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

RECEIVED
JAN 04 2008
OFFICE OF THE PRESIDENT

ANNUAL REPORT
FISCAL YEAR 2007

Janet Napolitano, Governor

Susan Gerard, Director
Arizona Department of Health Services

Eddy D. Broadway, Deputy Director
Arizona Department of Health Services
Division of Behavioral Health Services

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

Published By:
Arizona Department of Health Services
Division of Behavioral Health Services
150 North 18th Avenue, Suite 200
Phoenix Arizona 85007
(602) 364-4558
Permission to quote from or reproduce materials from this publication is granted when due acknowledgement is made.

~Leadership for a Healthy Arizona~

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH

TABLE OF CONTENTS

ADHS/DBHS

INTRODUCTION 3

OVERVIEW OF THE DIVISION OF BEHAVIORAL HEALTH SERVICES 3

PROGRAM HIGHLIGHTS 5

ADHS/DBHS FINANCIAL REPORT 8

THE ARIZONA STATE HOSPITAL

DESCRIPTION OF THE ARIZONA STATE HOSPITAL 12

PATIENTS SERVED AT THE ARIZONA STATE HOSPITAL 19

ARIZONA STATE HOSPITAL – EXISTING BUILDINGS & EQUIPMENT CONDITIONS 33

ARIZONA STATE HOSPITAL FINANCIAL SUMMARY 38

ARIZONA STATE HOSPITAL ORGANIZATIONAL CHART 39

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH

INTRODUCTION

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) submits the following financial and programmatic Annual Report for fiscal year 2007, in compliance with Arizona Revised Statute §36-3405(a)(b) and (c). The report provides an overview of the behavioral health system; highlights ADHS/DBHS' key initiatives and accomplishments; identifies the number of clients served by Geographic Service Area (GSA), funding category and program; and includes programmatic financial reports of revenues, expenditures and administrative costs.

OVERVIEW OF THE DIVISION OF BEHAVIORAL HEALTH SERVICES

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) is charged with the responsibility of overseeing publicly funded behavioral health services.

The State of Arizona's behavioral health delivery system is divided into six geographic regions, called Geographic Service Areas (GSAs). ADHS/DBHS contracts with Regional Behavioral Health Authorities (RBHAs) to administer behavioral health delivery systems to eligible persons residing in the GSA(s). In addition, ADHS/DBHS has Inter-Governmental Agreements (IGAs) with five tribes to deliver services to Arizona's tribal population.

ADHS/DBHS currently contracts for behavioral health services with four RBHAs:

- Northern Arizona Regional Behavioral Health Authority (NARBHA; GSA 1) includes the counties of Mohave, Yavapai, Coconino, Navajo and Apache
- Community Partnership of Southern Arizona (CPSA; GSA 5 and GSA 3) includes the counties of Pima, Graham, Cochise, Greenlee, and Santa Cruz
- Cenpatico Behavioral Health of Arizona (GSA 4 and GSA 2) includes the counties of Gila, Pinal, La Paz, and Yuma
- Magellan Health Services of Arizona (GSA 6) includes Maricopa County

In addition, ADHS/DBHS has Inter-Governmental Agreements (IGAs) with five tribes:

- Gila River Indian Community, (Tribal Regional Behavioral Health Authority or "TRBHA")
- Pascua Yaqui Tribe (TRBHA)
- White Mountain Apache Tribe (TRBHA)
- Colorado River Indian Tribe (prevention services only)
- Navajo Nation (case management services only)

The Arizona Department of Health Services receives funding to operate the behavioral health system through a variety of sources:

- Title XIX Medicaid fund
- Title XXI State Children's Health Insurance Program funds (KidsCare)

- Federal formula block grant funds provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)
  - The Substance Abuse Prevention and Treatment Performance Partnership (SAPT) Block Grant supports a variety of substance abuse services in both specialized addiction treatment and more generalized behavioral health settings
  - The Community Mental Health Services Performance Partnership (CMHS) Block Grant supports Non-Title XIX services to children determined to have serious emotional disturbance (SED) and adults determined to have serious mental illness (SMI)
- Discretionary grant funds
- State appropriations
- 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 publicly funded behavioral health system provides a comprehensive array of behavioral health services to persons of all ages if they are eligible for federal funding (Title XIX, Title XXI) and in need of services. In addition, medically necessary behavioral health services are provided to persons who are non-Title XIX/XXI eligible through utilization of the other funding sources listed above. Populations served through the public behavioral health system in Arizona include:

- Adults with serious mental illness
- Children with serious emotional disturbance
- Children and adults with substance abuse and/or general mental health disorders

Covered services available to enrolled behavioral health recipients include:

- Treatment Services
- Rehabilitation Services
- Medical Services
- Support Services
- Crisis Intervention Services
- Inpatient Services
- Residential Services
- Behavioral Health Day Programs
- Prevention Services

It should be noted that prevention programs are available for all interested children and adults regardless of eligibility or enrollment status.

