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

ANNUAL REPORT
FISCAL YEAR 2006

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~Leadership for a Healthy Arizona~

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DIVISION OF BEHAVIORAL HEALTH SERVICES

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. For fiscal year 2006, 139,927 clients received behavioral health services. Expenditures totaled $994,730,652.

The publicly funded behavioral health system provides services to both persons who are eligible for federal funding (Title XIX/Title XXI of the Social Security Act) and persons who are non-Title XIX/XXI eligible (utilizing State-only funds). Programs available include the following:

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

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 of Arizona behavioral health delivery system is divided into six geographic regions, called Geographic Service Areas (GSAs). The Division contracts with Regional Behavioral Health Authorities (RBHAs) who are responsible for administering behavioral health delivery systems to eligible persons residing in the GSA(s).

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) 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 Inter-Governmental Agreements (IGAs) with the Department. They are Gila River Indian Community, Colorado River Indian Tribe, Navajo Nation, and the Pascua Yaqui Tribe.

Covered behavioral health services provided include the following for enrolled behavioral health recipients:

- Treatment services
- Rehabilitation services
- Support services
- Medical services
- Inpatient services
- Behavioral health day programs
- Residential services

Please refer to the ADHS/DBHS Covered Behavioral Health Services Guide at http://www.azdhs.gov/bhs/bhs_gde.pdf for more information about the services.

DIVISION OF BEHAVIORAL HEALTH SERVICES PROGRAMMATIC REPORT

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) is responsible for the oversight of publicly funded behavioral health services. Further, the Division is responsible to continually monitor, and when indicated, improve upon the effectiveness and efficiency of its comprehensive system of care in order to better meet the needs of the people of Arizona. The ADHS/DBHS provides for responsive, comprehensive, community-based services tailored to the behavioral health recipient, the family, the community and culture.

In order to accomplish this, the ADHS/DBHS has numerous 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 2006, the ADHS/DBHS targeted several objectives in its 2006 Strategic Plan. The following section of the report highlights these activities.

Improve suicide prevention and treatment services in collaboration with other organizations

The ADHS/DBHS workgroup on suicide prevention is comprised of internal and external stakeholders focused on improving the continuum of suicide prevention and treatment services in collaboration with other organizations. External stakeholders involved in the process included Tribal and Regional Behavioral Health Authorities, providers, Arizona Suicide Prevention Coalition members, crisis workers, and survivors of suicide. During FY 2006, the ADHS/DBHS Suicide Prevention Workgroup finalized the suicide risk assessment and instruction guide, and implemented a pilot of the tool at three provider agencies. Statewide training was conducted in the fall of 2006.

In collaboration with the Arizona Suicide Prevention Coalition, ADHS/DBHS began planning the first annual Suicide Prevention Conference. Intended to draw a diverse, statewide audience of stakeholders, the conference held in October 2006 focused on suicide prevention across the lifespan, with tracks targeting elders, Native American tribes and components of quality prevention programs. Other training events included workshops on suicide prevention delivered at the annual Seeds of Success conference in October 2005 and the annual Summer Institute in Sedona. ADHS/DBHS hosted a special training in March 2006 for prevention programs serving Native Americans. The training included education on the Zuni Life Skills curriculum, an evidence based practice for suicide prevention among Native American populations.

ADHS/DBHS was awarded a Garrett Lee Smith Memorial Suicide Prevention Grant in the fall of 2005. This grant focuses on improving the quality and availability of suicide prevention services to school-age youth in three target sites in Arizona: Gila River Indian Community, Pima County and Pinal County. Funds from the grant supported the ADHS/DBHS Suicide Prevention Conference, implementation of best practice mental health screening programs in community colleges and targeted high schools, and development of a core of skilled trainers using Applied Suicide Intervention Skills Training (ASIST) – an exemplary practice focused on risk assessment screening for key gatekeepers, including health care professionals.

In the spring of 2006, ADHS/DBHS directed $98,000 in funding to eight Native American tribes to develop culturally-based prevention services targeting suicide, substance abuse, and methamphetamine prevention.

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 and secondly focusing on utilizing the lessons learned from Phase 1 to expand the project to cover all TXIX/XXI behavioral health recipients who are served by both the AHCCCS Health Plans and the behavioral health system.

The Collaborative Agreement Task Force gathered 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.

In the summer of 2006, the ADHS/AHCCCS collaboration of care project was incorporated into the larger statewide Governor's e-Health Initiative in order to develop automated tools for information sharing across the primary and behavioral health care community.

ADHS/DBHS is exploring options for sharing of behavioral health and medical data between Health Plans and T/RBHAs for shared behavioral health recipients. AHCCCS has developed a data warehouse for this purpose.

Results from the 2005 Independent Case Review, conducted in 2006 as a retrospective review of fiscal year 2005, revealed that care coordination between the behavioral and medical healthcare systems was evident in 72% of the charts reviewed.

The ADHS/DBHS has also participated in subcommittee meetings to collaborate with the primary care system to improve services to those with serious co-occurring physical and behavioral health disorders. The workshops goals are to:

- Identify information and data to define the problem areas;
- Implement a plan of action for each of the possible solutions, including the outcome measures for improvement;
- Evaluate effectiveness of the project through tracking, monitoring and analyzing results; and
- Implement additional actions that will support and sustain the outcomes that are attained, possibly including development of an interagency collaborative agreement and contract or policy changes.

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

ADHS/DBHS convened a group of community stakeholders including T/RBHAs, providers, behavioral health recipients, families, and advocacy groups to develop a strategy to reduce the stigma associated with seeking behavioral health services. The first meeting of the group occurred in August 2005, and featured two consultants with national experience in anti-stigma campaigns to facilitate the meeting. In November 2005, ADHS/DBHS released the Family/Advocacy RFP, an innovative procurement to establish direct service contracts with family and consumer organizations to address stigma and promote direct stakeholder involvement in behavioral health service delivery. Increasing the involvement of behavioral health recipients and families with life experience in behavioral health policy and practice at all levels is recognized as the single most effective strategy for reducing stigma. In the spring of 2006, National Alliance for the Mentally Ill – Arizona chapter (NAMI-AZ) was awarded the contract to develop and support a statewide coalition of community members to develop the first ADHS/DBHS Stigma Reduction Plan. The Coalition will be launched in the fall 2006 and access nationally-recognized media materials on stigma reduction made available through the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

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

In FY 2006, ADHS/DBHS led a Request for Proposal for agencies to recruit and train behavioral health recipients and family members to participate in ADHS/DBHS activities including committees, mystery shopping, satisfaction surveys, review of data and feedback on proposed initiatives. Contracts were awarded, beginning 7/1/06.

ADHS/DBHS established a monthly advocates meeting in the fall 2005. Attendees include individuals with life experience, staff of Maricopa County-based recovery centers, and representatives of statewide advocacy organizations representing children and adults. The group meets with ADHS/DBHS executive leadership to address issues and concerns in the Maricopa County system of care.

ADHS/DBHS released the Family/Advocacy RFP in the fall 2005 and awarded $830,000 in funds to six family and consumer organizations in the summer 2006. This

innovative RFP was designed to enhance involvement of behavioral health recipients, family members and grassroots organizations in the direct oversight of the behavioral health system. Service contracts awarded included the following:

- Services to promote individual/family involvement in policy and system oversight, including participation in the ADHS/DBHS Quality Management and Policy Committees and a contract to utilize behavioral health recipients and family members in ADHS/DBHS Mystery Shopper activities;
- Services to provide Peer and Family Support and Information programs on a statewide basis;
- Establishment of a Latino Family Involvement Center in Phoenix and in Yuma;
- Substance Abuse Peer Recovery Training programs;
- The ADHS/DBHS Stigma Reduction Committee;
- Services to support behavioral health recipients/family participation in local and national conferences and workshops; and
- Annual Depression Screening events.

As part of a strategic re-design of the Clinical Operations Bureau in the spring 2006, ADHS/DBHS created a new Family and Community Support Office. The Office will be staffed by individuals with life experience and involved family members, and will be charged with promoting and supporting a statewide network of behavioral health recipients and family participants in behavioral health service delivery, including expanding access to Peer and Family Support services and designing innovative mechanisms for incorporating family, individual and youth voice into the ADHS/DBHS system.

Through two federal infrastructure development grants – the Child/Adolescent State Infrastructure Grant (SIG) and the Adolescent/Young Adult Substance Abuse Coordination (SAC) Grant – ADHS/DBHS is creating venues to promote youth involvement in behavioral health services. During FY 2006, ADHS/DBHS funded youth councils within each T/RBHA system and provided peer leadership training to involved adolescents and young adults. In the fall 2006, ADHS/DBHS will launch the Youth Council – a quarterly roundtable meeting of youth leaders in behavioral health to promote active involvement of young people in various system activities, including a Youth Conference.

An ADHS/DBHS Liaison to the Human Rights Committees (HRCs) supported the following recruitment efforts to family members, behavioral health recipients, and community professionals to volunteer time in serving on regional human rights committees, sharing their relative expertise to make recommendations for improving the behavioral health system by:

- Web postings,
- 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, and
- Following up with interested parties to provide information about committee activities/purposes.

As a result of the efforts, several behavioral health recipients and family members were successfully recruited.

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

Recommendations on improving the quality of assessment and service planning continued to be addressed through the ADHS/DBHS Clinical Council during FY 2006. The Council reviewed findings of medical record reviews conducted at the RBHAs each year, as well as areas for performance improvement identified through the annual Independent Case Review. ADHS/DBHS laid plans in the summer 2006 to launch a Paperwork Reduction Initiatives that would include a review of the core assessment to reduce time spent by clinicians and behavioral health recipients seeking services at the doorway to behavioral health treatment.

ADHS/DBHS structurally realigned its Arnold v Sarn staff resources to respond to court-ordered stipulations regarding activities to ensure ValueOptions' compliance with the stipulations. ADHS/DBHS formed a three-person "Arnold v. Sarn Team" that reports directly to the ADHS/DBHS Deputy Director. The team's scope and authority is specific to ensuring ValueOptions meets the court-ordered Arnold stipulations and acts as the primary ADHS/DBHS contact and information gathering/disseminating body for the Arnold v. Sarn lawsuit.

ADHS/DBHS initiated a "new" Corrective Action Plan (CAP) with ValueOptions that was effective 8/10/05 to 12/31/05. CAP objectives not met by ValueOptions within that time are being incorporated into ADHS/DBHS' quality management system that will track, trend, and analyze ValueOptions data to ensure improvements at the clinics are sustained over time.

ValueOptions hired Boston University to consult and train ValueOptions staff on a "train the trainer" model for aligning assessment and service planning more closely with the principles of recovery with a strong focus on employment. The Boston University training model was developed by recovery-advocate Bill Anthony, and builds on the recovery principles outlined in the Maricopa County Case Management and Clinical Team Plan.

