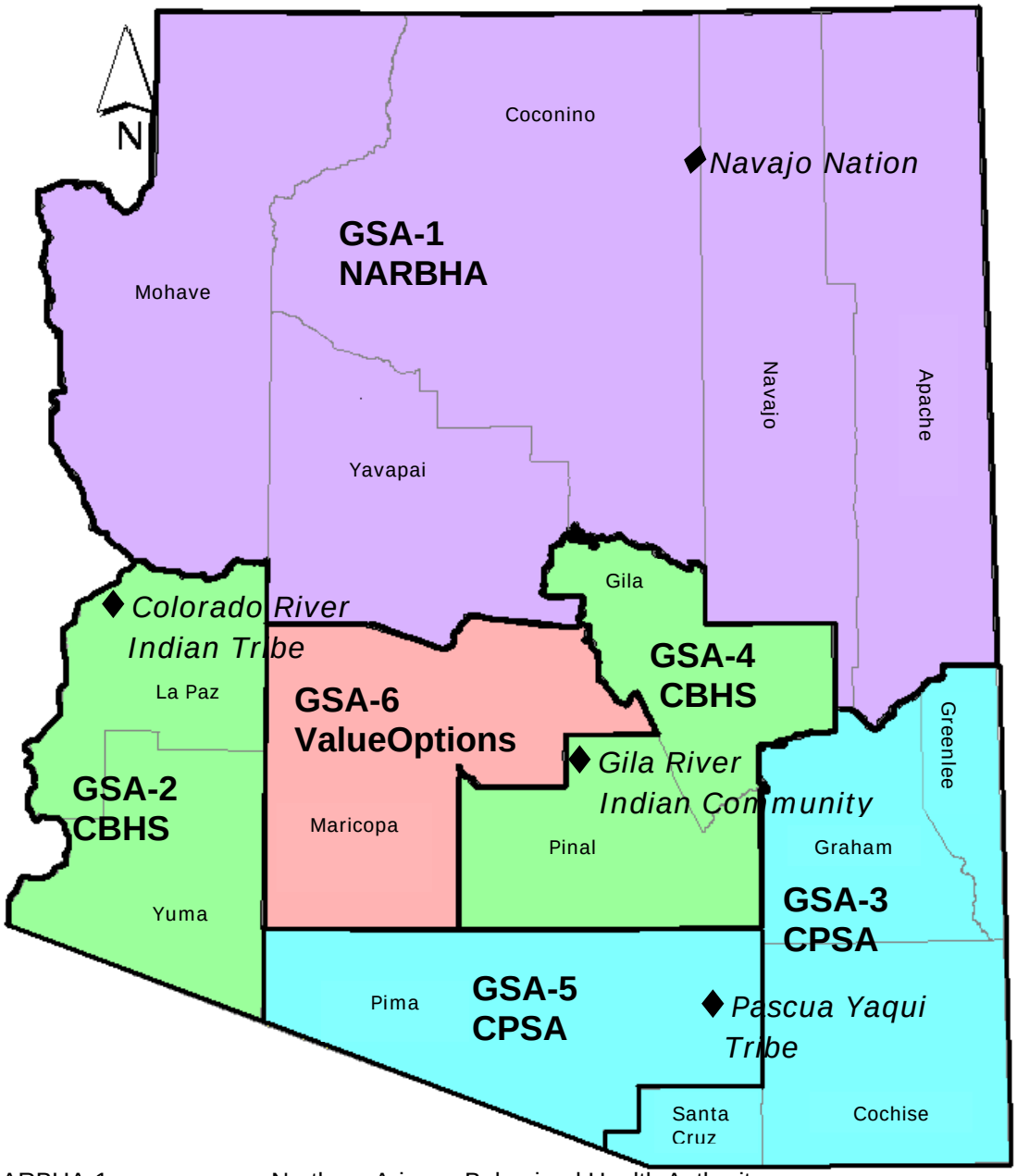
The State is divided into six geographic regions, called Geographic Service Areas (GSA). See the Geographic Service Areas map on the following page. The Division contracts with Regional Behavioral Health Authorities (RBHAs) who are responsible for administering delivery systems to eligible persons residing in the GSA(s). The Arizona Department of Health Services/Division of Behavioral Health Services currently

contracts with four RBHAs. The four RBHAs are: Northern Arizona Regional Behavioral Health Authority, Community Partnership of Southern Arizona, Cenpatico Behavioral Health of Arizona, and ValueOptions.

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

Services provided to Arizonans include treatment, rehabilitation, medical, support, crisis intervention, inpatient, residential, behavioral health day programs, and prevention.

ARIZONA'S REGIONAL BEHAVIORAL HEALTH AUTHORITIES



NARBHA-1 = Northern Arizona Behavioral Health Authority
CBHS-2 & CBHS-4 = Cenpatico Behavioral Health Services
CPSA-3 & CPSA-5 = Community Partnership of Southern Arizona
ValueOptions-6 = ValueOptions of Arizona

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 Senior Management Team of the Division of Behavioral Health Services.

The **Office of the Medical Director** currently includes an Acting Medical Director and a full-time Associate Medical Director. Together, they provide clinical guidance to the Deputy Director and to all Division Bureaus and Offices. The Acting Medical Director also provides medical guidance, to the Department Director through participation in the Physician Advisory Council. Working in collaboration with the Medical Directors of the Regional Behavioral Health Authorities, the Medical Directors develop clinical practice guidelines; standards and review instruments that are used throughout the State to ensure that best practices are being utilized. The Office of the Medical Director also maintains and updates the DBHS medication list. The Office of the Medical Director coordinates with the Medical Director of the Arizona Health Care Cost Containment System (AHCCCS) and with AHCCCS acute-care health plans for the joint management of clients' physical and behavioral health needs. The Office of the Medical Director is actively involved with policy development and revision, quality management activities, and participates in clinical investigations/reviews for individual cases as needed. The Medical Director or Associate Medical Director serve as team lead for the clinical Performance Improvement Projects, including Informed Consent, Polypharmacy, Birth-to-Five Assessments, and Access to Care.

Clinical Services provides clinical leadership, technical assistance and consultation to the Tribal and Regional Behavioral Health Authorities (T/RBHAs) 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 six Bureaus: 1. Adult Services, 2. Children's Services, 3. Substance Abuse Treatment and Prevention, 4. Network Development, 5. Training Services, and 6. Bureau for Intergovernmental Affairs.

The **Bureau for Consumer Rights** assists consumers in understanding, protecting and exercising their rights with respect to applying for and receiving behavioral health services. The Bureau provides a grievance and appeal system available to consumers, contractors, and providers for the administrative resolution of disputes; advocacy services for consumers and their families to assist in resolving problems; and administrative support for each regional Human Rights Committee. The Bureau is composed of the Office of Human Rights and Office for Grievance and Appeals.

The **Division of 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 Division include fiscal monitoring of RBHA financial statements, budget and operations, claims and

encounters oversight, personnel services, as well as financial fraud and abuse oversight. The Division 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.