In summary, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) offers a comprehensive array of services administered through

contracts with four Regional Behavioral Health Authorities and Intergovernmental Agreements with five tribal entities. ADHS/DBHS oversees the administration of these services to ensure that all behavioral health services are delivered in accordance with ADHS/DBHS system principles: easy access to care; behavioral health recipient and family member involvement; collaboration with the greater community; effective innovation; expectation for improvement; and cultural competency.

PROGRAM HIGHLIGHTS

During FY 2007, ADHS/DBHS undertook numerous new initiatives and celebrated many accomplishments. This section highlights a few of these activities and outcomes achieved.

Suicide Prevention

In 2005, ADHS/DBHS was a recipient of a Garrett Lee Smith Memorial Act Suicide Prevention grant from SAMHSA for 1.2 million dollars over three years. ADHS/DBHS has used this grant to enhance the capacity of prevention providers, including Arizona's Tribal Nations, to implement science-based suicide prevention strategies statewide. Numerous training opportunities have occurred during FY 2007 to strengthen the effectiveness of providers. ADHS/DBHS has been an active participant in the Statewide Suicide Prevention Coalition and co-sponsored both Annual Suicide Prevention conferences.

Methamphetamine Prevention

ADHS/DBHS received an allocation of $500,000 from the Arizona State Legislature for methamphetamine prevention programs in FY 2007. Funds were allocated to the Arizona Alliance of Boys and Girls Clubs, which distributed funds among 15 Boys and Girls Clubs statewide. Each club implemented the MethSmart methamphetamine prevention curriculum. This program served 9,719 unduplicated youths in SFY 2007. Outcomes included increases in knowledge about methamphetamines, their use, the consequences of that use, and strategies for avoiding contact with and use of that substance.

Methamphetamine Centers of Excellence:

Arizona's three Methamphetamine Centers of Excellence (COE) continue to thrive. These Centers are located in Sacaton (Gila River TRBHA), Tucson (La Frontera and Compass Healthcare within CPSA), and Phoenix (Community Bridges with Magellan). All three Centers adhere to evidence-based treatments that include cognitive behavioral therapy, motivational interviewing, peer support, aftercare support, family education, therapeutic urinalysis, and contingency management. During the FY 2007, there were 9,000 treatment sessions provided at the three centers.

Methamphetamine Treatment: for Adults with Serious Mental Illness

The state legislature provided a rate capitation increase to ADHS/DBHS to provide longer term intensive substance abuse treatment to individuals diagnosed with a serious

mental illness and methamphetamine issues. Each of the state's four RBHAs developed plans for increasing the identification and treatment of methamphetamine addiction among this population. ADHS/DBHS offered a series of trainings to provider staff around the state focused on reviewing the components of best practices such as Motivational Interviewing, Contingency Management, and use of American Society of Addiction Medicine (ASAM) criteria and assessment of co-occurring conditions. ADHS/DBHS continues to provide technical assistance to provider staff.

Expansion of Detoxification Centers
Through House Bill 2554, ADHS/DBHS was given a one-time appropriation of $2.5M to establish infrastructure for methamphetamine and other substance abuse treatment in rural communities with limited resources and a high need for services. New detoxification/substance abuse treatment facilities are currently under construction in Payson, Yuma, Globe, Holbrook, and Winslow.

Prevention of Underage Drinking
The Arizona Substance Abuse Partnership (ASAP) has commenced work on a media campaign to reduce/eliminate adult provision of alcohol to minors. The campaign is designed to be adaptable to the unique needs of each community. A marketing firm has been selected, focus groups have been conducted and the campaign is currently in development. When it is completed, multiple state agencies (including ADHS/DBHS) and organizations will promote it through their networks.

Meeting the Behavioral Health Needs of Aging and Older Adults
ADHS/DBHS published a Clinical Practice Protocol titled: "Older Adults: Behavioral Health Prevention, Early Intervention and Treatment" during FY 2007. This is a growing area of focus for ADHS/DBHS. Each RBHA implemented at least one substance abuse or suicide prevention program targeting older adults.

Meeting the Behavioral Health Needs of Children Aged Birth-to-Five
During FY 2007, ADHS/DBHS sponsored several trainings for clinicians working with young children, including bringing in nationally-recognized experts in the field of Infant Mental Health. ADHS/DBHS is finalizing a new Clinical Practice Protocol addressing best practice for children birth-to-5 (to be published during FY 2008). ADHS/DBHS is working on a statewide Early Childhood Mental Health Plan, also to be published during FY 2008.

Increasing the Utilization of Support and Rehabilitation Services for Children and Adolescents (Meet Me Where I Am Campaign)
During FY 2007, ADHS/DBHS began planning this exciting campaign aimed at increasing the utilization of in-home, community-based support and rehabilitation services for enrolled children. A statewide Kick-Off Event was held March 12, 2007 to present the mission and goals. Numerous local organizational meetings were then held and local design teams established. An extensive curriculum was developed to assist providers and family members in better understanding the potential benefits of these

services and how to ensure they are used effectively to achieve the desired outcomes. Financial incentives were incorporated into contract amendments for FY 2008.