ADHS/DBHS formalized its statewide Children’s Practice Review process during FY 2006 and conducted quarterly reviews in each geographic service area (GSA). Data from the reviews is used to develop technical assistance initiatives that target specific areas for needed practice improvement to ensure assessment, service planning and service delivery consistent with the Arizona 12 Principles and the Child and Family

Team model. A Family Advisory Committee was established to review and provide feedback on quality management data related to the children's systems of care. Committee members represent families served by each region of the state. ADHS/DBHS began publishing reports per the recommendation of the Family Committee during the summer 2006 that assess performance on the functional outcome measures for children and families based on whether the child had an active Child and Family Team. Preliminary data indicates that for children with an active CFT, outcomes measured by the Arizona 12 Principles exceed outcomes for children without a current CFT.

Implement the federal grievance system requirements

The ADHS/DBHS has fully implemented the federal grievance system requirements that provide due process to behavioral health recipients who are eligible for Medicaid services with respect to complaints; written notices to behavioral health recipients; appeals; and requests for State Fair Hearings.

The ADHS/DBHS maintains quarterly monitoring of T/RBHAs to ensure sustained compliance with the federal requirements, providing targeted technical assistance or taking contractual remedies 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 responsibility of the Regional Human Rights Committees is to provide independent oversight and monitoring and was expanded statutorily to include the non-Medicaid, non-Seriously Mentally Ill populations. The ADHS/DBHS notified the Regional Human Rights Committees of the expansion and 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/DBHS conducted a self-assessment of cultural competency activities using the National Association of State Mental Health Program Directors (NASMHPD) 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 (CSAT) developed two types of cultural competency training. The first pertains to the application of an organizational assessment tool within behavioral health agencies, while the second addresses integrating cultural competent services into daily clinical practice. The Cultural Competency Organizational Self-Assessment was implemented with several pilot sites during FY 2006, with feedback being utilized to

tailor the tool and approach to Arizona's unique communities. Based on the 2006 Consumer Satisfaction Survey, 92% of family members report that services were delivered in a culturally competent manner.

The ADHS/DBHS Data Subcommittee created a Language Capacity Reporting Form to be completed by T/RBHAs and submitted to ADHS/DBHS annually. The form was implemented in the spring of 2006 to collect data on bilingual capacity for the top four most prevalent languages within the region and American Sign Language. Data were reported for all levels of behavioral health professionals, physicians, technicians and paraprofessional staff in agencies contracted with the T/RBHA system.

Improve access to care in rural and geographically remote areas

For FY 2006, ADHS/DBHS focused on assessing regional capacity for telemedicine and access to prescribers for behavioral health medications. Working with the RBHA Medical Directors, ADHS/DBHS formalized a prescriber capacity network model that assesses both the number of child and adult prescribers per 100 enrolled behavioral health recipients as well as their geographic availability. The model was implemented in the spring of 2006, with all RBHAs achieving compliance with minimum standards of network access and sufficiency.

ADHS/DBHS conducted the annual RBHA Network Sufficiency Analysis in the spring and summer 2006, including a focus on telemedicine capacity and access to care in rural regions of the state. Beginning in the fall 2006, ADHS/DBHS targeted the transportation infrastructure within each regional area to ensure adequate access to transportation services for enrolled behavioral health recipients and families.

In order to improve its focus on issues of network access and sufficiency, ADHS/DBHS created the Network Operations Unit within the Bureau for Clinical and Recovery Services in the spring 2006. This new unit is responsible for on-going monitoring of network sufficiency within the RBHA system, including monitoring changes in the network due to provider closures or contract changes. The new unit is spearheading a systematic re-design of network sufficiency measures, with a focus on measurable indicators of performance, availability of specific specializations within the behavioral health workforce, and developing real-time data input that allows for more rapid assessment and response to changes in provider scope, location and capacity.

ADHS/DBHS was successful in securing passage of Senate Bill 1129 Behavioral Health Practitioner Loan Repayment Program in July 2005. This legislation established a tuition loan reimbursement program for Behavioral Health Professional and Behavioral Health Technician staff who agreed to serve for two years in an Arizona Mental Health Professional Shortage Area. ADHS/DBHS worked through 2006 to develop a rules package to implement this statute.

Expand and enhance the statewide network of providers

During FY 2006, the statewide network of behavioral health providers continued to grow, with significant increases in the areas of tribal partnerships, improving access to care through technology and focused development of peer and family support services and Therapeutic Foster Care. During the year, enrollment in the Title XIX program grew from 95,933 in July 2005 to 96,773 in June 2006 and enrollment in the Non-TXIX program grew from 32,420 in July 2005 to 39,631 in June 2006. Statewide, enrollment for TXIX adults with a serious mental illness remained stable or slightly declined, while enrollment of CMDP children and adults with general mental health/substance abuse conditions increased significantly.

All Regional Behavioral Health Authorities submitted an Annual Network Sufficiency Assessment and Plan on 5/30/05 and progress in implementing network milestones was assessed on a quarterly basis. Key growth areas included:

- Addition of telemedicine endpoints in three tribal areas: Hopi Tribe, Navajo Nation and Tohono O'odham Nation;
- Development of a unique partnership between the University of Texas and Cenpatico to provide rural areas with telemedicine access to psychiatrists licensed in Arizona who live in other states;
- More than 450 FTE behavioral health recipients provide Peer Support services through licensed behavioral health agencies and Community Service Agencies;
- More than 185 FTE family members provide Family Support services through licensed behavioral health agencies and Community Service Agencies;
- 550 children placed in Therapeutic Foster Care homes across the state, up from 340 in June 2005; and
- Opening of the Benson social detoxification program in November 2005.

Finally, ADHS/DBHS focused on addressing the methamphetamine crisis in Arizona through establishment of three Methamphetamine Centers for Excellence in Phoenix, Tucson, and Sacaton. The Centers for Excellence are an integrated best practice program that uses interventions with demonstrated effectiveness in treating methamphetamine use disorders. During FY 2006, more than 200 people were served through the three Centers.

Regular telephone conferences among Methamphetamine Centers of Excellence occur. Participants are now identifying and resolving emergent issues, facilitating shared learning among the participating programs, debugging the supplementary Internet-based data collection process that will augment ADHS/DBHS Client Information System (CIS) database. Dr. Bohanske is beginning to review Session Rating Scale and Outcome Rating Scale data to analyze with co-author Barry Duncan to generate implementation suggestions.

Strengthening partnerships with tribes remained a key theme for service delivery in FY 2006. ADHS/DBHS developed new programs to expand tribal access to behavioral

health services by establishing reservation-based supported housing in the Gila River Indian Community, creating a new protocol to expedite admissions into the Arizona State Hospital from the tribal courts, facilitated recognition of tribally-licensed foster care homes for children for TXIX funding and increasing the daily rate for Therapeutic Foster Care on reservation lands. In addition, ADHS/DBHS focused specifically on initiatives to target the leading causes of injury on reservation lands through a combination of new programs and technical assistance to address suicide and methamphetamine abuse, including:

- Targeting $122,500 in new funding to support native suicide prevention programs in rural and urban settings, including the Embrace Life initiative for the ten tribes of northern Arizona.
- Supporting the Tribal Suicide Prevention Coalition, a consortium of eleven tribes whose mission is "to change the conditions that result in suicidal acts in Arizona's Native American communities."
- Providing focused training in best practice suicide prevention interventions on Gila River and the Tohono O'odham Nation.
- Launching the Methamphetamine First Responder Training Program, an initiative to provide direct technical assistance to law enforcement, hospital emergency room staff, tribal social services and other first responders in addressing methamphetamine within tribal communities.

ADHS/DBHS, in collaboration with key tribal and rural stakeholders, was successful in receiving a $3M General Fund appropriation targeting methamphetamine treatment and prevention in rural areas of Arizona. The Addiction Reduction and Recovery Fund will support development of new detoxification and treatment services for alcoholism and methamphetamine abuse in areas of the state with great need and few local resources.

Three federal grants received by ADHS during FY 2005 also support development of the behavioral health provider network in the areas of suicide prevention, expanding access for children and creating a focus for Adolescent/Young Adult Substance Abuse Treatment. The federal grants are:

- ADHS was awarded the Garrett Lee Smith Memorial grant in September 2005. This 3-year, $1.2M grant provides funds to improve the availability and quality of suicide prevention programs, including gatekeeper training for schools, medical professionals and other youth-serving groups.

- ADHS was awarded a 3-year, $1.2M Substance Abuse Coordination (SAC) grant to establish infrastructure to treat substance abuse among 16-24 year olds. This funding will support building partnerships with families, implementing best practices in screening, assessment and treatment, and consulting with culturally rich resource agencies.

- The Child/Adolescent State Infrastructure Grant (SIG) provided more than $700,000 a year for five years to support ADHS/DBHS' implementation of the

children's system of care and the Child and Family Team. For FY 2006, the grant focused on strengthening family involvement, adolescent substance abuse treatment, developing capacity for infants and children birth to five years old, and serving children involved with CPS.

Implement the early childhood assessment

During FY 2006, ADHS/DBHS implemented the Early Childhood Assessment, which offers a comprehensive assessment and service planning process for children birth up to age five. The Early Childhood Workgroup continues to meet quarterly to discuss implementation issues and the need for additional training or technical assistance.

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

During FY 2005, ADHS/DBHS supported monthly meetings of stakeholders interested in development, implementation and measurement issues surrounding best practices in behavioral health care. In January 2006, the ADHS/DBHS formalized the structure of the stakeholder group into a 16-member Best Practices Advisory Committee. Membership was solicited through a statewide application process resulting in two year term appointments by the ADHS/DBHS Deputy Director. The new Committee began meeting in the summer 2006 with the goals of selective identification and implementation of best and promising practices in mental health, substance abuse and prevention services. The Clinical Division's re-design plan was implemented effective 5/12/06, establishing a new Office of Clinical Practice Improvement whose mission will support this objective.

The Best Practices Advisory Committee has met several times thus far and hosted their day-long annual strategic planning session on 12/15/06. Several new initiatives were selected for implementation at the 12/15 meeting. Other best practice initiatives include:

- An IGA has been established to allow Psychiatric Residents and Child/Adolescent Fellows to have an Administrative Psychiatry rotation at ADHS/DBHS. A similar arrangement is underway for Banner Good Samaritan Psychiatry residents. Additional discussions are underway to work with the ASU School of Social Work to address supervision best practices and other opportunities for collaboration.

- Child & Family Team (CFT) expansion continues. The goal is to have all children served with CFTs by 12/31/08. Work is underway on a guidance document addressing complexity/intensity of needs and how CFTs may differ between the two extremes.

- The Clinical and Recovery Services Bureau will be hiring several family members and behavioral health recipients in the near future. The need for Peer Support services continues to grow statewide.