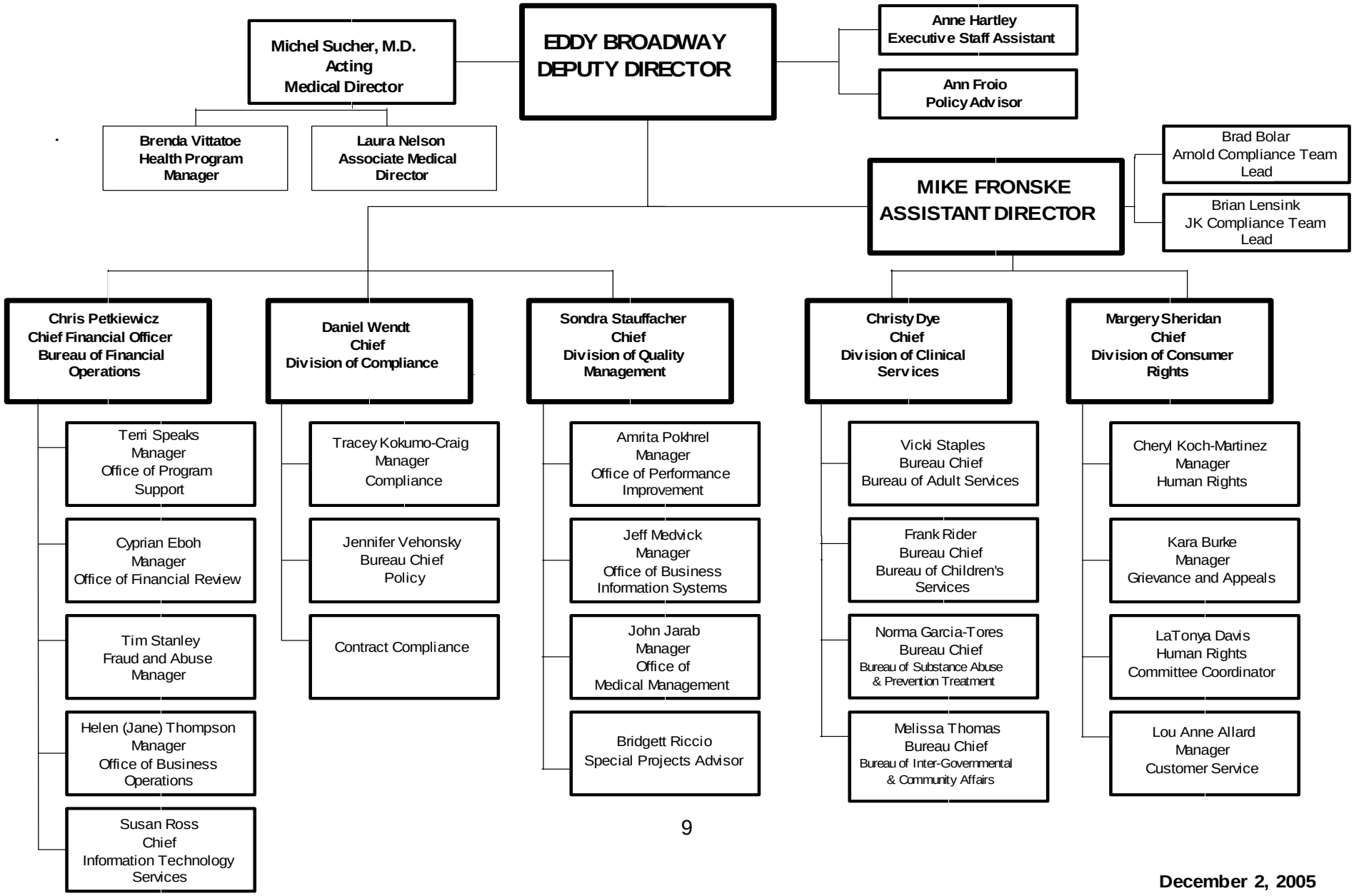
The **Bureau of Quality Management Operations** assumes responsibility for three major areas within Behavioral Health Services: Performance Improvement, Medical Management, and Research and Data Dissemination. These areas work together to develop and implement a system of continuous quality improvement by establishing performance measures, evaluating individual T/RBHA and statewide performance through data collection methods, identifying areas for improvement, and implementing improvement initiatives.

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 Tribal and Regional Behavioral Health Authorities (T/RBHAs) and the Arizona Health Care Cost Containment System (AHCCCS) 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 other Client Server based applications to support business needs within various Division of Behavioral Health Services offices as exampled by the Office of Grievance and Appeals (OGA) and Issue Resolution System (IRS).

The **Compliance Bureau** is responsible to support and coordinate strategic planning for the Division, Title XIX Certification of Community Service Agencies, behavioral health related rule-making, mental health disaster responses, the annual Administrative Reviews of the Regional Behavioral Health Authorities, the annual operational and financial reviews conducted by AHCCCS, implementation of the Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements, developing and revising ADHS/DBHS policies and procedures, revisions to the ADHS/DBHS Covered Services Guide, and developing and revising the ADHS/DBHS Provider Manual. In addition, the Bureau includes the Compliance Operations Unit, which includes designated staff who serves as the single point of contact for Tribal IGA and RBHA contract compliance issues.

DIVISION OF BEHAVIORAL HEALTH SERVICES ORGANIZATIONAL CHART

Arizona Department of Health Services
Division of Behavioral Health Services



December 2, 2005

DIVISION OF BEHARVIORAL HEALTH SERVICES FINANCIAL REPORT

The Division of Behavioral Health Services received a total of $920,821,670 in funding for the state fiscal year 2005. Administrative costs were $14,569,136. Statewide services costs were $906,252,532. Please see the tables below for programmatic funding detail.

Table 1

Total Behavioral Health Services Funding FY 2005		
Funding	**Amount Paid**	**Percentage**
Title XIX	$481,317,332	52.27%
Title XIX Proposition 204	$219,420,557	23.83%
Title XXI	$13,568,917	1.47%
Federal Funds	$44,165,009	4.80%
Non Title XIX/XXI Funds General Funds	$118,631,728	12.88%
County Funds	$37,384,706	4.06%
Tobacco Litigation/Settlement	$1,664,704	0.18%
Other (1)	$4,668,717	0.51%
Total	$920,821,670	100.00%

(1) Other includes PASRR, COOL Program, Institute for Mental Health Research, Comcare Trust & Indirect.

Table 2

Administrative Funding FY 2005		
Funding	**Amount Paid**	**Percentage**
Title XIX	$4,885,497	33.53%
Title XIX Proposition 204	$4,469,251	30.68%
Title XXI	$414,386	2.84%
Federal Funds	$1,458,372	10.01%
Non Title XIX/XXI Funds General Funds	$2,057,770	14.12%
County Funds	$125,700	0.86%
Tobacco Litigation/Settlement	$9,005	0.07%
Other (1)	$1,149,155	7.89%
Total	$14,569,136	100.00%

(1) Other includes PASRR, Liquor Fees, City of Phoenix LARC, COOL Program, Comcare Trust, & Indirect.

Table 3

Statewide Service Funding by Program FY 2005		
Funding	**Amount Paid**	**Percentage**
Title XIX Children	$240,595,983	26.55%
Non TXIX Children	$15,034,487	1.66%
TXXI Children	$8,385,736	0.93%
TXIX SMI	$305,538,721	33.71%
Non TXIX SMI	$122,450,438	13.51%
TXXI SMI	$3,260,222	0.36%
TXIX GMH/SA	$145,248,437	16.03%
Non TXIX GMH/SA	$49,246,645	5.43%
TXXI GMH	$1,508,574	0.17%
Non TXIX Prevention	$11,463,728	1.26%
Other Programs (1)	$3,519,561	0.39%
Total	$906,252,532	100.00%

(1) Other includes PASRR, Liquor Fees, City of Phoenix LARC, and COOL Program

DIVISION OF BEHAVIORAL HEALTH SERVICES NUMBER OF CLIENTS SERVED

As of June 30, 2005	CHILDREN				SMI				NON-SMI				Totals Column
	T19	T21	Non-T19	Children Subtotal	T19	T21	Non-T19	SMI Subtotal	T19	T21	Non-T19	Non-SMI Subtotal	RBHA Total
CPSA –3	1473	78	179	1730	691	1	275	967	2675	24	698	3397	6094
CPSA –5	6602	562	646	7810	4237	8	2238	6483	9467	142	4004	13613	27906
EXCEL	1155	101	131	1387	772	5	243	1020	1788	30	1085	2903	5310
NARBHA	3252	257	313	3822	2409	9	1061	3479	5762	72	1314	7148	14449
PGBHA	1907	126	179	2212	862	9	349	1220	2386	25	467	2878	6310
ValueOptions	16496	1382	1903	19781	11573	35	6696	18304	23365	333	8353	32051	70136
Statewide Total	30885	2506	3351	36742	20544	67	10862	31473	45443	626	15921	61990	130205

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 to 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, responsibilities 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 2005, the Division of Behavioral Health Services targeted several strategic plan objectives in its 2005 Strategic Plan. This section of the report highlights these activities.

Improve suicide prevention and treatment services in collaboration with other organizations

The Division formed a workgroup comprised of internal and external stakeholders to improve suicide prevention and treatment services in collaboration with other organizations during the summer of 2004. External stakeholders involved in the process included Regional Behavioral Health Authorities, providers, Arizona Suicide Prevention Coalition members, crisis workers, and survivors of suicide. A comprehensive literature review, including characteristics of at-risk populations and effective practices for suicide prevention, risk assessment, and treatment was conducted. Information was used to select target populations for DBHS prevention programs and statewide public information campaigns. DBHS directed a total of $245,000 additional funds towards these initiatives. Highlights include the development of an “Embrace Life” campaign in the northern region targeting 10 Native American tribes, a survey of caregivers and older adults in the southern region to inform suicide prevention efforts targeting older adults, physician education programs, intergenerational programs, and gatekeeper education.

Office of Prevention staff conducted two training sessions for providers and sponsored two Native American training workshops during 2005. Topics included effective practices for suicide prevention, Critical Incident Stress Management, community development, spirituality and healing, strategic planning, and effective evaluation strategies.

After reviewing practice guidelines from the American Psychiatric Association, American Academy of Family Physicians, and the American Academy of Child and Adolescent Psychiatry, the workgroup developed a checklist of essential elements of a suicide risk assessment. Existing tools utilized by behavioral health and crisis providers in the T/RBHA system were compared to this checklist, and a Special Suicide Risk Assessment Addendum was created. The standardized tool, along with a newly developed Technical Assistance Document on Assessing Suicidal Risk, was presented to RBHA Medical Directors and incorporated as an addendum to the DBHS Core Assessment. Training on the tool will begin in the spring of 2006.