Stigma Reduction

In August, 2005 ADHS formed a committee composed of advocates, providers, RBHAs and others to address stigma as a barrier to recovery from behavioral health disorders. In 2006, ADHS provided funds to the National Alliance of the Mentally Ill of Arizona (NAMI of Arizona) to provide administrative support to this coalition. NAMI facilitated a strategic planning process with the coalition resulting in development of a statewide plan to reduce stigma in March, 2007. In 2007, three sub-committees (Training, Community Outreach, and Media) met regularly to develop the action steps for the Stigma Reduction Plan. In 2008, the committee will implement the plan.

Behavioral Health Recipient and Family-Member Involvement in Design, Implementation and Monitoring of the Behavioral Health System

ADHS/DBHS executive leadership continues to meet with local advocate groups within each RBHA on a quarterly basis to address issues and concerns in the behavioral health system of care. Behavioral health recipients and family members participate on numerous ADHS/DBHS committees. In addition, ADHS/DBHS has created the Family and Consumer Support Office within the Bureau of Clinical and Recovery Services. The Office is staffed by individuals with life experience and involved family members and is 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 voices into the ADHS/DBHS system.

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.

More than 590 FTE behavioral health recipients provide Peer Support services through licensed behavioral health agencies and Community Service Agencies. More than 120 FTE family members provide Family Support services through licensed behavioral health agencies and Community Service Agencies.

System of Care Planning and Development

ADHS/DBHS formalized its statewide Children's Practice Review process called the Wraparound Fidelity Assessment System and has conducted monthly reviews in each 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.

Telemedicine Use for Rural Areas
In the FY 2007, ADHS/DBHS prioritized the identification of telemedicine availability. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers. Northern Arizona Regional Behavioral Health Authority (NARBHA) has received national recognition for its use of telemedicine services.

Cultural Competency
The ADHS/DBHS Cultural Competency training was initiated and provided statewide to behavioral health staff. This effort was conducted in collaboration with each RBHA. An additional version of the curriculum was developed for non-clinical staff, expanding the numbers of staff members who could receive the cultural competency training. The training is being used to train administrative, prevention and non-behavioral health staff statewide.

In summary, ADHS/DBHS began numerous new initiatives, continued to demonstrate progress related to ongoing efforts, and celebrated many accomplishments during FY 2007.

ADHS/DBHS FINANCIAL REPORT

In order for ADHS/DBHS to be successful with the activities discussed above, as well as to ensure that all behavioral health services are delivered in accordance with the previously mentioned ADHS/DBHS system principles, individuals in need of services need to be enrolled with the behavioral health system, and all available funding must be managed efficiently and appropriately.

During FY 2007, 210,854 behavioral health recipients received behavioral health services as depicted in the table below:

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH

Client Count for Annual Report

SFY2007

(July 1, 2006 through June 30, 2007)

	Children				SMI				Non-SMI				Total
	Title XIX	Title XXI	Non-Title XIX	Subtotal	Title XIX	Title XXI	Non-Title XIX	Subtotal	Title XIX	Title XXI	Non-Title XIX	Subtotal	
CBHS-2	1,822	158	136	2,116	859	6	243	1,108	3,366	72	993	4,431	7,655
CBHS-4	3,569	288	288	4,145	1,145	7	447	1,599	5,378	88	1,111	6,577	12,321
CPSA-3	2,113	140	103	2,356	837	1	317	1,155	4,517	41	1,069	5,627	9,138
CPSA-5	9,945	842	732	11,519	5,869	18	2,753	8,640	16,123	255	7,196	23,574	43,733
GRIC	649	13	10	672	43	0	0	43	348	3	18	369	1,084
NARBHA	5,232	486	453	6,171	3,398	19	1,347	4,764	10,286	176	2,524	12,986	23,921
NAVN	363	23	21	407	166	1	6	173	1,177	17	171	1,365	1,945
PYTA	294	26	123	443	13	0	1	14	521	8	462	991	1,448
VO	24,430	2,208	2,423	29,061	14,589	48	7,734	22,371	37,854	745	19,578	58,177	109,609
Statewide	48,417	4,184	4,289	56,890	26,919	100	12,848	39,867	79,570	1,405	33,122	114,097	210,854

ADHS/DBHS received a total of $1,051,605,314 in funding for FY 2007. Administrative costs totaled $23,558,690 and statewide service costs totaled $1,028,046,623. Please see the four tables which follow for a breakout of programmatic funding details.

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH

Table 1

Total Behavioral Health Services Funding Services & Administration SFY 2007		
Funding	Amount Paid	Percentage
Title XIX	$ 567,248,578	53.94%
Title XIX Proposition 204	$ 240,092,854	22.83%
Title XXI	$ 17,569,431	1.67%
Federal Funds	$ 42,490,599	4.04%
Non Title XIX/XXI Funds General Funds	$ 137,697,787	13.09%
County Funds	$ 40,404,683	3.84%
Tobacco Litigation/Settlement	$ 395,638	0.04%
Other (1)	$ 5,705,743	0.54%
Total	$ 1,051,605,314	100.00%

(1) PASRR, Liquor Fees, City of Phoenix LARC, COOL Program, Comcare Trust, Indirect, SSDI/GMH, MMA Part D, DES/RSA.
(2) Admin funds in the amount of $2,736,001.36 was actually expended on services, Tribal-Fee-For Service.