- ADHS/DBHS will also be modifying the current Practice Improvement Protocol (PIP) and Technical Assistance Document (TAD) structure to develop Practice Protocols that clearly identify any required service expectations and outline how they will be monitored. A Technical Assistance Document addressing polypharmacy has been published. The Practice Improvement Protocol addressing psychotropic medication use in children has been updated and now has required service expectations, which will be monitored.

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

The Bureau of Compliance maintains intergovernmental agreements with four tribes, two of which are Tribal Regional Behavioral Health Authorities (T/RBHAs), and contracts with four Regional Behavioral Health Authorities (RBHAs) for the provision of behavioral health services throughout the state. During FY 2006, the ADHS/DBHS Policy Office worked collaboratively with the Colorado River Indian Tribe to renew the Colorado River IGA. Furthermore, the Policy Office has been communicating with Pascua Yaqui, Navajo Nation and Gila River to incorporate necessary amendments to these IGAs. A Contract 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. Throughout the year, the Policy Office has also amended the RBHA contracts in accordance with AHCCCS/ADHS contract amendments and has held meetings with RBHAs to ensure implementation of new requirements. Contract Administrators are also assigned to each of the four RBHAs. To promote excellence in service delivery, regular meetings facilitated by the Contract Administrators 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 ADHS/DBHS Office of Program Support implemented monthly meetings and quarterly on-site visits to each Tribal and Regional Behavioral Health Authority (T/RBHA). As a result, the Arizona Health Care Cost Containment System (AHCCCS) encounter acceptance rate was 84.29% for the last year.

The Office of Program Support keeps in daily contact with T/RBHAs providing technical assistance as well as monitoring encounter submissions, pended encounter corrections, timeliness of submissions and producing provider/T/RBHA reports. A process was streamlined to allow T/RBHAs additional time when correcting an AHCCCS pended

encounter. The new process allows a pended file to be sent to T/RBHAs within one day of receipt, giving them an additional 4-5 days to process corrections.

The ADHS/DBHS Office of Program Support has adopted several of AHCCCS' practices in monitoring and providing technical assistance to T/RBHAs and their providers. A "mini data validation" process has been implemented on a quarterly basis with each T/RBHA. ADHS/DBHS and T/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 T/RBHAs to check for submission, timeliness and accuracy.

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

Improve the information and reports available to meet community needs

The ADHS/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 Tribal and Regional Behavioral Health Authorities (T/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.

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

The ADHS/DBHS Information Technology Systems Office implemented changes to the demographic system identified by the DRIIP (Data Reporting Integrity Improvement Project) 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 the demographic data was submitted and produced starting 10/1/05. These monitoring reports will help both ADHS/DBHS and Tribal and Regional Behavioral Health Authorities (T/RBHAs) determine the demographic data that is not complete or has not been updated in a timely manner.

Also in 2006, the ADHS/DBHS Data Committee, consisting of membership from all functional areas within the Division was implemented. The purpose of this committee is

to systematically review, approve and implement any proposed modifications to ADHS/DBHS' data system as well as to provide oversight of T/RBHA data submission.

DIVISION OF BEHAVIORAL HEALTH SERVICES FINANCIAL REPORTS

The Division of Behavioral Health Services (ADHS/DBHS) received a total of $1,012,061,641 in funding for State Fiscal Year 2006. Administrative costs totaled $17,330,988 and statewide service costs totaled $994,730,652. Please see the four tables below for a breakout of programmatic funding details.

Table 1

Total Behavioral Health Services Funding Services & Administration SFY 2006		
Funding	**Amount Paid**	**Percentage of Total Funding**
Title XIX	$544,448,895	53.8%
Title XIX Proposition 204	$244,046,740	24.11%
Title XXI	$15,979,068	1.58%
Federal Funds	$43,466,324	4.29%
Non Title XIX/XXI Funds General Funds	$120,972,568	11.95%
County Funds	$38,857,865	3.84%
Tobacco Litigation/Settlement	$61,051	0.01%
Other (1)	$4,229,130	0.42%
Total	**$1,012,061,641**	**100.00%**

(1) Other includes PASRR, Liquor Fees, City of Phoenix LARC, COOL Program, Comcare Trust, Indirect, Crisis Counseling Immediate Services Program

Table 2

Administrative Funding SFY 2006		
Funding	**Amount Paid**	**Percentage of Administrative Funding**
Title XIX	$6,129,965	35.37%
Title XIX Proposition 204	$6,442,333	37.17%
Title XXI	$378,364	2.18%
Federal Funds	$1,649,072	9.52%
Non Title XIX/XXI Funds General Funds	$2,293,741	13.23%
County Funds	$125,700	0.73%
Other (1)	$311,813	1.8%
Total	**$17,330,988**	**100.00%**

(1) Other includes PASRR, COOL Program, Comcare Trust, & Indirect.

Table 3

Statewide Funding by Program SFY 2006		
Funding	**Amount Paid**	**Percentage of Statewide Funding**
Title XIX Children	$272,903,413	27.43%
Non TXIX Children	$15,137,911	1.52%
TXXI Children	$9,364,914	0.94%
TXIX SMI	$350,416,547	35.23%
Non TXIX SMI	$125,257,560	12.59%
TXXI SMI	$4,629,944	0.47%
TXIX GMH/SA	$152,603,377	15.34%
Non TXIX GMH/SA	$47,509,558	4.78%
TXXI GMH	$1,605,846	0.16%
Non TXIX Prevention	$11,384,266	1.14%
Other Programs (1)	$3,917,316	0.39%
Total	**$994,730,652**	**100.00%**

(1) Other includes PASRR, Liquor Fees, City of Phoenix LARC, COOL Program, Crisis Counseling Immediate Services Program

Table 4

Statewide Funding by Program With TXIX Sub-Programs SFY 2006		
Funding	**Amount Paid**	**Percentage with TXIX Sub-Programs**
Title XIX Children	$172,493,746	17.34%
Title XIX Children/Proposition 204	$2,095,816	0.21%
TXIX DES/DD	$10,254,384	1.03%
TXIX CMDP Children	$88,059,467	8.85%
Non TXIX Children	$15,137,911	1.52%
TXXI Children	$9,364,914	0.94%
TXIX SMI	$178,385,166	17.93%
TXIX SMI Proposition 204	$163,078,133	16.39%
TXIX SMI DES/DD	$8,953,248	0.90%
Non TXIX SMI	$125,257,560	12.59%
TXXI SMI	$4,629,944	0.47%
TXIX GMH/SA	$80,172,918	8.06%
TXIX GMH/SA Proposition 204	$72,430,459	7.28%
NTXIX GMH/SA	$47,509,558	4.78%
TXXI GMH	$1,605,846	0.16%
Non TXIX Prevention	$11,384,266	1.14%
Other (1)	$3,917,316	0.39%
Total	**$994,730,652**	**100.00%**

(1) Other includes PASRR, Liquor Fees, City of Phoenix LARC, COOL Program, Crisis Counseling Immediate Services Program

ARIZONA DEPARTMENT OF HEALTH SERVICES/
DIVISION OF BEHAVIORAL HEALTH SERVICES
NUMBER OF CLIENTS SERVED – 2006
As of June 30, 2006

Program / Funding	NUMBER OF CHILDREN				NUMBER OF SMIs				NUMBER OF NON-SMIs (SA&GMH, DV, SED Children)				Totals Column
	T19	T21	Non-T19	Children Subtotal	T19	T21	Non-T19	SMI Subtotal	T19	T21	Non-T19	Non-SMI Subtotal	Total
Cenpatico – 2	1,271	103	228	**1,602**	746	7	329	**1,082**	1,936	46	1,199	**3,181**	**5,865**
Cenpatico – 4	2,255	182	413	**2,850**	863	6	480	**1,349**	2,903	55	1,023	**3,981**	**8,180**
CPSA – 3	1,370	81	124	**1,575**	676	2	310	**988**	2,754	24	904	**3,682**	**6,245**
CPSA – 5	6,516	519	756	**7,791**	4,181	10	2,603	**6,794**	9,652	160	5,221	**15,033**	**29,618**
GRIC	430	13	18	**461**	30	0	3	**33**	201	0	24	**225**	**719**
NARBHA	3,413	299	448	**4,160**	2,317	11	1,244	**3,572**	5,875	90	1,636	**7,601**	**15,333**
NAVN	196	12	43	**251**	54	0	4	**58**	457	3	201	**661**	**970**
PYTA	185	12	107	**304**	11	0	1	**12**	287	4	338	**629**	**945**
ValueOptions	15,635	1,401	2,412	**19,448**	11,115	30	7,441	**18,586**	21,444	453	12,121	**34,018**	**72,052**
Statewide Totals	**31,271**	**2,622**	**4,549**	**38,442**	**19,993**	**66**	**12,415**	**32,474**	**45,509**	**835**	**22,667**	**69,011**	**139,927**

ARIZONA STATE HOSPITAL PROGRAMMATIC REPORT

As a component of the statewide continuum of behavioral health services provided to the residents of Arizona, the Hospital is a part of the Arizona Department of Health Services/Division of Behavioral Health Services.

The mission of the clinical members of the hospital is to provide safe and effective psychiatric and medical care to those who suffer from serious psychiatric, neurological and medical illnesses. These illnesses hamper a patient's ability to provide self-care safely in the community because they are a danger to themselves or to others.

Civil adult patients are involuntarily court ordered to the State Hospital 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. The Hospital treats people who suffer from complicated 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 the Hospital's mission, we strive for clinical excellence and humanitarian concern. The guidelines for our practice are to make careful and precise diagnostic formulations and to use best practices in our treatment approach to aid our patients in their recovery process.

STAFFING

Patient care on each treatment unit is delivered by an interdisciplinary team consisting of a psychiatrist MD (team leader), clinical social worker, registered nurses, rehabilitation specialists, and mental health program specialists. Each discipline provides specialized, individual patient treatment based on national and state best practice standards.

Registered nurses (RNs) and mental health program specialists (MHPSs) provide the day-to-day 24-hour care for patients. The number and skill mix of nursing staff assigned to the various units is based on the patient acuity as identified by the RN caring for the patients. These staffing needs based on patient acuity (level of presenting nursing care required) are completed prior to each of the three staff shifts in the 24 hour day.

In response to the emerging treatment needs, a clinical reorganization occurred that resulted in developing treatment plan coordinator/therapist positions. The treatment plan coordinators/therapists provide treatment planning services and direct active treatment to the hospital patients. They work with the interdisciplinary treatment teams to develop patient treatment plans that are individualized with measurable treatment goals. They ensure that the treatment plans meet all quality and regulatory standards. The treatment plan coordinators/therapists also provide individual and group psychotherapy services.

ARIZONA STATE HOSPITAL CLINICAL SERVICES OVERVIEW

Interdisciplinary Clinical Team Approach

The interdisciplinary clinical team consists of a qualified psychiatrist (board certified or board eligible), a qualified family practice physician (board certified or board eligible) or a certified physician assistant, a registered nurse, a social worker, rehabilitation professionals, a nutritionist, a therapist, a treatment plan coordinator and a psychologist, when required. The interdisciplinary clinical team assesses and evaluates each patient upon admission to the hospital, at periodic intervals, and at any time necessary during the course of hospitalization, based upon the condition of the patient.