Collaborate with the primary care system to improve services to those with serious co-occurring physical and behavioral health disorders

Beginning in January 2005, the Collaborative Agreement Task Force was initiated for a 2-phase project, first focusing on those with serious mental disorders with co-occurring chronic medical conditions. Phase 2 will utilize the lessons learned from Phase 1 to expand the project to cover all TXIX/XXI persons who are served by both the AHCCCS Health Plans and the Behavioral Health System.

The Collaborative Agreement Task Force developed and agreed upon a set of guiding principles for the project. The task force facilitated three (3) focus groups to gather input regarding issues and possible solutions for improving coordination of care between acute medical providers and behavioral health providers. The information collected was synthesized into a thematic analysis that was utilized by a workgroup designed to propose final solutions to improve the coordination of care between acute medical and behavioral health systems.

Workgroup participants were established and initial meetings occurred on June 15 and June 29 to develop solutions. Additional workgroup meetings were scheduled for July 13 and July 27.

Collaborate with stakeholders to reduce the stigma associated with being a behavioral health recipient

ADHS convened a group of community stakeholders including RBHAS, tribes, providers, and behavioral health recipients, and advocacy groups to develop a strategy to reduce the stigma associated with seeking behavioral health services. The first meeting of the group was scheduled in August 2005. Two consultants with national experience in Anti-Stigma campaigns were hired to facilitate training at the meeting.

Actively involve consumers and families in the design, implementation and monitoring of the behavioral health system

Consumers and family members were involved in focus groups and open forums regarding the Arnold v Sarn Corrective Action Plan (CAP) and the Mentoring Plan as well as mentoring teams at five-targeted ValueOptions and direct care clinic sites. A survey tool was developed and implemented to gather feedback from consumers on a

weekly basis. Surveys were submitted to ADHS and presented to those involved in the CAP. Peer and family members also submit feedback on a weekly basis.

There were five consumers and family members involved in the RFP evaluation process.

Clinical and Quality Management staff developed an RFP for consumer and family involvement in policy review, the satisfaction survey and other quality management activities. It is complete.

Consumer and family members' input was incorporated into the consumer survey. The survey tool was disseminated to RBHAs for distribution and returned to ADHS in June 2005.

A DHS/DBHS Liaison to the HRC's supported the following recruitment efforts to family members, consumers, and community professionals to volunteer time in serving on a regional human rights committee, sharing their relative expertise to make recommendations for improving the behavioral health system:

- Web posting
- Word of mouth
- Newspaper advertisements
- Soliciting interest at public speaking events related to mental health issues
- Distributing brochures at public forums
- Distributing brochures at provider and service delivery points
- Following up with interested parties to provide information about committee activities/purpose

As a result of the efforts several consumers and family members were successfully recruited.

The Children's Bureau researched ways to develop effective youth voice within the Children's Behavioral Health System in Arizona. The Children's Bureau received guidance from Marlene Matarese, a national expert for SAMHSA on Youth Involvement, at a System of Care Meeting (Dallas, Feb 2005). The Bureau secured Marlene's "Youth Involvement in Systems of Care: A Guide to Empowerment" as a working resource.

ADHS staff met with the Governor's Youth Involvement Coordinator to identify opportunities to begin developing youth voice within the behavioral health system.

The Arizona Medical Association established a Youth Board that provides youth voice in shaping a statewide strategic plan to improve health care for youth. DBHS has applied a small sum of grant funds to support youth participation in that effort with stipends.

In Tucson, Community Partnership of Southern Arizona (CPSA) and Mentally Ill Kids in Distress (MIKID) have facilitated and nurtured a new youth group called ACERS. The Family Involvement Center in Phoenix is beginning to host youth group meetings. Both family groups are supported financially by DBHS to develop and support youth voice.

Develop, implement and monitor an individual assessment and plan of care with every consumer and family

The assessment committee met quarterly to review necessary adjustments in the assessment process. A training sub-group met to begin development of additional training on clinical supervision specific to assessment and service planning.

As part of the Administrative review, ADHS reviewed a sample of 40 cases at each T/RBHA in order to measure compliance with the Assessment and Clinical Liaison policy. Results indicated substantial compliance in using the new assessment tool and several areas in which improvement is necessary. The results of this review were disseminated to all T/RBHAs, and discussed with T/RBHA Clinical staff during Adult Coordinators' and Assessment and Service Planning Meetings.

Training materials were developed and distributed to address issues found to be problematic in the Administrative Review. The Clinical Bureaus assigned specific staff to an ongoing training and technical assistance function.

The Arnold v Sarn Plan of Correction was developed and submitted to the Court on October 8, 2004. An Arnold v. Sarn Performance Improvement Plan was implemented. The Division developed a process for evaluation of strategies. The results of the evaluation indicated improvements in the sites that received mentoring. Mentoring was made available at all sites. The original plan was completed and a revised long-term plan was in development and completed by the end of July, 2005.

The results of the Independent Case Review were used as data sources for the Administrative Review. A meeting was held with all T/RBHAs regarding the specific performance improvement needs for each T/RBHA. Each T/RBHA submitted a Plan of Correction.

Ensure the Arizona Principles are implemented by out-of-home providers

An urgent behavioral health response for children entering foster care has been operating statewide since October 2003. More than 7,000 children have entered the behavioral health system through this process, which has received national recognition as an important, positive innovation from the Child Welfare League of America and the National Technical Assistance Center for Children's Mental Health. As a direct result of Governor Janet Napolitano's Child Protective Services (CPS) Reform initiative, this process is being monitored by Arizona Department of Health Services and Regional Behavioral Health Authorities for its effectiveness in fulfilling its intended purposes.

Arizona Department of Health Services/Division of Behavioral Health Services' practice improvement protocol, Out of Home Care Services, was adopted on March 9, 2005, and incorporated by reference into all Tribal and Regional Behavioral Health Authority (T/RBHA) contracts effective July 1, 2005. This protocol describes best practices regarding the appropriate use of out-of-home services as part of an overall system of care, based on the premise that "the primary goal of out of home care is to prepare the

child and family, as quickly as possible, for the child's return to the home and community." The RBHAs now actively apply the protocol's service expectations to guide the use of out-of-home services, with the current result that fully 97.5% of enrolled children are able to be served in their own homes and communities, and fully 40% of the remaining children receive out-of-home care services within therapeutic foster care families, thus realizing an important Jason K Settlement principle "Most appropriate setting."

Implement the federal grievance system requirements

The Division of Behavioral Health Services (DBHS) has fully implemented the federal grievance system requirements that protect the rights of behavioral health recipients who are eligible for Medicaid services. Specifically, the federal grievance system requirements significantly impacted the treatment of oral and written complaints; written notices to behavioral health recipients; appeals; and requests for state fair hearings.

All contracts, policies, and member handbooks were revised to accurately reflect the procedural changes. Extensive training was developed and delivered to T/RBHAs, providers and other stakeholders, with mandates for the T/RBHAs to conduct additional training to their contracted providers. The Division provided ongoing technical assistance to T/RBHAs upon request, disseminating scenarios and written technical assistance responses to all T/RBHAs to ensure consistency in interpretation of the requirements across T/RBHAs.

Training was also provided to the Advocates within the Office of Human Rights to assist behavioral health recipients and their family members in understanding the requirements and utilizing the complaint, appeal and state fair hearing processes.

The Division conducted quarterly monitoring of T/RBHAs to determine compliance with the federal requirements, providing targeted technical assistance or taking action under the contract to compel compliance when indicated.

Implement the statutory expansion of the oversight responsibilities of Regional Human Rights Committees to include the non-Medicaid, non-Seriously Mentally Ill population

The responsibilities of the Regional Human Rights Committees to provide independent oversight and monitoring were expanded statutorily to include the non-Medicaid, non-Seriously Mentally Ill population. The Division of Behavioral Health Services notified the Regional Human Rights Committees of the expansion of their responsibilities, and modified applicable policies to ensure the Regional Human Rights Committees are provided the data and information necessary to conduct their duties.

Improve access to culturally competent behavioral health care

ADHS conducted a self-assessment of cultural competency activities using the National Association of State Mental Health Program Directors Tool. Results from the tool were used to update the annual Cultural Competency Plan.

The Cultural Competency Advisory, Training, Data, and Translation/Interpretation meetings met monthly to implement the plan. The Cultural Competency Advisory Committee in collaboration with consultants from the Centers for Substance Abuse Treatment developed two types of cultural competency training. One of the trainings pertains to the application of an organizational assessment tool and the other on integrating cultural competent services into daily clinical practice. Both trainings will take place over the next year. The Data Subcommittee created a Language Capacity Reporting Form to be completed by T/RBHAs and submitted to ADHS annually.

ADHS worked with the Centers for Substance Abuse Treatment (CSAT) to develop a self-assessment tool for T/RBHAs to use in assessing their organizational and service delivery cultural competency.