Table 2

Administrative Funding SFY 2007		
Funding	Amount Paid	Percentage
Title XIX	$ 10,350,436	43.93%
Title XIX Proposition 204	$ 7,517,234	31.91%
Title XXI	$ 436,467	1.85%
Federal Funds	$ 2,552,947	10.84%
Non Title XIX/XXI Funds General Funds	$ 2,241,684	9.52%
County Funds	$ 125,700	0.53%
Other (1)	$ 334,221	1.42%
Total	$ 23,558,690	100.00%

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

(2) Admin funds in the amount of $2,736,001.36 was actually expended on services, Tribal-Fee-For Service.

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH

Table 3

Statewide Funding by Program SFY 2007		
Funding	Amount Paid	Percentage
Title XIX Children	$ 286,580,753	27.88%
Non TXIX Children	$ 20,397,614	1.98%
TXXI Children	$ 11,999,002	1.17%
TXIX SMI	$ 333,667,602	32.46%
Non TXIX SMI	$ 136,889,288	13.32%
TXXI SMI	$ 3,260,717	0.32%
TXIX GMH/SA	$ 169,225,408	16.46%
Non TXIX GMH/SA	$ 49,240,577	4.79%
TXXI GMH	$ 1,873,244	0.18%
Non TXIX Prevention	$ 11,814,110	1.15%
Other Programs(1)	$ 3,098,309	0.30%
Total	$ 1,028,046,623	100.00%

(1) PASRR, Liquor Fees, City of Phoenix LARC, COOL Program, SSDI/GMH, MMA Part D.

Table 4

Statewide Funding by Program With TXIX Sub-Programs SFY 2007		
Funding	Amount Paid	Percentage
Title XIX Children	$ 187,633,365	18.25%
Title XIX Children/Proposition 204	$ 2,876,134	0.28%
TXIX DES/DD	$ 10,251,032	1.00%
TXIX CMDP Children	$ 85,820,221	8.35%
Non TXIX Children	$ 20,397,614	1.98%
TXXI Children	$ 11,999,002	1.17%
TXIX SMI	$ 170,805,030	16.61%
TXIX SMI Proposition 204	$ 151,230,455	14.71%
TXIX SMI DES/DD	$ 11,632,117	1.13%
Non TXIX SMI	$ 136,889,288	13.32%
TXXI SMI	$ 3,260,717	0.32%
TXIX GMH/SA	$ 90,756,377	8.83%
TXIX GMH/SA Proposition 204	$ 78,469,031	7.63%
NTXIX GMH/SA	$ 49,240,577	4.79%
TXXI GMH	$ 1,873,244	0.18%
Non TXIX Prevention	$ 11,814,110	1.15%
Other (1)	$ 3,098,309	0.30%
Total	$ 1,028,046,623	100.00%

(1) PASRR, Liquor Fees, City of Phoenix LARC, COOL Program.

THE ARIZONA STATE HOSPTIAL

VISION AND MISSION STATEMENTS

VISION STATEMENT

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

MISSION STATEMENT

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

DESCRIPTION OF THE ARIZONA STATE HOSPITAL

The Arizona State Hospital is located on a 93-acre campus at 24th Street and Van Buren in Phoenix, Arizona. 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. The Arizona State Hospital provides long term inpatient psychiatric care to the most seriously mentally ill Arizonans. The facility operates programs within a 338 funded bed capacity and is accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") and is certified to receive reimbursement from Medicare.

As Arizona's only state-operated psychiatric hospital, it is imperative to communicate the hope of recovery for each individual served. The care is delivered in collaboration with the patient, family or legal representatives and community providers. There is continual focus to identify individual recovery supports that will lead toward community reintegration, which becomes a cornerstone of the admission and treatment process at the Arizona State Hospital.

Treatment at the Hospital is considered the "the highest and most restrictive" level of care in the state, and patients are admitted as a result of an inability to be maintained in a community facility, or because of their legal status. Hospital personnel continually strive to provide state-of-the-art inpatient psychiatric and forensic care. The Hospital is committed to the concept that all patients and personnel are to be treated with dignity and respect.

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

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

The Hospital receives overall direction from the **Chief Executive Officer (CEO)** who reports to the Deputy Director of the Arizona Department of Health Services / Division of Behavioral Health Services. The CEO supervises the various leaders of the Hospital. These leaders include the Chief Medical Officer, the Chief Operating Officer, the Chief Quality Officer, the Chief Nursing Officer and the Chief of Security. These Executive Management Team members oversee Hospital operation, establish administrative policies and procedures and direct Hospital planning activities.