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

Clinical Therapy/Treatment Planning Services

The Clinical Therapy/Treatment Planning Services program provides treatment planning services and active treatment to hospital patients. The therapist/treatment plan coordinators ensure that the treatment plans developed by the interdisciplinary treatment teams meet all standards and specifically address the behaviors which admitted the patient to the most restrictive level of psychiatric care available in the state. These coordinators provide support to the treatment teams. They serve as consultants; provide ongoing training on writing quality treatment plans; track treatment plan reviews, and work to ensure that all standards and timelines are met. In addition, the therapist/treatment plan coordinators provide specialized treatment approaches specific to the individuals and direct individualized services to the patients referred. They provide both individual and group therapies that can positively influence and maximize patient functioning. They also work directly with the treatment teams to identify and develop the most appropriate counseling treatment that will affect change and enhance the success of patient discharge planning.

Inpatient Treatment and Discharge Plan (ITDP)

The Inpatient Treatment and Discharge Plan (ITDP) is an individualized plan of care that contains measurable long and short-term goals and specific interventions to assist patients towards discharge. The plan is developed using the initial assessment by the patient's clinical team, information from the patient, the patient's family and/or guardian, and the community team representative. An ITDP meeting occurs when the treatment team and others involved in service provision to the patient meet to discuss, prepare and/or review a written plan outlining the patient's progress. The preliminary ITDP is initiated at the time of the patient's admission and completed within 24 hours of admission. The master ITDP is developed and completed within 10 days of admission.

The ITDP seeks to address the patient's biological, psychological, spiritual, cultural, linguistic and socio-economic needs. The patient's psychiatrist coordinates the patient's

care and ensures there is a well-defined plan in place that may include the following 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

Recovery Model

The recovery model practice is a consumer-based treatment model with the cornerstone of hope and respect for those receiving services. It empowers the consumer to exercise their choice in treatment and explore new aspects of their lives. The consumer is strengthened to create new opportunities to be successful in accomplishing their goals. The consumer is able to involve friends and family as they become reconnected to support systems and to the community.

Recovery Model Services

Our mission is to change our focus as well as the nature of the services we provide to our patients/consumers. Arizona State Hospital has taken on the task of introducing this new culture for both our employees and consumers. All services and treatment are consumer and family-centered. We seek to offer our consumers meaningful choices and treatment options. Secondly, recovery principles focus on the consumer's ability to be successful in coping with life's challenges. Therefore, a goal is to change old thoughts and build resiliency as the consumer engages in the process of recovery.

When new employees are hired by the hospital, they are oriented to the recovery model culture and mission during the first week on the job in New Employee Orientation. The hospital CEO initiates this message with other key clinical staff highlighting how the principles are put into practice at the Arizona State Hospital.

The following are essential components of the recovery model at Arizona State Hospital:

Clinical Care: to provide mental health services which promote and enhance the recovery processes;
Family Support: to work with family as defined by each patient/consumer to enhance recovery;
Peer Support and Relationships: to grow with those around and who care and understand;

Work and Meaningful Activities: to provide both economic and self-esteem benefits;
Power and Control: to employ personal decision making to enhance recovery;
Destigmatization: to decrease the negative stereotypes associated with mental illness;
Community Involvement: to enhance social integration and affiliation;
Access to Resources: to increase the ability to use products and services to promote recovery; and
Education: to use formal education to promote growth and change.

Dialectical Behavior Therapy (DBT)

The DBT Program at Arizona State Hospital creates a context of validating rather than blaming the patient. Within that context it works to block or extinguish maladaptive behaviors, teach more acceptable behaviors to patients, as well as making the new behaviors so reinforcing that patients continue the new ones and stop the maladaptive ones (adapted from a quote by Marsha Linehan, PhD).

Arizona State Hospital's dialectical behavior therapy programs are operated on units that treat individuals diagnosed with thought, mood, and personality disorders. Eventually, DBT programs will be available (within 2-3 years) on all units that treat patients diagnosed with borderline personality disorder (BPD) or who have a primary problem with emotion regulation as well as the cognitive abilities necessary to benefit from the approach.

Current members of the Core Consultation Team (CCT) at Arizona State Hospital provide the individual DBT therapy component. As more individual therapists are added, a separate program component to train individual therapists will be developed.

Skills training sessions are conducted by two trainers. One trainer is a member of the CCT and the other is a staff member from the unit. We provide two classes per week, at a minimum. A complete cycle of all four skills modules takes approximately eight months to complete. Patients who are specifically prescribed DBT are encouraged to complete the cycle twice if they remain at the hospital.

Many trained staff are available around the clock to coach the use of the skills. Individual therapists are also available for this coaching. We are continually exploring ways to best teach staff all of the skills as well as important strategies and concepts with respect to effective coaching (e.g., effective coaching, validation, commitment strategies, and principles of reinforcement.)

Weekly, consultation meetings are held on each unit for individuals who are providing coaching, skills training, and/or individual therapy. We have developed a list of topics to study during the first half of each meeting followed by case consultation.

The overall targets of our DBT program follow Charles Swensen's, the psychiatrist who developed the inpatient DBT program protocol, suggestions for inpatient targets. The targets for inpatient DBT use the acronym, "CAMP":

- Re-establish behavioral **C**ontrol;
- **A**nalyze and address the variables prompting dangerous behaviors and continued hospitalization;
- **M**aster skills needed to reduce and manage stress; and
- **P**lan for post-discharge situation with optimum stability.

The Hospital's DBT team provides training, coordination, and consultation on this approach to additional providers around the state. To date, approximately fifty Regional Behavioral Health Authority (RBHA) employees statewide have attended the 15-hour DBT overview training. Additionally, the hospital's DBT program manager chairs the DBT Task Force, a semi-annual teleconference to discuss and coordinate services statewide.

Social Services Program

Social workers provide individualized treatment to patients in many ways. They utilize both individual sessions and groups. Weekly, during 30-minute individual sessions, social workers address specific issues that resulted in the patient's admission and/or issues that are preventing the patient's progression towards discharge. Monthly, they coordinate a staffing for each patient, and invite community members and family members to participate. During these staffings, each patient has an opportunity to discuss their treatment with the entire interdisciplinary team as well as with their outpatient case managers. In addition, the social workers provide a variety of groups that are tailored to the individual patient's needs and goals.

Social workers are also an important point of contact. Specifically, they serve as the primary contact for questions or concerns the RBHA or family may have about the patient's treatment/progress/status. They provide education for the patient and their family members/significant others. For instance, each patient's specific and unique discharge needs are assessed and education is provided regarding community resources with the goal of ensuring a successful re-integration. Through ongoing contact with community providers, they cultivate collaborative relationships with the goal of ensuring that continuity of care is provided upon discharge.

Once a patient's discharge date is set, the social worker initiates the process for a discharge preparation review. During this review, the treatment team meets with the patient and reviews the psychiatric, medical, nursing, social work and rehab sections of the discharge data sheet.

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; 53 BEDS) Consists of two treatment units providing pre-trial evaluation, treatment and restoration to competency to stand trial. Within this program Guilty Except Insane-75 Day Evaluation (non-violent crimes) is also completed (7 BEDS).
    - **POST-TRIAL FORENSIC PROGRAM** Consists of three 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 a PSRB-approved Conditional Release Plan for transitioning into the community and for those working toward application for Conditional Release.
3. **ADOLESCENT TREATMENT PROGRAM:** (ATU; 16 BEDS) Consists of a 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.
4. **MEDICAL BED:** (1 BED) Consists of a bed utilized for infection control purposes.

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.

On or before August 1 of each year, the Deputy Director and the Hospital collect 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 2006, the funded capacity and allocation of the hospitals' beds was as follows:

- **Civil Adult (41% of capacity) 141 Beds**
- **Forensic Adult (54% of capacity) 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**

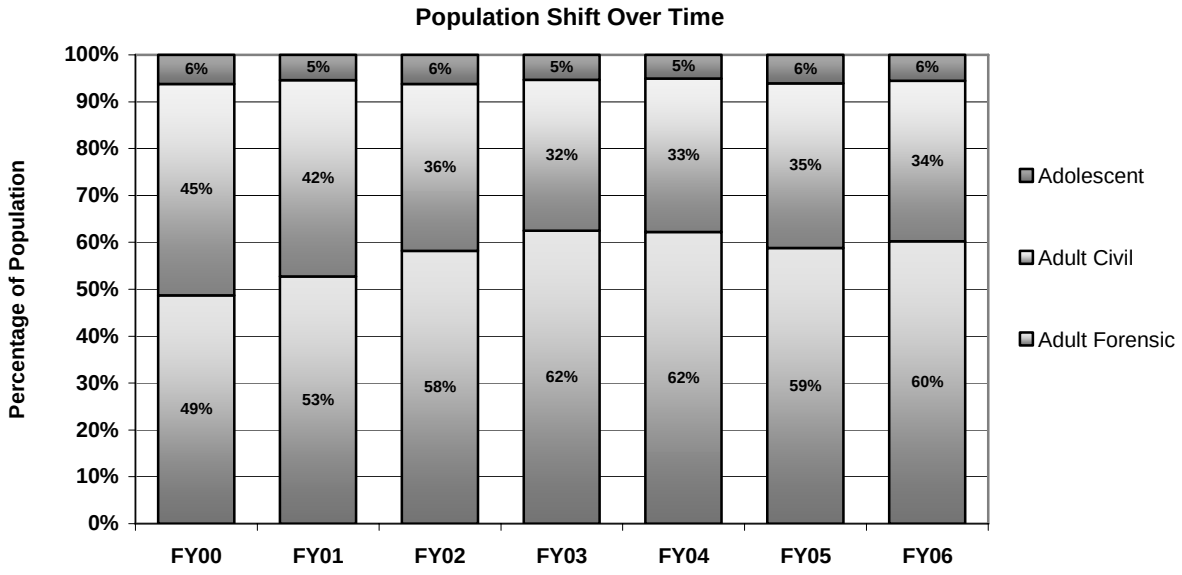
TOTAL BEDS FY 2006: 338 Beds

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 implemented a wait list for the first time for the Adolescent and Pre-Trial Forensic Restoration to Competency Programs. From 11 in October 2002, the number of persons on the RTC Wait List grew to 121 during FY 2003. Since then, the census has been managed without a wait list.

Population Shift

Since FY 2000, the hospital has experienced an overall population shift and now serves more forensic than civil patients.