Culturally and Linguistically Appropriate Standards (CLAS) were incorporated into the Provider Manual and clinical guidance documents. The Policy Office developed a Cultural Competency Practice Improvement Protocol that addressed the recommended elements of the CLAS standards.

Improve access to care in rural and geographically remote areas

The second meeting of the Behavioral Health/Higher Education Partnership was held in September 2004. The group developed a mission statement and selected three strategies for more focused activity this year. The Behavioral Health Higher Education Partnership Strategy workgroup is targeting the recruitment and preparation of a workforce that represents the composition of local communities. This workgroup began to address the need for rural communities to “grow their own” workforce that reflects the community’s cultural composition.

Senate Bill 1129 established a unique loan repayment program within ADHS/DBHS. ADHS anticipates the program will help reduce workforce shortages in rural areas of Arizona. ADHS anticipates initiating the program in the spring of 2006.

ADHS/DBHS has participated on the legislatively established Study Committee on Regional Detoxification Centers, which included an assessment of current capacity and need for rural crisis services for substance use disorders.

ADHS/DBHS continued its participation on the legislative Study Committee on Regional Detoxification Centers and provided recommendations for the committee report. DBHS staff initiated its annual review of provider network sufficiency, including a focus on remote and rural regions of the state.

The DBHS provided two rounds of technical feedback on the annual network sufficiency assessment and plan, with particular attention to the needs of rural areas. This on-going monitoring process is well established under the oversight of the Clinical Division Chief.

The ADHS was successful in securing passage of SB 1129 Behavioral Health Practitioner Loan Repayment Program. This legislation established a tuition loan

reimbursement program for Behavioral Health Professional and Behavioral Health Technician staff who agree to serve for 2 years in an Arizona Mental Health Professional Shortage Area. DBHS will begin a rules package in SFY 2006 to implement this statute.

Expand and enhance the statewide network of providers

The Arizona Department of Health Services expanded and enhanced its statewide network of providers and behavioral health services including therapeutic foster care, out of home placement, detoxification, and peer and family support services.

Statewide, there was an increase of nearly one million dollars in spending for the provision of children's respite services from fiscal year 2003 to 2004. During the fiscal year 2004, expenditure for respite services totaled $3,244,637. The previous years expenditure was $2,274,569.

While the numbers of children in out-of-home placement remained relatively constant (despite statewide increase in overall enrollment), the percent of those children who were placed in family-based therapeutic foster care during the same time trended upward to 40% of the total out-of-home placements. Total therapeutic foster care placements for children have expanded from 9 statewide in September 2003 to 340 by June 30, 2005.

In November 2004, the ADHS/DBHS Bureau for Substance Abuse launched a technical assistance initiative to develop a recovery/peer support specialist workforce operating within licensed behavioral health agencies. For FY 2005, DBHS allocated $700,000 in Substance Abuse Block Grant funding to support infrastructure development for the peer workforce, including recruitment, training and service funding for adults with substance use disorders. As of July 2005, more than 70 staff positions were filled across the state. Staff operates in a variety of treatment settings including: Level 1crisis stabilization/detoxification, Level 2 substance abuse residential, outpatient clinics, methadone clinics, and supported housing programs.

As previously referenced, ADHS/DBHS participated on the legislatively established Study Committee on Regional Detoxification Centers, which included an assessment of current capacity and need for rural crisis services for substance use disorders. In addition, the RBHA Network Development Teams provided direct assistance and monitoring for FY 2005 RBHA development plans for detoxification capacity in Benson, Payson, Casa Grande, and Yuma.

DBHS improved its focus on network sufficiency through the establishment of a Network Development and Training Team and a Manager for Network Sufficiency within the Division of Clinical Services.

In conformance with the ADHS/RBHA contract, all regional authorities submitted an annual network sufficiency assessment and plan on March 1st. ADHS participated in technical assistance meetings with each RBHA review and analyze findings of the data related to capacity for a continuum of detoxification services prior to finalizing the plan.

The Bureau for Substance Abuse provided on-site training in detoxification services in Yuma and Flagstaff.

A new Level 2 step-down detoxification/stabilization facility opened in Benson, Arizona in November 2005. Progress continues on construction of a new Level 1 sub acute facility in Payson as part of a collaborative effort between Southwest BHS and Tonto Apache Tribe.

Implement the early childhood assessment

The Early Childhood Workgroup met monthly during 2004 to develop the birth-to-five assessment tool. The assessment tool was piloted at four sites in Maricopa and Pima Counties during the Spring of 2005. Feedback was compiled and incorporated into the assessment by the Early Childhood Workgroup. Southwest Human Development, in cooperation with DBHS, began to develop a one-day training curriculum around the assessment that will include a two-hour overview of infant mental health. It is planned that the curriculum will be delivered across the state during August and September in time for the October 1, 2005, statewide implementation of the new assessment.

Execute a systematic method to implement best practices across the statewide publicly funded behavioral health system

The Best Practices Subcommittee was developed and started meeting internally in January 2005. The subcommittee divided itself into two groups, one focusing on children's issues and one on adults.

A number of Clinical Guidance Documents related to children's services were implemented during the year. These are listed below. All of the documents were incorporated by reference into RBHA contracts to ensure that the RBHA's reflect these protocols in ongoing staff training, practices and other activities.

- Practice Improvement Protocol, "Transitioning to Adult Services" was effective on July 1, 2004. This document outlines the steps needed to ensure the timely and seamless transition of children into the adult service system, and dispel myths related to the transition process.

- On September 17, 2004, "The Child and Family Team Process" Technical Assistance Document became effective. The purpose of this document is to define and describe the steps of the Child and Family Team process, and define ADHS expectations for application of this approach with enrolled children. It also supports specific teaching/coaching on the Child and Family Team Process.

- Practice Improvement Protocol, "Therapeutic Foster Care Services (TFC) for Children" was effective on November 1, 2004. The intent of this document was to establish protocols that promote the provision of TFC services in a manner consistent with the best interests of the child, the child's family and the 12 Arizona Principles.

- On March 7, 2004, the “Children and Adolescents Who Act Out Sexually” PIP was implemented. It established protocols for behavioral health interventions for children and adolescents who display sexually inappropriate behavior.

- The “Out of Home Care Services” PIP became effective on March 9, 2005 and established protocols that operationalize best practices in hospitals, crisis stabilization facilities, residential treatment centers, therapeutic foster care homes, and therapeutic and other behavioral health group homes.

- A “Best Practices” Practice Improvement Protocol that identifies approaches, treatments and modalities that ADHS recognizes and endorses for use by behavioral health providers delivering services in the public behavioral health system, was implemented on April 1, 2005.

- In May 2005, Practice Improvement Protocol, “The Unique Behavioral Health Service Needs of Children Involved with CPS” was effective. This document provides an understanding of the special needs of children in The child protective system and gives guidance to Child And Family Teams in responding to those needs.

- Finally, Technical Assistance Document (TAD) “Providing Services to Children in Detention” was effective on June 1, 2005. This TAD was created to support coordination between the public behavioral health system and the juvenile justice system for children needing behavior health services who are in a county detention facility and eligible, or may have the opportunity to become Title XIX/XXI eligible.

The ADHS “Higher Education Partnership” held an all-day conference on April 14, 2005. Faculty from higher education institutions across the state were provided with training and materials on the Arizona practice models and initiatives to incorporate directly into coursework. This partnership will be fostered and strengthened with more meetings in the coming months.

DBHS staff participated in the data and practice sub committee meetings for the Governor’s Drug and Gang Policy Council. The Council adopted guidelines for evidence-based practices for all substance abuse prevention and treatment programs. DBHS submitted a report on the status of evidence-based practices and a plan to increase availability and infusion of best practices in substance abuse treatment to the Governor’s Drug and Gang Policy Council. Based on the report: 80% of RBHAs have implemented the five DBHS priority practices in substance abuse treatment; 100% of RBHAs are submitting data to measure treatment outcomes.

DBHS in consultation with the Best Practice Committee began development of a statewide Methamphetamine Initiative. The Initiative will support the development of “centers for excellence” in methamphetamine treatment in Maricopa and Pima county using evidence-based interventions with known efficacy. In other areas of the state, DBHS is providing supplemental funding as available to support direct treatment

services for adults/youth with methamphetamine use disorders. (Cenpatico, NARBHA) Enhanced training will be provided through the Pacific Southwest Addiction Technology Transfer Center at the University of Arizona.

Continue to develop and implement the best possible publicly funded behavioral health system

The Bureau of Compliance Office of Contracting has coordinated agreements and contracts with several Tribal and Regional Behavioral Health Authorities (RBHA) throughout the state. The Office of Contracting successfully negotiated two Intergovernmental Agreements with Indian Tribes, Pascua Yaqui and Gila River, to reflect a shared vision for publicly funded behavioral health. In addition, a Compliance Administrator has been assigned to the Tribes to assist with oversight, monitoring and technical assistance to meet the behavioral health care needs of tribal members. This valuable partnership promotes the sharing of best practices and excellence in service delivery. The implementation of the Greater Arizona RFP process has resulted in contract awards to three RBHAs. The implementation of the Maricopa County Contract is in its second year. To promote excellence in service delivery, regular meetings are held and information is reviewed to track, monitor, and enforce contract performance.