ARIZONA STATE HOSPITAL CLINICAL SERVICES OVERVIEW

Interdisciplinary Clinical Team Approach

The interdisciplinary clinical team consists of a qualified (board certified or board eligible) psychiatrist, who is the team leader, a qualified (board certified or board eligible) family practice physician or certified physician assistant, a registered nurse, a social worker, rehabilitation professionals, a mental health therapist/treatment plan coordinator, and a other professionals as required. The interdisciplinary clinical team assesses and evaluates each patient upon admission to the Hospital, at periodic intervals, and at any time during the course of hospitalization, based upon the condition of the patient.

The interdisciplinary clinical team considers the patient's acuity level and the patient's legal status at the time of admission in determining the patient's least restrictive and most appropriate level of placement within the Hospital. The treatment team works together with the patient and patient representatives to develop the Master Individual Treatment and Discharge Plan (ITDP).

Clinical Therapy/Treatment Planning Services

The clinical therapy / treatment planning services program provides treatment planning services and active treatment to the 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. Treatment plan coordinators provide support to the treatment teams. They serve as consultants to help the treatment team incorporate recovery goals into the treatment plans; track treatment plans 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 a wide variety of individual and group therapies that can positively influence and maximize patient functioning.

Nursing Services
Nursing Services are provided for all patients at the Arizona State Hospital 24 hours a day. The Nursing staff has the most patient contact, both in frequency and duration. Each patient is assigned a "Primary RN" to ensure all their needs are identified, that these needs are communicated to the treatment team, and the patient's response to treatment is assessed and relayed to other members of the Nursing and interdisciplinary team.

The Nursing staff is involved in all types of structured and unstructured treatment activities. The management of the therapeutic treatment environment and the implementation of the individualized treatment plans is in large part a Nursing responsibility. The administration of medications along with the assessment of response to medication is a vital role of the Registered Nurses. Nursing programs and active treatment on the units are provided within the hospital's Recovery Model and include:

Basic Problem Solving
Symptom Management
Anger Management
Relaxation Strategies
Disease Prevention
Socialization Skills
Coping Mechanisms
Relapse Prevention
Individual Counseling
Addiction Education
Medication Education
Skill Development
Healthy Lifestyles
Personal Hygiene

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 shifts in the day.

This past year has been an exciting time for our Nursing Program. Our intensive staff retention program and the RN salary equity program has resulted in a monthly vacancy rate averaging 6 percent, compared to almost 40 percent the previous year. In addition, we have implemented a RN Preceptor program for new graduates and RNs without previous behavioral health experience.

The severe shortage of Nursing Instructors and training resources in the community for nursing students prompted us to assess how our department could assist those community nursing programs asking the hospital for accommodations. Several of the hospital RNs volunteered to be Community College Clinical Instructors in Behavioral Health Nursing; they provide teaching and supervision while the student Nurses are at the facility.

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 patient is an active participant in the development of his or her treatment plan, and works closely with staff at all stages of treatment plan development and monthly reviews. Patient involvement is crucial to success. The plan is developed using the initial assessments by the patient's clinical team, information from the patient about their wants and needs, 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 these components:

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

Recovery Model
The recovery model supports an environment of care that endorses, promotes and nurtures a person-centered approach, "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness" (Anthony, 1993). The recovery model supports and enriches rehabilitation and medical models of healing. A number of factors are common in the recovery paradigm. These include hope, medication, and other psychiatric treatments, choice, empowerment, support, education, self-help, spirituality, employment, and meaningful activities.

Recovery Model Services
Our mission is to change our focus as well as the nature of the services we provide to our consumers. The 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. In addition, recovery principles focus on the consumer's ability to be successful in coping with life's challenges. Our 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 Arizona State Hospital.

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

Clinical Care: to provide evidenced-based psychiatric treatments which promote and enhance the recovery process;
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. The program 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, originator of DBT).

Arizona State Hospital's dialectical behavior therapy programs are operated on units that treat individuals diagnosed with thought, mood, and personality disorders. The programs also are now also offered to patients in both civil and forensic units. Detailed statistics are kept to measure program effectiveness. Training on DBT is provided to Hospital staff on a bi-monthly basis.

The overall targets of our DBT program follow those outlined by Charles Swensen, the psychiatrist who developed the inpatient DBT program protocol. 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
- **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 50 state Regional Behavioral Health Authority (RBHA) employees 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, they 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. They serve as the primary contact for questions or concerns the RBHA 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.

Project Tobacco-Free

Recent national medical studies have shown that the people receiving our services die on average of 25 years before the general population. The largest contributing factor to this disparity is associated with smoking. Silently and insidiously, tobacco sales and tobacco use became an accepted way of life in our public mental health treatment facilities like Arizona State Hospital.

Tobacco kills our patients. And it kills those with mental illness disproportionately and earlier, as the leading contributor of disease. A preponderance of evidence has clearly established the deleterious health effects of tobacco use and second hand or environmental tobacco smoke. Science as well as experiences in mental health facilities have also shown that smoking leads to negative outcomes for mental health treatment, the treatment milieu, overall wellness and, ultimately, recovery.

We have seen great shifts in our community culture away from tobacco use. It is no longer legal to smoke in restaurants, bars, airports, airplanes, buses, etc. There is much more emphasis on wellness – being physically active, eating healthier diets, etc. It is believed that our patients deserve the same culture shift in our hospital.