Exhibit 1



End of Month Census

The Hospital began FY 2006 with a patient census of 254 and ended the fiscal year on June 30th with a census of 263, an increase of 9 patients or 3.5%. During the year, 275 patients were admitted and 268 patients were discharged. The average daily census for the fiscal year was 246 patients. These patients accounted for a total of 89,827 patient days*, a decrease of 8,361 days compared to FY 2005. The patient end of month census from FY 2004 through FY 2006 is depicted in Exhibits 2A and 2B below.

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 2A

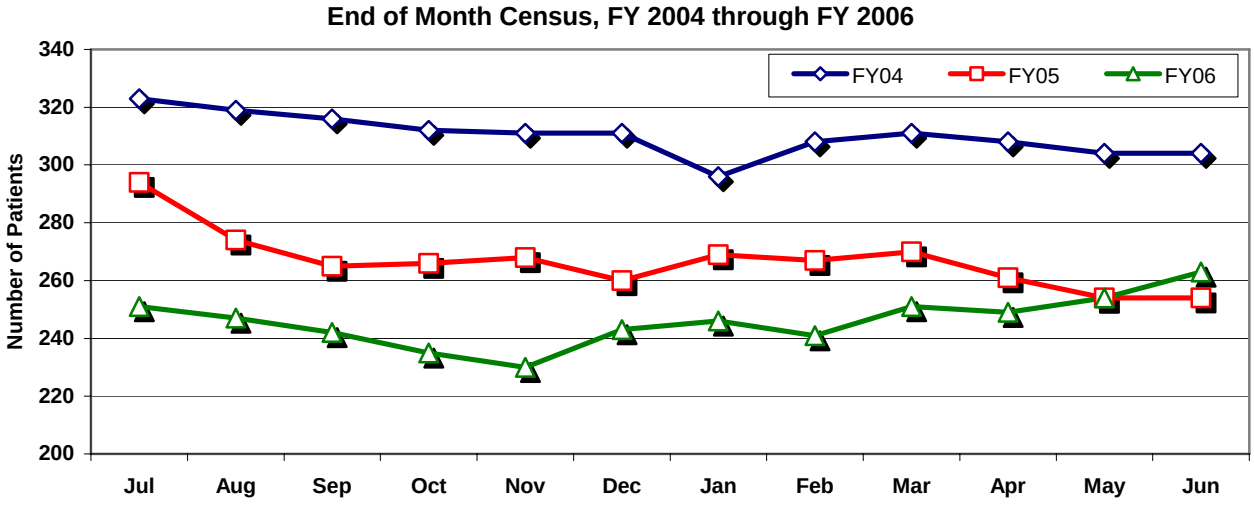


Exhibit 2B

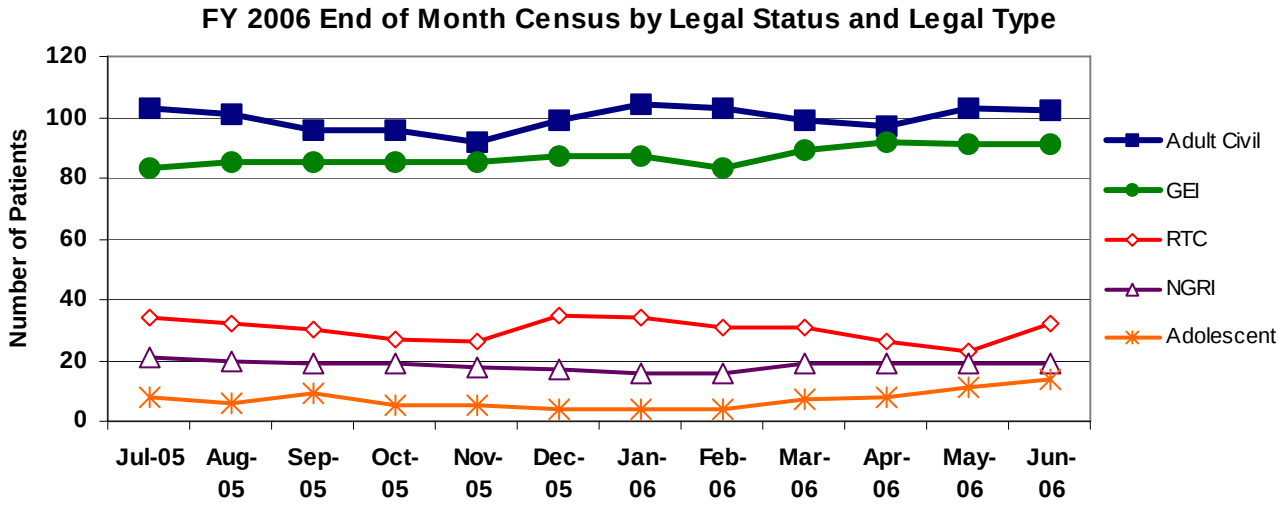
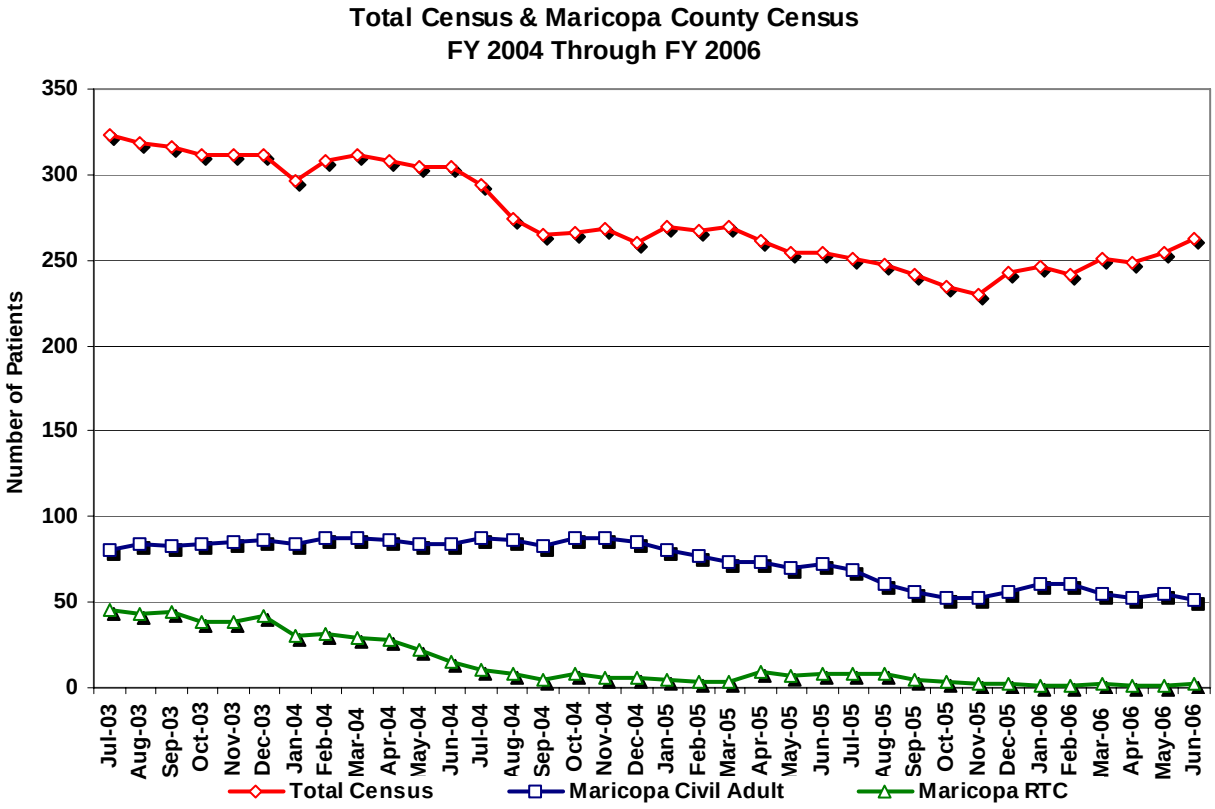


Exhibit 2C



The decrease in the census from FY 2004 to FY 2006 is due primarily to the reduction in Maricopa County Restoration to Competency referrals and the discharges of civil adult patients in Maricopa County to meet the Arnold vs. Sarn maximum capacity of 55 patients.

ADMISSIONS AND DISCHARGES

Admission Statistics

In FY 2006, the Hospital admitted 275 patients. The average monthly admission rate was 23 patients, an 8% decrease from the FY 2005 average monthly admission rate of 25 patients. During FY 2006, the admissions ranged from a low of 11 admissions in February 2006 to a high of 34 admissions in May 2006. Of the 275 patients admitted during this fiscal year, 246 or 89% were adults and 29 or 11% were adolescents.

During FY 2006, 209 or 76% of all admissions were first-time admissions. Admissions by diagnostic grouping indicated that patients diagnosed with schizophrenic disorders accounted for 29% (n=80) of all admissions during FY 2006, a 0.4% increase from FY2005. In addition, patients diagnosed with affective psychoses (24%) and other non-organic psychoses (11%) comprise the major diagnostic groupings for patient admissions to the Hospital.

Discharge Statistics

In FY 2006, the Hospital discharged 268 patients. The average monthly discharge rate was 22.3 patients, a 23% decrease from the FY 2005 average monthly discharge rate of 29 patients. During FY 2006, the discharges ranged from a low of 16 discharges in February 2006 to a high of 30 discharges in September 2005. Of the 268 patients discharged during this fiscal year, 245 or 91% were adults and 23 or 9% were adolescents.

The number of non-forensic patients discharged during FY 2006 with a length of stay less than 365 days was 52 or 58%, which is 2% lower than FY 2005. 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 philosophy that non-forensic patients be admitted to the hospital for intensive treatments of shorter durations rather than extended hospitalization.

During FY 2006, 27 patients were discharged with a length of stay of greater than three years including 10 patients hospitalized for over seven years, and 3 patients hospitalized for over twenty years. These patients require extensive treatment and discharge planning coordination between the hospital and the community providers, who will provide follow-up services.