Improve submission of claims and encounters received from providers and Regional Behavioral Health Authorities

The Arizona Department of Health Services' (ADHS), Office of Program Support implemented monthly meetings and quarterly on-site visits to each Regional Behavioral Health Authority (RBHA). As a result, the Arizona Health Care Cost Containment System (AHCCCS) encounter acceptance rate increased from 77% to 92% in the last year.

The Office of Program Support keeps in daily contact with RBHAs providing technical assistance as well as monitoring encounter submissions, pended encounter corrections, timeliness of submissions and producing provider/RBHA reports. A process was streamlined to allow RBHAs additional time when correcting an AHCCCS pended encounter. The new process allows a pended file to be sent to RBHAs within one day of receipt, giving them an additional 4-5 days to process corrections.

The ADHS, Office of Program Support has adopted several of AHCCCS' practices in monitoring and providing technical assistance to RBHAs and their providers. A "mini data validation" process has been implemented on a quarterly basis with each RBHA. The Division of Behavioral Health Services and RBHA staff, review client records at the provider site to ensure submission, timeliness and accuracy of claims. On a quarterly basis, submitted encounters are compared to actual payments recorded by RBHAs to check for submission, timeliness and accuracy.

Improve the information and reports available to meet community needs

The Division of Behavioral Health Services (DBHS), Bureau of Quality Management Operations has made great progress in the area of improving the quality of the reporting

and information provided for dissemination. A significant number of reports were provided to the Regional Behavioral Health Authorities (RBHAs) for the purpose of data analysis and program development. This information enabled them to direct their contracted providers around implementation of services positively impacting behavioral health recipients and the behavioral health system.

Through utilization reporting, DBHS is better equipped to determine what service needs are at normal utilization, as well as which services are under and over utilized. DBHS is able to determine if there are any trends and decide which area should be of central focus. Based on the reports, each RBHA can now make accurate decisions on funding, provider location, and staff training in specific service areas.

Improve the timeliness, completeness, accuracy and consistency of enrollment and disenrollment transactions and demographic data sets

The Division of Behavioral Health Services (DBHS), Information Technology Systems Office implemented changes to the demographic system identified by the DRIIP committee. In addition to placing new edits to help strengthen the quality of the data being submitted, the Information Technology office started collecting several new pieces of information to help track outcome measures for the JK population statewide and to help track the priority-SMI population in Maricopa County.

New reports on the completeness and timeliness of demographic data are scheduled to be submitted and produced starting October 1, 2005. These monitoring reports will help both DBHS and Regional Behavioral Health Authorities determine which clients have demographic data that is not complete or has not been updated in a timely manner.

THE ARIZONA STATE HOSPTIAL

VISION AND MISSION STATEMENTS

VISION STATEMENT:

By the year 2010, Arizona State Hospital will be recognized as a center of excellence, a progressive Arizona employer, and as an effective community partner.

MISSION STATEMENT:

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

DESCRIPTION OF THE ARIZONA STATE HOSPITAL

The Arizona State 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 mental ill Arizonans who are court-ordered for treatment to its 338 funded 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 "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 FY 2005 for all patient populations was 267 patients.

Authorized by A.R.S. §36-201 through 36-207, the Arizona State 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 behavior health of all Arizonans through

education, intervention, prevention and delivery of services. The Hospital is one of the 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.

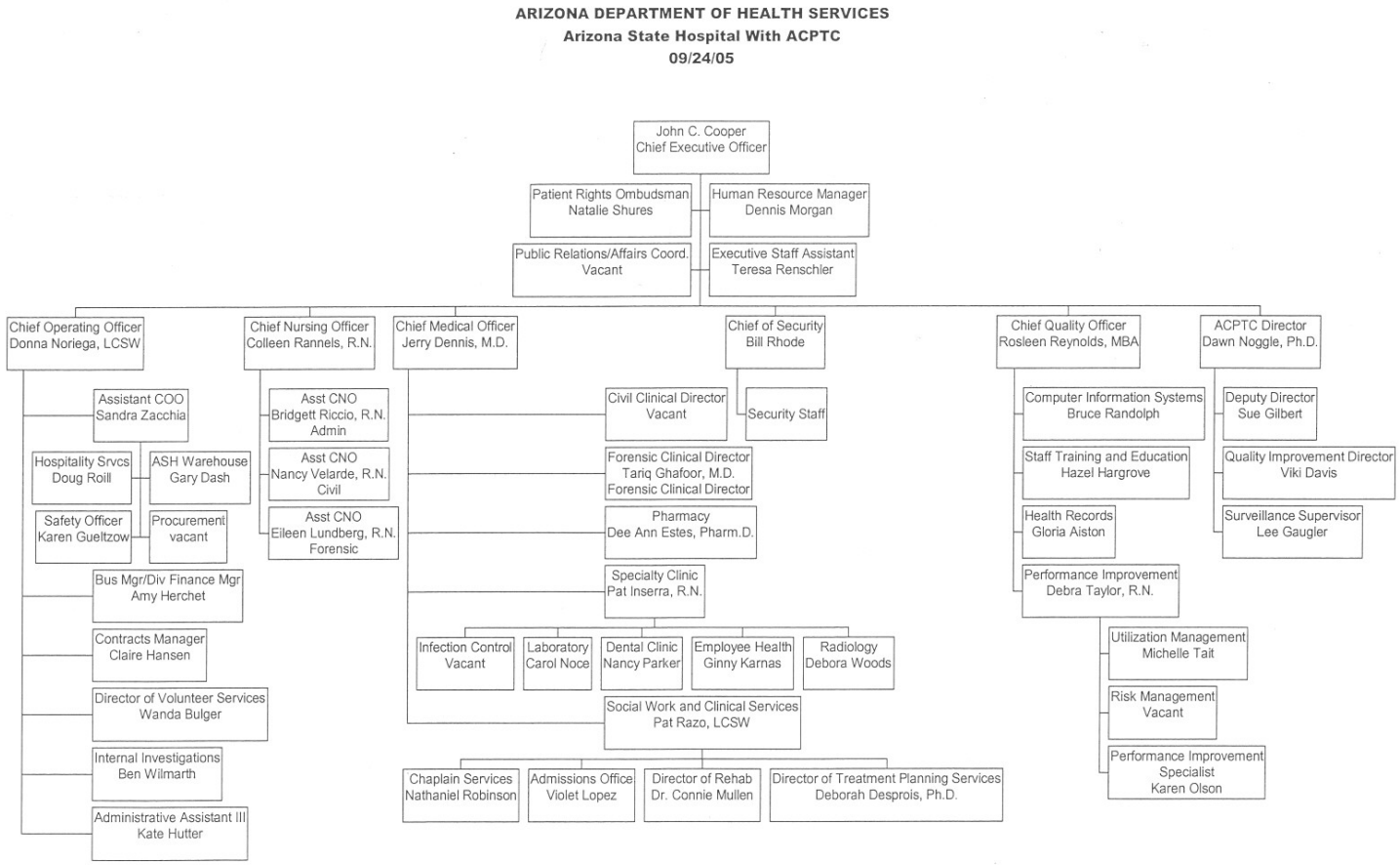
Overall guidance for Hospital leadership is provided by the **Arizona State Hospital Governing Body**, which is regulated under federal guidelines. The Deputy Director of the Arizona Department of Health Services/Division of Behavioral Health Services chairs this committee. The Governing Body consists of the Deputy Director, a Hospital Physician and a Community Representative.

As required in statute (A.R.S. §36-217), the **Arizona State Hospital Advisory Board** advices the Deputy Director of the Arizona Department of Health Services/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 the Arizona Department of Health Services / 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 operation, establish administrative policies and procedures and direct Hospital planning activities. Other Executive Management Team members include critical department directors, legal counsel, public relations officers and others at the discretion of the Chief Executive Officer.

ARIZONA STATE HOSPITAL ORGANIZATIONAL CHART



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 the 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 we 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 their selves, 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.
17. **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.