The staff at Arizona State Hospital is committed to supporting health, wellness and recovery. As a healthcare agency, we must act on what we know. Therefore, Arizona State Hospital is taking a stand against tobacco and will take assertive steps to stop its use within the next year. This year will be filed with education, support, nicotine replacement therapy and celebrations for success – for both employees and patients.

Strategically, our goal is to be tobacco free at Arizona State Hospital by July 1, 2008.

PATIENTS SERVED AT THE ARIZONA STATE HOSPITAL

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

CIVIL ADULT REHABILITATION PROGRAM (141 BEDS) consists of eight treatment units specializing in providing services to adults who are civilly committed as a danger to self, danger to others, gravely disabled and/or persistently and acutely disabled, who have completed a mandatory 25 days of treatment in a community inpatient setting prior to admission.

FORENSIC ADULT PROGRAM (180 BEDS TOTAL): Court-ordered commitments through a criminal process for either:

PRE-TRIAL RESTORATION TO COMPETENCE PROGRAM ("RTC; 47 BEDS") consists of three treatment units providing pre-trial evaluation, treatment and restoration to competency to stand trial.

POST-TRIAL FORENSIC PROGRAM consists of two treatment units for those adjudicated as **GUILTY EXCEPT INSANE** ("GEI; 102 BEDS") who are serving determinate sentences under the jurisdiction of the Psychiatric Security Review Board (PSRB), or for those adjudicated prior to 1994 as **NOT GUILTY BY REASON OF INSANITY** ("NGRI; 24 BEDS").

COMMUNITY REINTEGRATION PROGRAM (BEDS utilized by GEI or NGRI patients, see above) consists of one treatment unit for forensic patients with an approved Conditional Release Plan approved by the PSRB for transiting into the community and for those working toward application for Conditional Release.

ADOLESCENT TREATMENT PROGRAM: Consists of a 16-bed treatment facility which serves as the admission, assessment and treatment program for male and female juveniles, up to and including age 17, who are committed through civil or criminal (forensic) processes.

MEDICAL BED: 1 Medical 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.

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

The Deputy Director notifies the Governor, the President of the Senate, the Speaker of the House of Representatives and the Chairmen of the County Board of Supervisors throughout the state of the funded capacity and allocation formula for the current fiscal year. For FY 2007, the funded capacity and allocation of the Hospital's beds was as follows:

Forensic Adult (53% of beds):	**180**	**Beds**
• Restoration to Competency	47	Beds
• Guilty Except Insane – 75 day evaluation	7	Beds
• Guilty Except Insane	102	Beds
• Not Guilty By Reason of Insanity	24	Beds
Civil Adult (42% of beds):	**141**	**Beds**
Adolescent (Civil & Forensic; 5% of beds):	**16**	**Beds**
Medical Bed (reserved for infection control):	**1**	**Bed**
TOTAL BEDS FY 2007	**338**	**Beds**

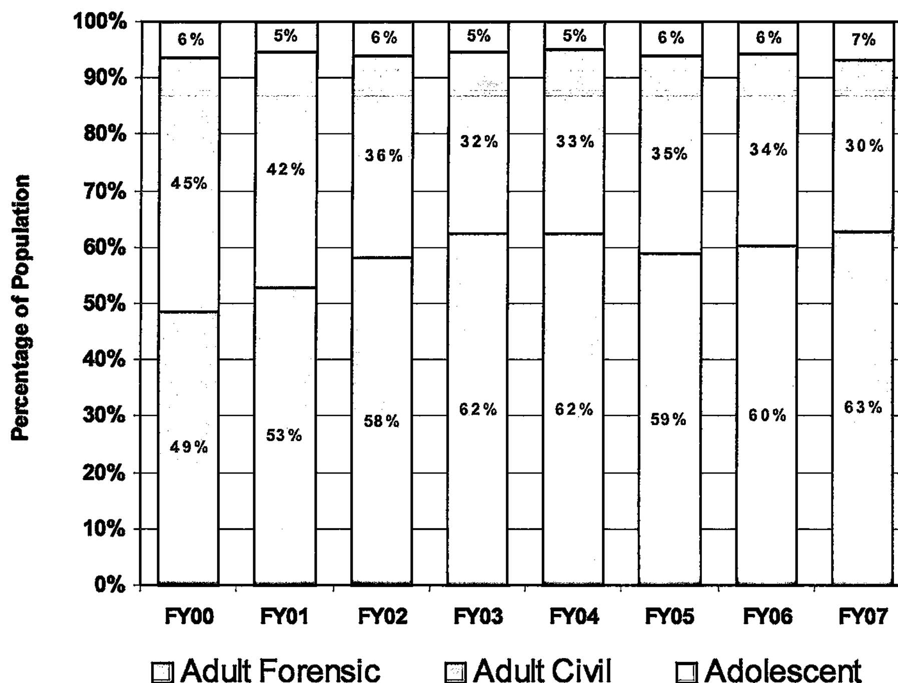
The law requires the Superintendent of the Hospital to establish a waiting list for admission based on the date of the court order when funded capacity is reached in any population category. When funded capacity is reached, referring agencies are notified and the person is placed on the waiting list until an appropriate bed becomes available. These persons remain in a community inpatient setting or a county jail psychiatric ward while on the waiting list. During FY 2002, the Hospital found it necessary to implement a wait list for the first time for Adolescent and Pre-Trial Forensic Restoration to Competency Programs. The number of persons on the RTC Wait List grew to 121 during FY 2003, up from 11 in October 2002.