Exhibit 3

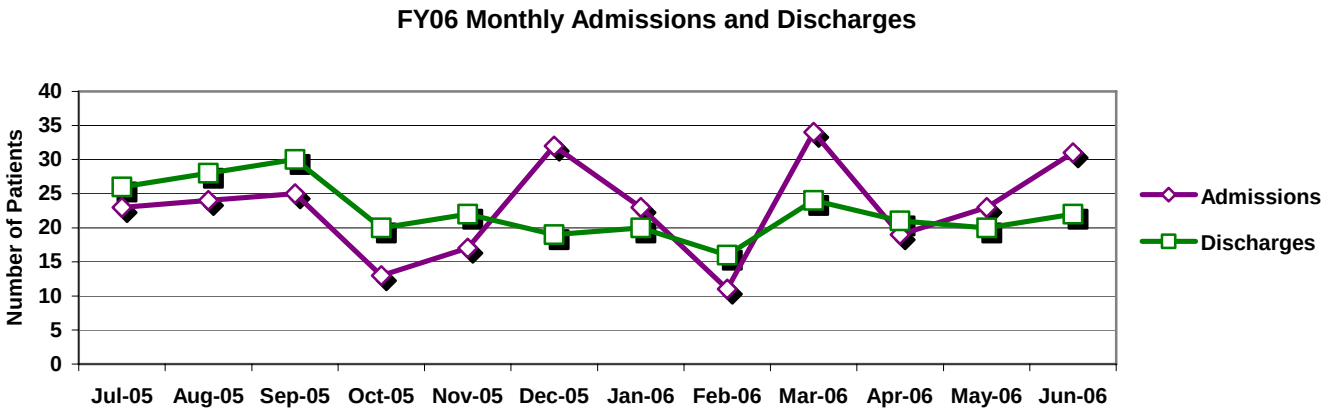


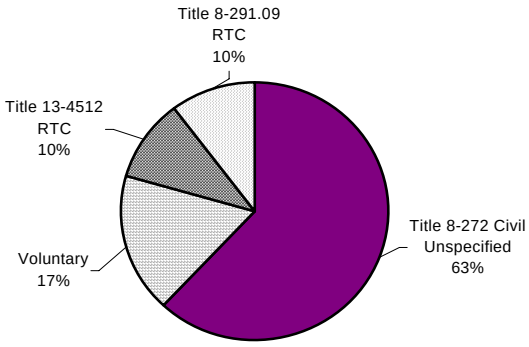
Exhibit 4

SUMMARY OF ADMISSIONS AND DISCHARGES FY 2006		
	Total Admissions	**Total Discharges**
Adolescents:		
Forensic	6	5
Civil	23	18
Subtotal	**29**	**23**
Adult:		
Forensic	191	173
Civil	55	72
Subtotal	**246**	**245**
Total for FY 2006	**275**	**268**

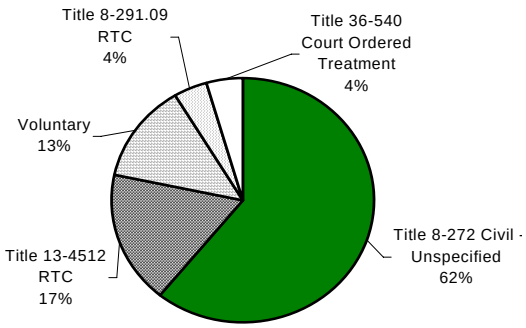
ARIZONA STATE HOSPITAL – STATE FISCAL YEAR 2006
ADMISSION AND DISCHARGE STATISTICS

Exhibit 5

Adolescent Admissions



Adolescent Discharges

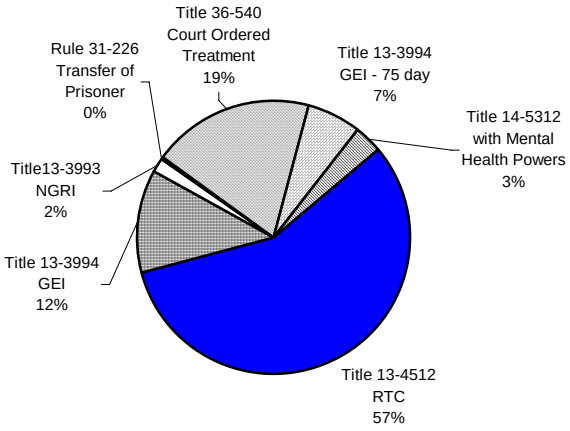


Admission Legal Status	
Title 13-4512 RTC	3
Title 36-540 Court Ordered Treatment	0
Title 8-272 Civil - Unspecified	18
Title 8-291.09 RTC	3
Voluntary	5
Total	**29**

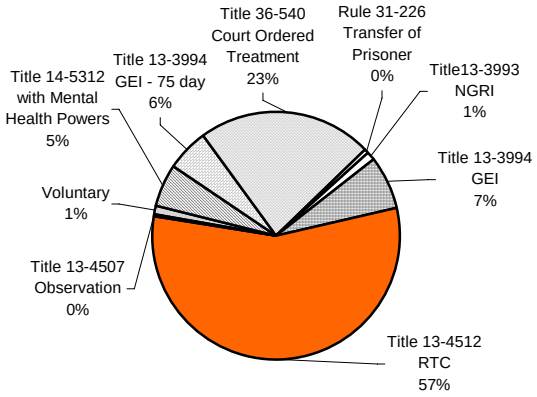
Discharge Legal Status		Average LOS
Title 13-4512 RTC	4	100.8
Title 36-540 Court Ordered Treatment	1	245.0
Title 8-272 Civil - Unspecified	14	64.6
Title 8-291.09 RTC	1	65.0
Voluntary	3	73.7
Total	**23**	**80.6**

Exhibit 5 Continued

Adult Admissions



Adult Discharges



Admission Legal Status	
Rule 31-226 Transfer of Prisoner	1
Title 13-3994 GEI	30
Title 13-3994 GEI - 75 day	16
Title 13-4507 Observation	0
Title 13-4512 RTC	140
Title 13-3993 NGRI	4
Title 14-5312 with Mental Health Powers	8
Title 36-540 Court Ordered Treatment	47
Voluntary	0
Total	**246**

Discharge Legal Status		Average LOS
Rule 31-226 Transfer of Prisoner	1	47.0
Title 13-3994 GEI	17	1565.2
Title 13-3994 GEI - 75 day	14	52.6
Title 13-4507 Observation	1	694.0
Title 13-4512 RTC	137	78.0
Title 13-3993 NGRI	3	254.7
Title 14-5312 with Mental Health Powers	13	1483.7
Title 36-540 Court Ordered Treatment	56	1019.8
Voluntary	3	824.3
Total	**245**	**448.9**

Admission by County

Pima County had the highest number of admissions during FY 2006 with 94 patients or 34% of all statewide admissions. This was a 10% decrease from FY 2005. Maricopa County accounted for 20% of the admissions, a decrease of 37% from FY 2005. The remaining thirteen counties accounted for 125 or 46% of the state admissions.

Discharge by County

Maricopa County had the highest number of discharges during FY 2006 with 81 patients or 30% of all statewide discharges. This was a 39% decrease from FY 2005. Pima County accounted for 79 or 30% of the discharges, a decrease of 35% from FY 2005. The remaining thirteen counties accounted for 108 or 40% of the state discharges.

Exhibit 6

Admissions and Discharges by County FY 2006

County of Admission	Admissions	Percentage		Discharges	Percentage
Pima	**94**	34.2%		79	29.6%
Maricopa	56	20.4%		**81**	30.3%
Pinal	41	14.9%		38	14.2%
Yavapai	27	9.8%		20	7.5%
Mohave	12	4.4%		8	3.0%
Coconino	11	4.0%		14	5.2%
Yuma	11	4.0%		8	3.0%
Cochise	10	3.6%		7	2.6%
Gila	5	1.7%		6	2.2%
Santa Cruz	3	1.0%		1	0.4%
Apache	2	0.7%		1	0.4%
Graham	1	0.4%		3	1.2%
La Paz	1	0.4%		1	0.4%
Navajo	1	0.4%		1	0.4%
Greenlee	0	0.0%		0	0.0%
Total for FY 2006	**275**	**100.0%**		**268**	**100.00%**

Exhibit 7

Placement of Patients Discharged during FY 2006

Living Arrangements after Discharge	Adult	Adolescent	Total	Overall %
Correctional Facility	142	15	157	58.7%
Group Home	48	3	51	19%
RTC 24-hour (not PHF)	16	0	16	6%
Family	12	2	14	5.2%
Nursing Home	7	0	7	2.6%
Independent Living	4	0	4	1.5%
Licensed Supervisory Care	3	0	3	1.1%
Non Psych Hospital/Ward	3	0	3	1.1%
Other	4	2	6	1.1%
Psych Health Facility	2	0	2	0.7%
Residential SAP/SMI-Dual Diagnosis	2	0	2	0.7%
Foster Home	0	1	1	0.4%
None	1	0	1	0.4%
RTC Semi-Supervised (not PHF)	1	0	1	0.4%
AWOL	0	0	0	0%
Sponsored Based Housing	0	0	0	0%
Total	**245**	**23**	**268**	**100.0%**

Exhibit 8

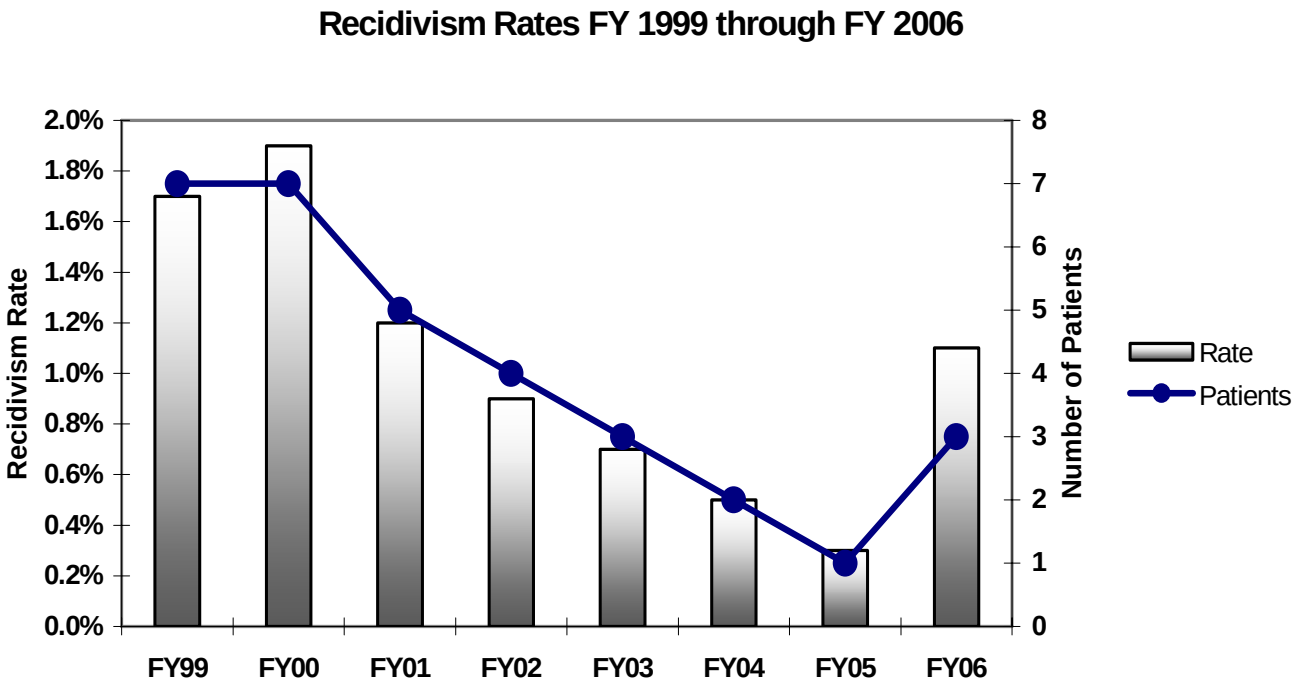
Discharge Length of Stay FY 2006

Length of Stay	Non-Forensic		Forensic		Total	
	Patients	%	Patients	%	Patients	%
0-6 Months	31	11.6%	156	58.2%	187	69.8%
6 Months - 1 Year	21	7.8%	7	2.6%	28	10.4%
1 - 2 Years	13	4.9%	2	0.7%	15	5.6%
2 - 3 Years	9	3.4%	2	0.7%	11	4.1%
3 - 5 Years	6	2.2%	6	2.2%	12	4.5%
5 - 7 Years	0	0%	2	0.7%	2	0.7%
7 - 10 Years	5	1.9%	1	0.4%	6	2.3%
10 - 15 Years	2	0.7%	2	0.7%	4	1.5%
15 - 20 Years	0	0%	0	0%	0	0%
20+ Years	3	1.1%	0	0%	3	1.1%
Total	**90**	**33.6%**	**178**	**66.4%**	**268**	**100.0%**

Recidivism

Recidivism is defined as the readmission of a patient within 30 days from their previous discharge date. The FY 2006 overall recidivism rate was 1.1% (n=3) of the 268 discharges for the year. Recidivism rates for prior fiscal years vary from a low of 0.3% in FY 2005 to a high of 1.9% in FY 2000. In total, there were 21 readmissions during FY 2006 with an average community stay of 123 days before the subsequent readmission to the hospital.