PATIENTS SERVED AT THE ARIZONA STATE HOSPITAL

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

1. **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.
2. **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.
3. **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 its capacity by even just one patient on one unit for one day endangers 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 2005, the funded capacity and allocation of the Hospital's beds was as follows:

• Civil Adult (41% of beds):		141 Beds
• Forensic Adult (54% of 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 capacity)		16 Beds
• Medical Bed (reserved for infection control)		1 Bed
TOTAL BEDS FY 2005		338 Beds

The law requires the Superintendent of the Hospital to establish a waiting 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 waiting list until an appropriate bed becomes available. These persons remain in a community inpatient setting or a county jail psychiatric ward while on the waiting list. During FY 2002, 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 2003, 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 and discontinuance of the wait list since July 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 2005**	**Increase or Decrease**
Civil (Adult) Beds	51%	44%	-7%
Forensic Beds	44%	52%	+8%
Adolescent Beds	5%	4 %	-1%

End of Month Census

The Hospital began FY 2005 with a patient census of 304 and ended the fiscal year on June 30th with a census of 254, a decrease of 50 patients. During the year, 297 patients

were admitted and 347 patients were discharged. The average daily census for the fiscal year was 269 patients. These patients accounted for a total of 98,188 patient days*, a decrease of 15,955 days compared to the previous fiscal year. The patient end of month census from July 2003 through June 2005 is depicted in Exhibit #1.
*Patient days: includes patients assigned to a unit, i.e. occupying a bed on that unit, even if he or she is on pass.

EXHIBIT # 1 (A)
End of Month Census – All Populations, FY 2004 through FY 2005

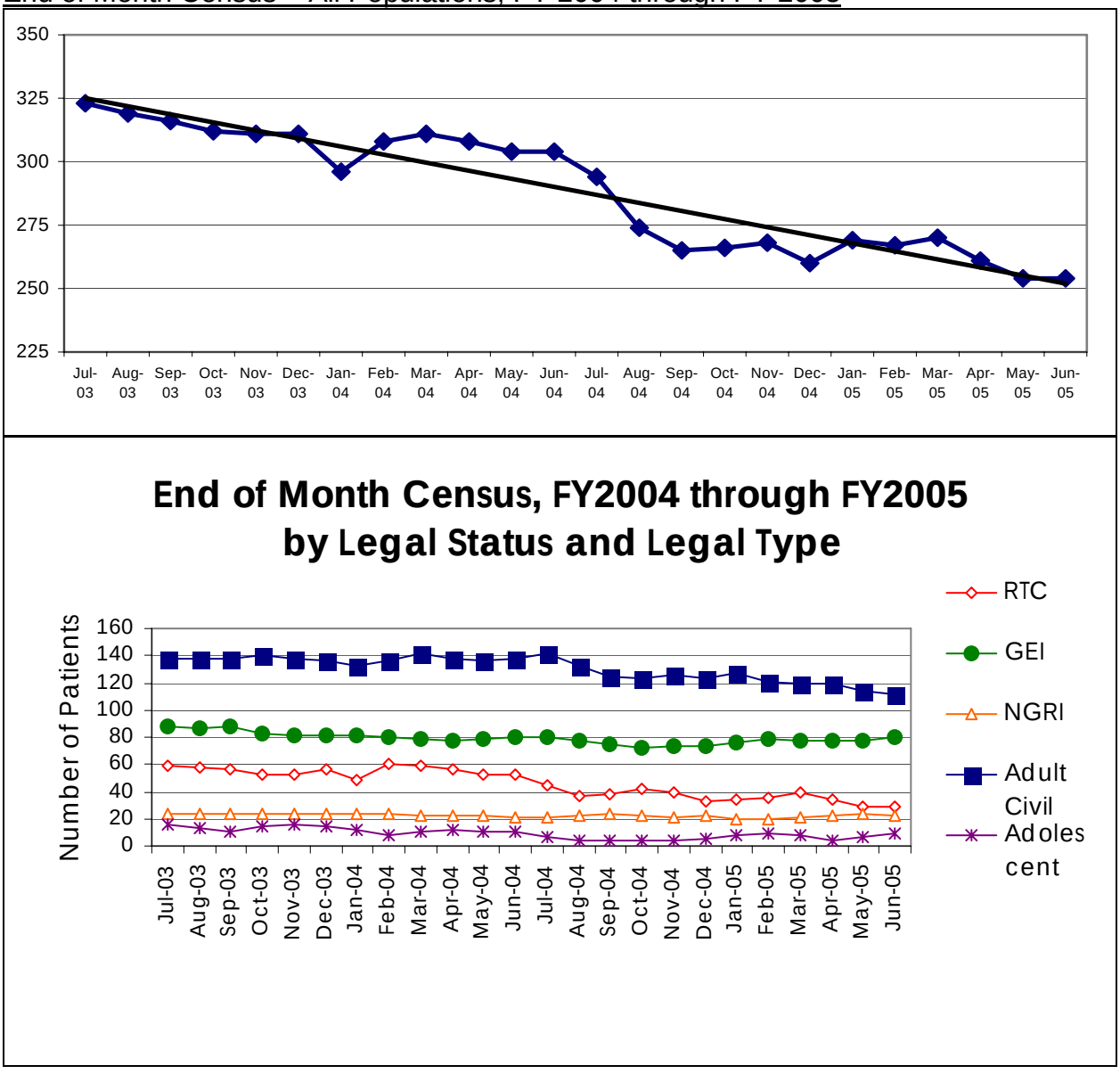


EXHIBIT # 1 (B)

End of Month Census FY 2004 through FY 2005							
Fiscal Year 2004				**Fiscal Year 2005**			
July	324	January	296	July	294	January	269

August	319	February	308	August	274	February	267
September	316	March	311	September	265	March	270
October	312	April	308	October	266	April	261
November	311	May	304	November	268	May	254
December	311	June	304	December	260	June	254

EXHIBIT #2: Monthly Admissions and Discharges

FY 2005	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	Total
Admissions	29	20	25	34	23	22	31	23	33	18	18	21	**297**
Discharges	39	40	34	33	21	30	22	25	30	27	25	21	**347**

FY 2004 Data:		FY 2005 Data:	
Beginning Census as of July 1, 2003:	324	Beginning Census as of July 1, 2004:	304
Ending Census as of June 30, 2004:	304	Ending Census as of June 30, 2005:	254
Admissions 7/1/03 – 6/30/04:	417	Admissions 7/1/04 – 6/30/05:	297
Discharges 7/1/03 – 6/30/04:	**432**	**Discharges 7/1/04 – 6/30/05:**	**347**
Average Daily Census FY 2004:	311.9	Average Daily Census FY 2005:	269.01
Number of Patient Days:	114,413	Number of Patient Days:	98,188

Admission Statistics

The Hospital admitted 297 patients this fiscal year. Individuals admitted to the Hospital for the first time accounted for 225, or 75.8% of all admissions during FY 2005. Admissions by diagnostic grouping indicated that patients diagnosed with schizophrenic disorders accounted for 28.6% (n=85) of all admissions during FY 2005, which is a 3.7% decrease from 29.7% during the previous fiscal year. During FY 2005, patients diagnosed with affective psychoses (23.9%) and other non-organic psychoses (14.5%) comprise the major diagnostic groupings for patient admissions to the Hospital. Patients were discharged to the community to the following placements:

Patients Discharged during FY 2005

Living Arrangements after Discharge	**Adult**	**Adolescent**	**Total**	**Overall %**
AWOL	1	0	1	0.3
Correctional Facility (primarily RTC Patients)	203	12	215	61.9
Family	11	5	16	4.6
Foster Home	1	2	3	0.9
Group Home	46	6	52	14.9
Independent Living	6	0	6	1.73
Licensed Supervisory Care	12	0	12	3.46
None	3	0	3	0.9
Non Psych Hospital/Ward	1	0	1	0.3
Nursing Home	5	0	5	1.44
Other	0	1	1	0.3
Psych Health Facility	5	0	5	1.44
Residential SAP/SMI-Dual Diagnosis	3	0	3	0.9
RTC 24-hour (not PHF)	12	6	18	5.18
RTC Semi-Supervised (not PHF)	2	0	2	0.6
Sponsored Based Housing	4	0	4	1.15
Unknown	0	0	0	0
Total	**315**	**32**	**347**	**100.00%**

ARIZONA STATE HOSPITAL – STATE FISCALYEAR 2005

Adolescent Forensic SMI Admissions		**Adolescent 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	**1**	**21**	**5**	**0**	**2**	**30**
Adolescent **Forensic SMI Discharges**		**Adolescent 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	
0	**1**	**27**	**4**	**0**	**0**	**32**

ADOLESCENT ADMISSIONS AND DISCHARGES

ARIZONA STATE HOSPITAL – STATE FISCALYEAR 2005
ADULT ADMISSIONS AND DISCHARGES

Adult Forensic SMI Admissions					**Adult 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		
170	**20**	**6**	**7**	**6**	**6**	**49**	**3**	**267**
Adult Forensic SMI Discharges					**Adult 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		
193	**17**	**8**	**5**	**4**	**13**	**69**	**6**	**315**