In September 2003, Maricopa County appropriated $500,000 to fund an in-house restoration to competency program in the new jail system. The Hospital has been working closely with Maricopa County in the development of its program and this collaboration has resulted in a significant drop in the number of referrals. In FY 2007, it was not necessary to activate the wait list. Members of the Hospital and County clinical staffs review cases jointly to determine the most appropriate setting for treatment and care. As a result, the Hospital is receiving individuals who require a high level of specialized psychiatric treatment and who are considered to be suffering from serious mental illness.

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 2007 with a patient census of 261 and ended the fiscal year on June 30th with a census of 270, an increase of 9 patients or 3.3 percent. During the year, 296 patients were admitted and 287 patients were discharged. The average daily census for the fiscal year was 264 patients. These patients accounted for a total of 96,334 patient days*, an increase of 6,507 days over the previous fiscal year. The patient end of month census from July 2004 through June 2007 is depicted in Exhibits #2 (A) and #2 (B) 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 # 2 (A)

End of Month Census, FY 2005 through FY 2007

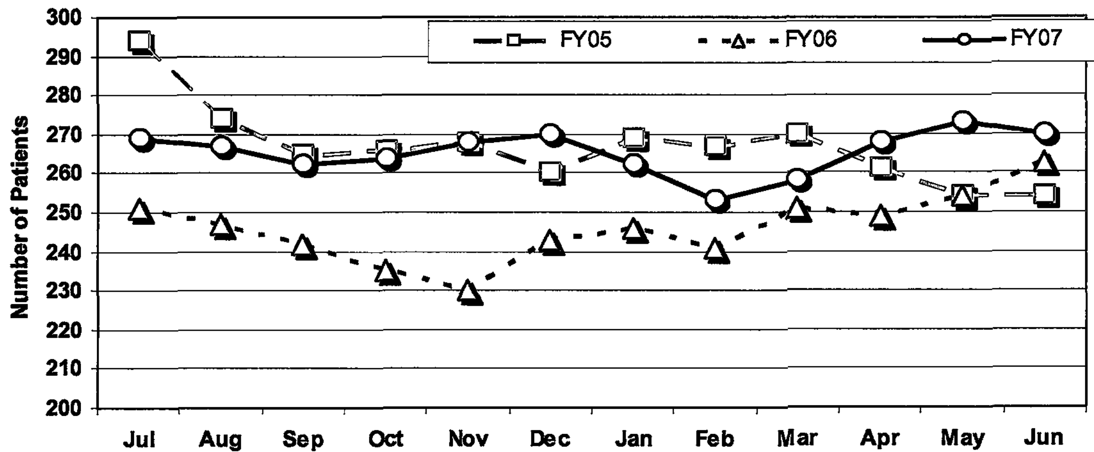


EXHIBIT # 2 (B)