Exhibit 9



ARIZONA STATE HOSPITAL – EMPLOYMENT AND PERSONNEL

EMPLOYMENT STATISTICS

Current Number Employed

The Hospital is authorized 690.7 full time equivalent (FTE) positions. There is a continuous review of these positions to ensure that direct care is maximized, while having the administrative and managerial staff in place to ensure efficient operations. The continuous review involves job description creation, modification, and abolishment.

The following table summarizes the major categories of positions filled at fiscal year end and the number terminating and retiring during the fiscal year:

Classification	Number Filled	Number Terminated
Psychiatrist	11	1
Psychologist	5	1
Social Worker	12	5
Health Planning Consultants (Treatment Plan Coordinators)	8	1
Licensed Practical Nurse	12	4
Psychiatric Nurse II	68	22
Psychiatric Nurse Shift Supervisor	20	8
Psychiatric Nurse Unit Manager and Psychiatric Nurse Coordinator	12	1
Mental Health Program Specialists	175	61
Recreation Therapists	23	5
Occupational Therapists	4	0
Therapy Technicians	8	1
Security Officers	67	29
Managerial Staff	57	7
Administrative Support	90	17
Total	**572**	**157**

Turnover

Hospitals have a difficult time retaining staff, particularly those with critical and needed skills. The State Hospital is no exception, particularly with critical shortages in classes like registered nurses. Additional circumstances at the State Hospital which create retention difficulties are within the nature of our patient population. Our patients tend to be very psychiatrically ill with behaviors that create management challenges for staff. These behaviors sometimes include threats of harm and occasionally aggressive assaults on staff. To recruit staff in a tight market, the hospital has taken these steps:

- Instituted a recruitment and referral bonus. The recruitment bonus provides three payments to a direct care RN for a total of $4,000. The referral bonus

provides a department employee $300 for assistance in recruitment of the RN. Certain exclusions are in place to avoid abuse.

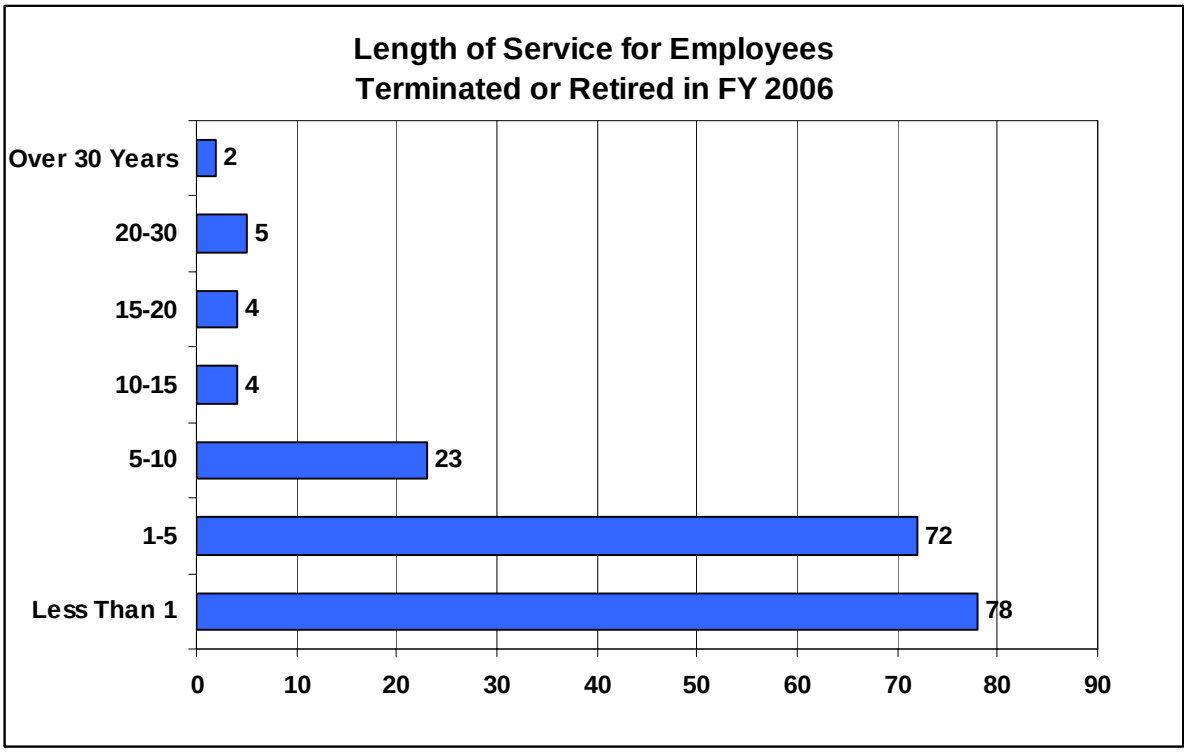
- Expanded the tools available to recruiters beyond typical newspaper advertisements, the state's azstatejobs.gov web site, and job fairs; including internet based sites specific to the recruited occupations and accompanying trade publications, and industry management association web sites.
- Increased pay for direct care positions with a special appropriation to greatly improve recruitment and retention efforts.

Direct care RNs are a vital position for the hospital. There are continuous efforts to recruit and retain direct care RNs. The following table reflects the vacancy percentages of psychiatric nurses and psychiatric nurse shift supervisors.

FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Estimate *
31%	30%	31%	16%

: With the special appropriation and recruitment bonuses, the RN vacancy decreased to 16% in the first quarter of FY 2007 and should continue at this rate.

There are many reasons why employees leave the hospital and many are understandable such as promotion and disability. The chart below illustrates terminations and retirements based upon length of service.



ARIZONA STATE HOSPITAL - CONDITION OF EXISTING BUILDINGS AND EQUIPMENT

The new **Civil Hospital** was opened in January 2003 and represents 26% of the Arizona State Hospital campus. The remaining buildings represent 74% of the campus and can be divided into two categories: needs maintenance and major repair (48%) or needs renovation (26%).

The new **Civil Hospital** buildings are beginning to show indications of construction settlement with cracks in the floor, walls and roofs caused by the floating concrete slabs and foundation settlement. This requires a great amount of time and considerable maintenance budget to repair. The building movement has created roof cracks at the plastic membrane resulting in roof leaks every time it rains damaging the walls, ceiling tiles, and at times, furniture and equipment. Although the roof is still under a 10 year warranty, the manufacturer is at times slow to respond to repair needs.

The **Old Forensic** portion of the hospital was built in the 1950's. It was designed to care for a geriatric mental population. Over the years some of the wings have been partially renovated into a medium security forensic unit to treat Restoration to Competence (RTC) patients, Guilty Except Insane (GEI) patients, and the Not Guilty by Reason of Insanity (NGRI) patients. The buildings are deteriorating rapidly due to their age and the types of materials used in the 50's for construction. The majority of the galvanized water piping is corroded and leaks throughout the buildings. In addition, the roof leaks whenever a rainstorm occurs, the walls are cracking, the electrical systems are aged and the air conditioning system is obsolete making it impossible to find replacement parts.

The Hospital received $3.1 million in 2004 for capital improvement projects. This will extend the life expectancy of some of the buildings and has helped with the overall campus energy consumption. Although these improvements have a positive effect on individual buildings, the deteriorated condition of the other buildings is endangering patients and personnel. Some examples of urgent buildings issues are as follows:

A temporary **Modular Building** which housed the psychology personnel sank into the ground and was on the verge of collapsing. An emergency evacuation of the staff was necessary to avoid a dangerous situation. The personnel were moved into old forensic unit room until a building could be renovated to make a permanent work space. After careful consideration and analysis of all available space the **Old Commissary** was the only structure that required the least amount of work to bring it up to occupancy standards and give a safe work environment to the staff. The old commissary is currently under reconstruction to replace offices for the personnel who were displaced due to the sinking of the modular structure.

The Van Buren entrance **Guard Shack** is in disrepair. The structure is failing, portions of the walls are rotten and falling apart. The building needs a new electrical system, a new data communication system, replacement of the remote controls, a new floor, new windows and thermal insulation.

The lower level of **Granada** building is practically obsolete because of the deteriorated condition of the building and the lack of compliance with state and federal codes.

The **General Services** building needs additional renovations to be in compliance with ADA federal regulations. Also, repairs to the interior, hallways, restrooms, doors, ramps, and door handles are needed.

The **Paint Garage Shop** is in need of attention. The wood structure needs to be fire proofed, the restrooms must comply with the ADA federal regulations, ventilation and air conditioning needs to be added, fire sprinkler coverage is necessary and a new sand and oil trap is required.

The **Engineering – Housekeeping** building needs a new roof, ADA compliant restrooms, a fire sprinkler, new fire alarms, and a new electrical system.

The **Laundry** building is no longer utilized as a laundry but it is used as a warehouse for hospital materials and housing some program materials. The building needs a new roof, ACM abatement, piping, electrical, lighting and air conditioning.

The **Warehouse** is in need of renovation to comply with the ADA federal regulations. In addition the warehouse needs emergency lighting, loading dock repairs, roof eaves, new evaporative coolers, and smoke detectors.

The **Old Main Administration Building** is an abandoned building with historical value, however, it is a potential for problems. The floors are unstable and ready to collapse. The foundation and walls need seismic reinforcement/bracing. In addition, the entire interior needs to be renovated to meet current regulations and ADA requirements.