SUMMARY OF ADMISSIONS AND DISCHARGES FY 2005

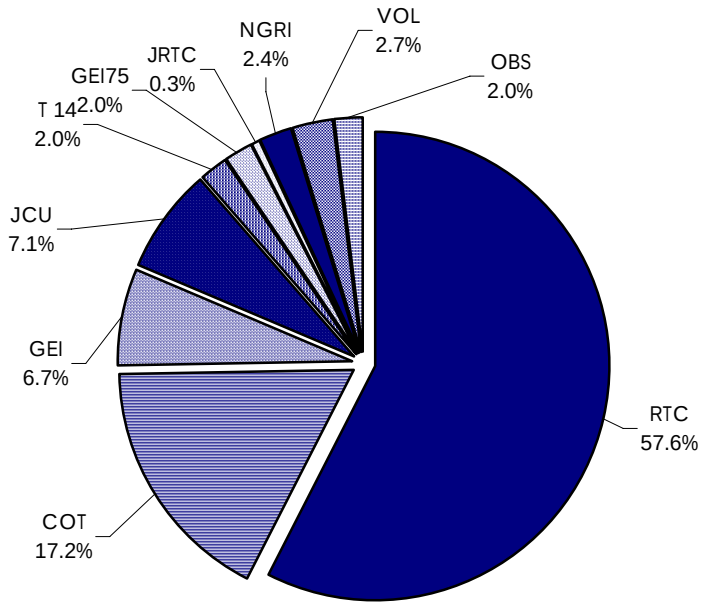
	Total Admissions	Total Discharges
Adolescents:		
Forensic	2	1
Civil	28	31
Subtotal	**30**	**32**
Adult:		
Forensic	209	227
Civil	58	88
Subtotal	**267**	**315**
Total for FY 2005	**297**	**347**

Admission Averages

The average monthly admission rate for FY 2005 was 25 patients, ranging from a low of 18 admissions in April 2005 and May 2005 to a high of 34 admissions in October 2004. This was a 28.6% decrease from the FY 2004 average monthly admission rate of 35 patients.

EXHIBIT #3

Legal Status at Admission FY 2005



Legal Status At Admission FY 2005		
Legal Status	**Admits**	**Percentage**
Title 13 - 45.12 Restoration to Competency	171	57.6%
Title 36 - 450 Court Ordered Treatment	51	17.2%
Title 13 Guilty Except Insane	20	6.7%
Title 8 - Juvenile Commitment - Unspecified	21	7.1%
Title 14 with Mental Health Powers	6	2.0%
Title 13 Guilty Except Insane 75 day	6	2.0%
Title 8 - Juvenile Commitment - Restoration to Competency	1	.4%
Title 13 - 3994 Not Responsible for Criminal Conduct by Reason of Insanity	7	2.3%
Voluntary	8	2.7%
Title 13 - 45.07 Observation	6	2.0%
Total FY 2005 Admissions	**297**	**100.0%**

EXHIBIT #4

Admissions by County FY 2005

County of Admission	Total	Percentage
Apache	3	1.01%
Cochise	8	2.69%
Coconino	10	3.37%
Gila	5	1.68%
Graham	3	1.01%
Greenlee	2	0.67%
La Paz	2	0.67%
Maricopa	89	29.97%
Mohave	12	4.04%
Navajo	7	2.36%
Pima	104	35.02%
Pinal	28	9.43%
Santa Cruz	0	N/A
Yavapai	16	5.39%
Yuma	8	2.69%
Total Admissions FY 2005	**297**	**100.0%**

Admission by County:

Maricopa County had the highest number of admissions during FY 2005 with 89 patients or 29.96% of all statewide admissions. Admissions from Maricopa County decreased by 60.8% from the previous year's total of 227 admissions. Pima County accounted for 104 or 35.02% of the total admissions. This was a decrease of 4.6% from last fiscal year's 109 Pima County admissions. The remaining thirteen counties

accounted for 104 or 29.96% of the state admissions during the period July 2004 to June 2005.

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 2005 recidivism rate was 6.4% (n=19). Readmission rates for prior fiscal years vary from a low of 4.4% in FY 2000 to a high of 9.2% in FY 1999. In total, there were 38 readmissions during FY 2005 with an average community stay of 300 days before the subsequent admission in the Hospital.

Discharge Statistics

The Hospital discharged 347 patients during this fiscal year.

EXHIBIT #5

Discharge Length of Stay FY 2005

Length of Stay	Non-Forensic		Forensic		Total	
	Patients	%	Patients	%	Patients	%
Less Than 90 days	27	22.7	140	61.4	167	48.1
90 to 180 days	18	15.1	66	28.9	84	24.2
181 to 365 days	26	21.8	5	2.2	31	8.9
366 to 1095 days	39	32.8	5	2.2	44	12.7
1096 to 2190 days	7	5.9	11	4.8	18	5.2
2191 to 3650 days	2	1.7	1	0.5	3	0.9
Over 3651 days	0	0.0	0	-	0	0
Total	**119**	**100%**	**228**	**100%**	**347**	**100%**

EXHIBIT #6

Mean Discharge Length of Stay FY 2005

Length of Stay	Total Patients Discharged	Mean
Less than one year	282	93.6
More than 1 year but less than 3 years	44	633.45
More than 3 years but less than 6 years	18	1438.6
More than 6 years but less than 10 years	3	2666.67
More than 10 years	0	
Mean Discharge Length of Stay Total	**347**	**254.1**
Note: The mean discharge length of stay is the average number of days of hospitalization per patient during FY 2005.		

Adult Discharges

Of the 347 patients discharged during this fiscal year, 315 or 90.8% were adults. Overall, the average length of stay for this age group was 271.2 days. During FY 2005, 88 non-forensic patients had an average length of stay of 538 days: 69 patients were discharged from the Title 36 Court Ordered Treatment program with an average length of stay of 511 days; 13 patients under Title 14 with Mental Health Powers were discharged in an average of 639 days; and 6 Voluntary patients were discharged in an average of 630.5 days. (Exhibit #7) During the same time period, 227 forensic patients were discharged with an average length of stay of 167 days: 193 patients were discharged from the Title 13 Restoration to Competency program with an average length of stay of 78.2 days; 17 Title 13 Guilty Except Insane patients were discharged in an average of 1251.8 days; 8 Title 13 Guilty Except Insane – 75 Day patients were discharged in an average of 49.8 days; and 5 patients were discharged from the Title 13 Not Responsible for Criminal Conduct by Reason of Insanity treatment in an average of 205.2 days.

Adolescent Discharges

Of the 347 patients discharged during FY 2005, 32 or 9.2% were adolescents. Overall, the average length of stay for this age group was 85.8 days. The 31 non-forensic patients stayed an average of 86 days during FY 2005: 27 patients were discharged from Title 8 Juvenile Commitment after an average of 91.6 days and 4 Voluntary patients were discharged in 48 days. The 1 forensic patient –a Title 8 Juvenile Restoration to Competency– was discharged this fiscal year with a length of stay of 78 days.

Discharge Averages

The average monthly discharge rate for FY 2005 was 29 patients, ranging from a low of 21 discharges in November 2004 and June 2005 to a high of 40 discharges in August 2004 (Exhibit #2). This was a 19.4% decrease from the FY 2004 average monthly discharge rate of 36 patients.

EXHIBIT #7

Average Length of Stay by Legal Status FY 2005

Legal Status	Number of Patients	Average Length of Stay
Title 13-45.07 Observation	3	47
Title 13 - 3994 Not Responsible for Criminal Conduct by Reason of Insanity	5	205.2
Title 13 - 45.12 Restoration to Competency	193	78.2
Title 13 Guilty Except Insane	17	1251.8
Title 13 Guilty Except Insane 75 day	8	49.8
Title 14 with Mental Health Powers	13	639
Title 36 - 450 Court Ordered Treatment	69	511
Title 8 - Juvenile Commitment - Restoration to Competency	1	78
Title 8 - Juvenile Commitment – Unspecified	30	86.5
Voluntary	10	397.5
Total FY 2005 Discharges and Average Length of Stay	**347**	**254.1**

The number of non-forensic patients discharged during FY 2005 with a length of stay less than 365 days was 71 or 59.6%, which is 4.3% 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 2005, 21 patients were discharged with a length of stay of greater than 3 years including 3 patients hospitalized for over 6 years. These patients require extensive treatment and discharge planning coordination between the Hospital and community providers, who will provide follow-up services.

FY 2004/2005

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's 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. § 8-271 et seq.** **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. § 8-291 et seq.** **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 - CONDITION OF EXISTING BUILDINGS AND EQUIPMENT:

$80 million was appropriated in 2000 for the renovation, demolition and construction of a new 16-bed Adolescent Treatment Facility (opened July 2002), a new Adult Civil 200-Bed Facility (opened January 2003), and hospital infrastructure. This 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.

In September 2004, the Joint Committee on Capital Review approved the transfer of $3.5 million from the Hospital Capital Construction Fund to the Department of Administration to fund capital projects and improvements to older hospital buildings.