Recently, the air handler and cooling system were replaced at the **Dietary** building. This will help with energy conservation efforts in the coming years. Other building systems are in need of repair. The sewer lines are collapsing, the seismic system needs to be updated.

The **Chapel for Multiple Faiths** was built in 1963 and is in fairly good condition. The outside of the Chapel was recently patched, repaired and painted to prevent further deterioration of the stucco walls. The air conditioning units for the main assembly area and the Chaplin's office were replaced. The interior is currently being updated with new carpeting, paint and window coverings. The only deficiency is a large break in the concrete due to floor settlement on the main chapel floor. This deficiency within time will create a tripping hazard requiring a new floor or substantial repair.

Other Campus Deficiencies

The Hospital is in need of an updated **lock-key security system** with good key control. The existing key system has been in place for decades and it is easy for an unauthorized person to open a lock when they have access to the right keys. As a special hospital we are vulnerable to unauthorized entry by unwanted guests and/or unauthorized exit by patients.

The **Fire Alarm system** is old and needs to be replaced in order to provide reliable, safe and adequate fire protection to the hospital patients and staff.

The **CTV video surveillance** cameras are not compatible. Over the years, three different proprietary systems have been installed. This reduces the capabilities of a campus-wide surveillance system with an open architecture.

The Hospital's **cooling and heating** 4-pipe system is in need of additional upgrades. The capital construction money aided the hospital in replacing the steam boilers at the power plant but other equipment such as the condensate return holding tank and the hot water supply tank needs replacement. The heat and plate exchanger needs to be upgraded to utilize the cooling towers to full capacity. The existing unit is not large enough to serve the entire campus as it was designed to service only the forensic side of the campus.

Some of the campus time clocks are based on **atomic time clocks** that need to be synchronized from a single source. A campus wide time control system is needed to be integrated with a campus wide broadcast system. Most of the campus speakers are humming, noisy, and broken.

The hospital also lacks a hospital-wide **public address system** and the necessary radio controlled devices in order to respond in an emergency.

Avatar Implementation Assessment

AVATAR is the hospital's electronic medical record that has been at the facility for approximately six years. There are many functions of the product that are not being utilized and new functionality has been developed by the vendor. June 2006 saw a new addition to the hospital team with the addition of a full-time project manager dedicated to the information technology needs of the hospital. One of the goals is to ensure that Avatar is being used to its full potential. Progress has already been made toward this goal. New functionality has been implemented and we are configuring other enhancements to the system. We have upgraded our system from RAD 6.2 to RADplus 2004. This change unified the user interface and added new development tools that can be used to tailor the system and better meet the needs of the hospital staff. In addition, we are setting up Incident Tracking, Group Scheduling and Group Notes as well as exploring options for the implementation of a physician's order entry system. Lastly, we are integrating Microsoft Access applications into Avatar thus bringing more patient data into the Central Patient Data Repository. These upgrades will allow the hospital to complete the transition of our staff from pencil and paper to a true electronic medical record.

Computer Connectivity and Related Issues

The servers used for Avatar are old and past their life expectancy. The recent upgrade to RADplus 2004 emphasized the need to replace them. In addition, the hospital needs an environment where our RAD developers can build new functionality without the fear

of impacting the production system. This year, we are implementing a hardware configuration change to address these needs. Two new servers are being purchased to replace the current Avatar servers. One of the current servers will be used to provide a platform for the new middleware that runs between the client computer and the Avatar server while the other will become our development server. Additionally, we are looking into implementing wireless access at the State Hospital.

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. This year, the hospital is exploring our options including in-house development and vendor packages. We have initiated vendor contact and are in the process of evaluation and review of the options available to us.

'06 LEGISLATIVE CHANGES IMPACTING THE ARIZONA STATE HOSPITAL

Direct Care Staff Salary Increases

The hospital received funding during the FY 06 legislative session to provide essential salary increases for direct care staff. In a very short time period, these increases have improved the hospital's ability to deal with significant recruitment and retention problems and the high turnover and vacancy rates which made it difficult to meet the needs of the patients and to meet national/state regulatory standards. The increases have significantly improved the ability of the hospital to remain competitive with other state agencies and the private sector.

Bed Capacity Wait List Law Made Permanent

The session law that allowed the hospital to implement a wait list after the funded capacity was reached in the forensic, adolescent and civil treatment programs was made permanent in statute during this past legislative session. Wait lists are a critical census management tool that allows an orderly admission process to the hospital without exceeding licensed capacity jeopardizing our accreditation and Medicare reimbursement status. Wait lists help keep the hospital in compliance with both federal and state regulatory standards and allow the hospital to provide a safe and secure environment for all patients.

Changes to Restoration to Competency Program Funding

The session law requiring rural counties to pay 50% of the RTC costs and Maricopa, and Pima County as well as all cities and towns to pay 86% was changed during the '06 legislative session. As of 7/1/06, rural counties are no longer charged for RTC services. This may result in a significant increase in referrals to the hospital for RTC services.

RECOMMENDATIONS FOR IMPROVEMENTS

Funding for a New Forensic Hospital Is Needed

The state budget crisis in 2002 resulted in the final phases of funding ($10.5 million) being withdrawn for the renovation of the Forensic Hospital. Today, due to inflation, the costs to complete this project have risen to over $37 million dollars.

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 are aged and in need of repair. The plumbing is of galvanized steel with major leaks and repairs are needed. The piping needs to be totally replaced with new copper piping. 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 include new piping nor did it 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. This will provide a safe and secure environment for forensic hospital patients.

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. This 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 with little protection due to the condition of the current Gatehouse. This would ensure the safety of security personnel as well as improve the appearance of the entrance to the hospital.

Restoration to Competency and Institution of Mental Diseases (IMD) Revenue Losses

With a change in legislation as of 7/1/06, the Arizona State Hospital will no longer be able to bill for RTC services to any county with a population of less than 800,000. This change in financial reimbursement from these smaller counties will likely result in an increase in the number of patients sent to Arizona State Hospital for RTC Services. To manage this increase in utilization it is anticipated that the hospital will need to open another RTC unit to handle the higher census. Funding to open another unit will be needed.

The Arizona State Hospital will be losing its Institution of Mental Disease (IMD) waiver as of 9/30/07, which currently allows billing of Title 19 services for the general adult (21-64 years of age) population. Under this Federal waiver the hospital is currently allowed to bill, for the first 30 days of services, those patients with Title 19 coverage. These monies are deposited into the State Hospital Fund, which was established to supplement the hospital's operating funds. Due to the phasing out of this waiver, the hospital will only be able to bill 50% of the current rate as of 10/1/07. This will result in a loss of revenue which will need to be replaced.

Utility Cost Increases

The cost of utilities (water, gas, and electric) at the Arizona State Hospital has increased by an average of over 7% per year over the past five years. The increases have been covered in prior years by using vacancy savings monies particularly in the nursing area. In fiscal year 2007, the hospital received monies to fund pay raises for direct care staff allowing salaries to be more competitive. It is anticipated that the vacancy rate at the hospital will significantly decrease, eliminating the funding source for increased utility costs.

Hepatitis C Funding

Hepatitis C viral infection is now at 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 a few Hepatitis C positive patients.

Electronic Medical Record

The State Hospital provides patient care 24 hours a day, 7 days a week and is currently operating on a partial electronic medical record. In order to comply with the Governor's Executive order 2005-25 for implementation of a full electronic medical record by 2010, additional resources are needed. An electronic medical record will allow clinicians to record and have access to patient assessments, progress notes, treatment plans, lab reports, medications, etc. in an automated system. Secure access to system data in a 24-hour, 7 day a week operational environment, cannot be assured without adequate resources, including technical support staff.

This integrated electronic medical record ideally would include clinical assessments and documentation by all disciplines, treatment plans, laboratory results and pharmacy. Today, staff continues to use the hard-copy medical record to review important patient information such as lab reports, medication orders, or other significant documents.

Security Officer Compensation

The Arizona State Hospital faces increased difficulty in staffing the hospital with an adequate number of security officers to ensure that patients have active treatment in a therapeutic, safe, and secure environment. The current vacancy rate for security officers is 7.3% and the turnover rate is 42%. The ability to recruit and retain qualified security officers is severely hampered because potential employees are attracted to higher-wage comparable positions at other state facilities. Salary increases are necessary to remain competitive with other state agencies and the private sector.

Guilty Except Insane, Statutory Change Needed

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)

Arizona law does not provide the ability for the Hospital to discharge a dangerous person no longer suffering from mental illness from the Hospital to an alternative setting. These patients pose a significant threat to the safety of vulnerable patients and staff. Furthermore the cost to house and care for residents no longer needing the services of the psychiatric hospital is substantial when compared to the cost of most alternative settings. Other states such as Oregon have adopted laws that allow for a "dual commitment" of dangerous person from psychiatric hospitals to alternative settings when intensive behavioral health treatment is no longer necessary. A fourth option could allow the PSRB to refer persons no longer mentally ill, but still dangerous to the Arizona Superior Court for an alternative disposition such as community supervision or completion of the presumptive sentence in a correctional facility.

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 these individuals. 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 length of stay for GEI patients was over 1000 days this past fiscal year, versus 180 - 270 days for civil patients. These patients are here much longer and the trend appears to be rising. Keeping people confined at the hospital who do not require our services at an average cost of $435 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
STATE FISCAL YEAR 2006

Funding Sources (General Operations Based on Budget Allocations): *	
Personal Services and Related Benefits - General Fund	$32,219,385
All Other Operating - General Fund/AZ State Hosp Fund	$13,089,448
Corrective Action Plan - AZ State Hosp Fund	$3,564,600
Non-Title 36 Revenue	$0
Rental Income	$526,362
Endowment Earnings	$350,000
Patient Benefit Fund	$35,000
Donations	$10,000
Psychotropic Medications	$63,500
Community Placement - General Fund	$5,574,100
Community Placement - AZ State Hosp Fund	$1,130,700
Total Funding	**$56,563,095**
Expenditures: *	
Personal Services and Related Benefits	$32,210,923
Professional and Outside Services **	$7,518,074
Travel (In-State)	$59,426
Travel (Out-of-State)	$4,954
Food	$0
Other Operating	$5,509,598
Capital Equipment	$296,260
Assistance to Others	$6,704,800
Total Cost of Operations	**$52,304,035**
Collections :	
Patient Care Collections to General Fund	$1,024,034
Patient Care Collections to AZ State Hosp Fund - RTC	$4,115,538
Patient Care Collections to AZ State Hosp Fund - Title XIX	$1,110,792
Non-Patient Care Collection to General Fund	$1,859
Total Collections	**$6,252,223**

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

Daily Costs by Treatment Program: ****	
Specialty Rehabilitation	$547
Adolescent Treatment	$981
Psychosocial Rehabilitation	$488
Forensic - Restoration to Competency	$532
Forensic Rehabilitation	$435
Average	$506

******** Rates became effective 7/01/05