The projects currently being funded by this appropriation include:

- Replace air handler and boiler in administration building
- Replace a sewer line at the warehouse
- Replacing an emergency generator
- Re-roof of a building
- Downsizing oversized boilers and replacing with energy efficient boilers
- Replace a hazardous elevator
- Replace electrical and wiring in General Services
- Replace condenser tubes
- Upgrade Dietary building HVAC and exhaust system

When completed, these projects will extend the lifetime of the existing buildings and improve energy efficiency and overall appearance.

Need for New Forensic Hospital

Although the $3.5 million has improved many of the buildings, a new Forensic Hospital is desperately needed.

The state budget crisis in 2002 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. Today, the costs to complete this project have risen to over $30 million dollars, due to inflation.

The Forensic Units treat Restoration to Competency (RTC), Guilty Except Insane (GEI), and Not Guilty by Reason of Insanity (NGRI) populations. These buildings were built in the 1950's and are deteriorating and becoming unsafe and dangerous structures. The Forensic Units need major mechanical, electrical, plumbing, roofing and other infrastructure renovations to ensure patient safety. The roof leaks whenever there is a rainstorm requiring staff to line hallways with buckets to avoid wet floors. The exterior of the buildings need joint repair and wall penetration repair at a minimum. The electrical systems and plumbing are aged and in need of repair. Recently the plumbing in one unit including the installation of a lift station for sewage removal cost the state $250,000. These repairs did not address electrical or exterior problems.

Construction of a new facility will allow for the units to be brought up to a level 5 (Arizona Department of Corrections) standard for security of the level of forensic patients the Hospital treats.

Included on the Forensic side of the Arizona State Hospital is the entrance from Van Buren Street which is the public's first impression of the hospital. Currently, an old shack is in the center of the entrance road to the hospital. The shack is showing signs of aging and disrepair. The floor has been weakened over time and is disintegrating. Staff who "man" the shack have no restroom and the air conditioner and heating systems do not provide adequate shelter from the weather. Due to the hospital's location at 24th Street and Van Buren, transients and other streetwise people attempt to enter the hospital grounds. This results in threats to security personnel and little protection due to the condition of the current Gatehouse. The Hospital Control Center for communication is located in the Gatehouse and currently operates four separate radios and microphones. Our current system has many "dead zones" prohibiting communication between staff and officers within the hospital as well as at the Maricopa County Hospital. Therefore, a repeater and operating console for Hospital Control is needed. This will provide more power to the system and eliminate the dead zones as well as allow the control officer to operate the staff and security channels from one console microphone rather than 4 separate radios. This would ensure the safety of security personnel as well as improve the appearance of the entrance to the Hospital.

Other Building Deficiencies

The Old Main Administration Building has several needs including seismic bracing, hot water systems replacement and upgrading of the rest rooms to conform to ADA requirements. The Old Main Administration Building is deteriorating, and at the very minimum, a new roof membrane is needed to prevent further water damage.

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

The General Services Building is ADA accessible from the exterior, however the interior needs ADA improvements, including upgrading the elevator, seismic bracing, ductwork replacement, as well as other upgrades to exhaust systems and the sump pump.

The Paint and Garage Shop is in need of attention. Wood trusses need to be fire proofed, rest rooms must be ADA compliant, a ventilation system in the work area is needed, fire sprinkler coverage is required, new sand and oil interceptor at vehicle maintenance area is needed and new receptacle wiring needs to be installed.

The **Engineering Building (the old Laundry Building)** is recommended for complete demolition and replacement, but in lieu of replacement major deficiencies in mechanical, plumbing, electrical, HVAC, interior and exterior and roofing are in need of correction.

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, and in addition needs new 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.

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 Psychiatric Security Review Board, which oversees the Guilty Except Insane patients, needs permanent accommodations.

ARIZONA STATE HOSPITAL RECOMMENDATIONS FOR IMPROVEMENT

Issues for FY 2005/2006:

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 from 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. <u>This session law expires at the end of FY 2005/2006, 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 $6.5M if the law lapses.</u>

NEW FORENSIC HOSPITAL

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 $30 million dollars to complete.

In 1997, the Auditor General found these buildings to be seriously deficient. Built in the 1950's, the existing forensic Hospital consists of Units that 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. The Juniper Units were never renovated and are unsuitable to house forensic/criminal patients, due to lack of appropriate security measures. Although some units are closed now, if the forensic census escalates it may become necessary to house patients in units which lack appropriate security measures.

Compensation: Recruitment and Retention Issues
Nursing – Difficulty in Recruiting New Nurses: Nationally, there is an acknowledged serious nursing shortage. Within the state of Arizona, for the Arizona State Hospital, it is even worse. 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 additional monies to implement a tier system that was comparable to other state agencies employing nurses, local markets have continued to accelerate their recruitment strategies to include hiring bonuses of up to $5000 per year and pay scales that are significantly higher than the state hospital can offer. The Arizona State Hospital is also non-competitive in its inability to offer flexible work schedules or tuition reimbursement packages.

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. Three years ago, the Hospital had a 15% vacancy rate in its' RN staff; this fiscal year, we are averaging a 40% vacancy rate.

Rehabilitation, Social Work, Psychology, and Psychiatry – Compensation is non-competitive with the private sector and other governmental agencies especially with regard to Therapists and Psychiatrists. Arizona State Hospital is facing a risk of being unable to provide adequate psychiatric services for the patients we serve due to our psychiatrists being attracted to other positions outside of the hospital.

At the time of the most recent Western Psychiatric State Hospital Association (WPSHA) salary survey, Arizona State Hospital was approximately $7,000 below the WPSHA average for psychiatrists. Furthermore, according to Salary.com, the median for a psychiatrist is $157,684; the 25 percentile is $140,338; our current average is $134,500 for psychiatrists.

This has lead to increased staff vacancies and high turnover in these critical direct care positions.

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.

Computer Connectivity and related issues

There is a need for Arizona State Hospital to have a post implementation of AVATAR assessment. AVATAR is the hospital's electronic medical record that has been at the facility for approximately five years. During this period there are many functions of the product that have not been utilized for various reasons, and other functions that the company has improved through the annual user agreement/contract. This assessment should result in an IT strategic plan that works toward further development of an integrated electronic medical record at Arizona State Hospital. This integrated electronic medical record ideally would include clinical assessments and documentation by all disciplines, treatment plans, laboratory results and pharmacy. Staff today continues to use the hard copy medical record to review important patient information such as lab reports, medication orders, or other significant documents.

Training

Mandatory training is required by certification and licensing agencies. Staff who cannot obtain training risk violating JCAHO and Medicare standards. Current resources only allow for training to be conducted in the traditional classroom type setting. Unit staff must work additional hours to obtain training or be relieved by another staff member to attend training. Additional resources are needed to develop training CD's, Internet opportunities and purchase equipment.

Scheduling and Patient Acuity System – The Nursing Department is responsible for determining nursing staff schedules to meet acuity levels. This is a complex and very time-consuming task and the current manual system fails to ensure an efficient, decision driven, timely, cost effective allocation. An electronic system is desperately needed to allow for more accurate staffing projections.

Dietary, Engineering, and Grounds Keeping

Some capital 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 equipment Dietary and Engineering staff can focus on completing projects in a more timely manner thereby 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.

Guilty Except Insane, Missing 4th Disposition

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 (say to a 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.

ARIZONA STATE HOSPITAL FINANCIAL SUMMARY

ARIZONA STATE HOSPITAL

FINANCIAL SUMMARY

FISCAL YEAR 2004 – 2005

Funding Sources (General Operations Based on Budget Allocations): *	
Personal Services and Related Benefits -General Fund	$30,822,601
All Other Operating -General Fund/AZ State Hosp Fund	$12,852,099
Supplemental - Corrective Action Plan	$1,281,400
Non-Title 36 Revenue	$82,244
Rental Income	$827,370
Endowment Earnings	$350,000
Patient Benefit Fund	$35,000
Donations	$12,000
Psychotropic Medications	$63,500
Community Placement - General Fund	$5,574,100
Community Placement - AZ State Hosp Fund	$1,130,700
Total Funding	$53,031,014

Expenditures: *	
Personal Services and Related Benefits	$31,021,722
Professional and Outside Services **	$8,465,255
Travel (In-State)	$54,399
Travel (Out-of-State)	$7,757
Food	$0
Other Operating	$5,692,254
Capital Equipment	$115,827
Assistance to Others	$6,704,800
Total Cost of Operations	$52,062,014

Collections:	
Patient Care Collections to General Fund	$715,403
Patient Care Collections to AZ State Hosp Fund - RTC	$5,960,201
Patient Care Collections to AZ State Hosp Fund - Title XIX	$2,022,345
Non-Patient Care Collection to General Fund	$1,809
Total Collections	$8,699,758

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

Daily Costs by Treatment Program: (Rates became effective 7/01/03)	
Specialty Rehabilitation	$502
Adolescent Treatment	$683
Psychosocial Rehabilitation	$415
Forensic - Restoration to Competency	$428
Forensic Rehabilitation	$371
Average	$427