FY 2007 End of Month Census by Legal Status and Legal Type

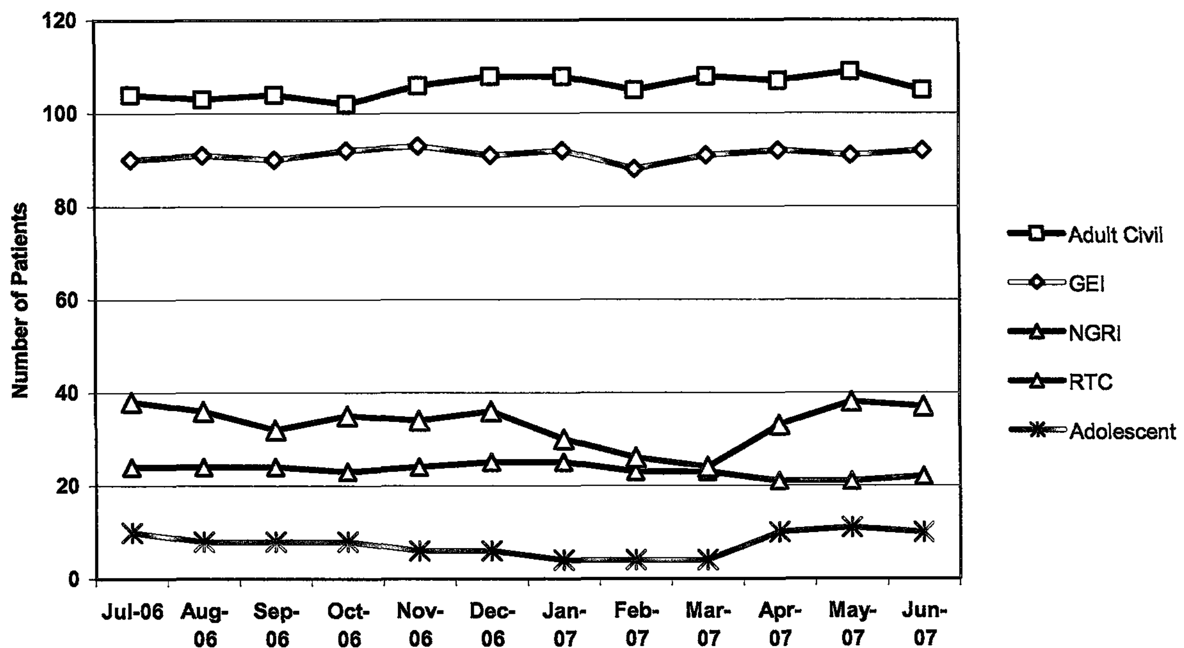
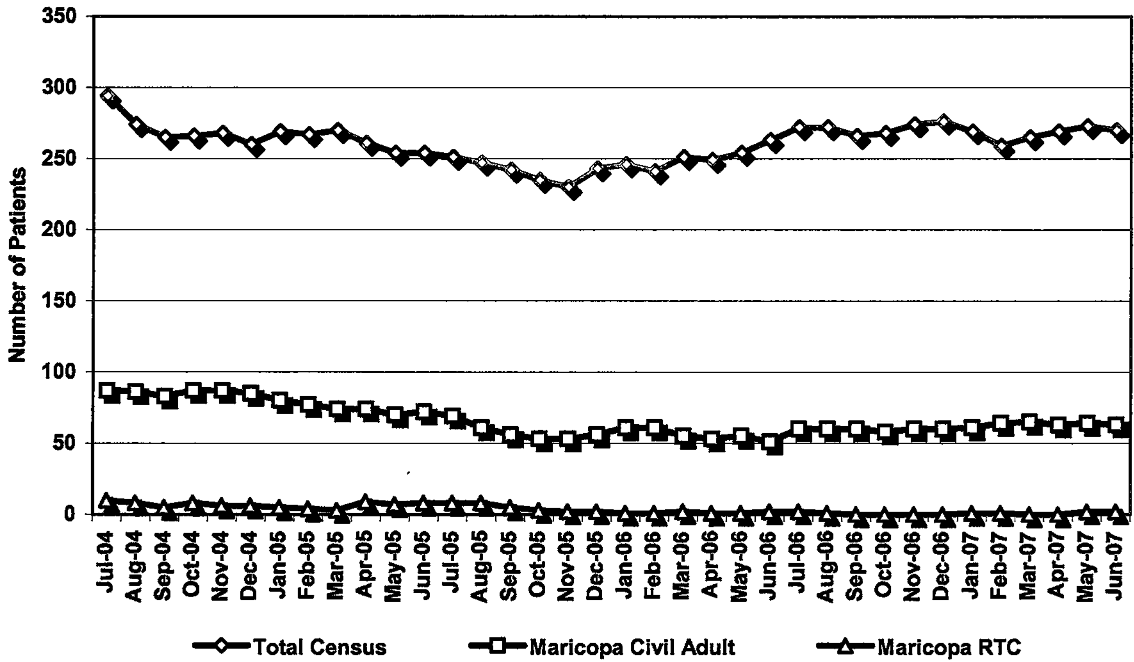
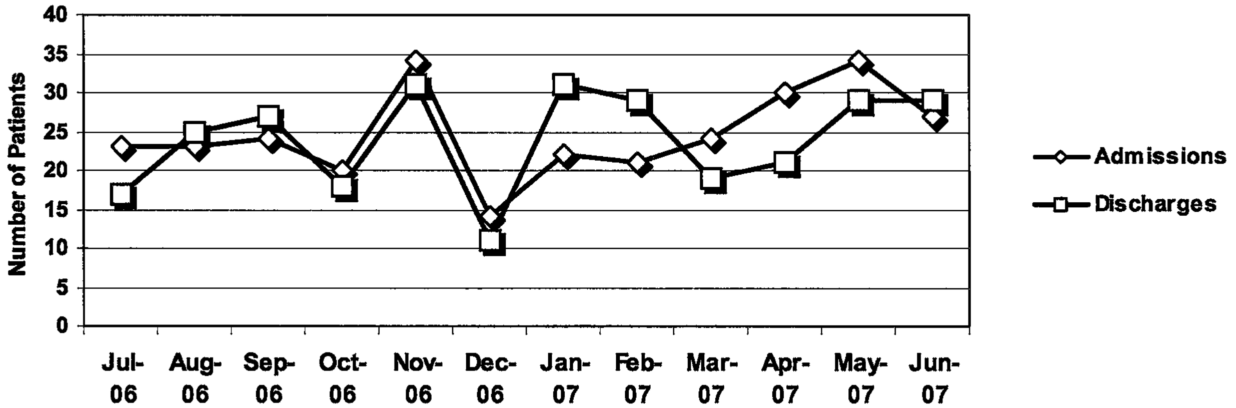


EXHIBIT #2 (C):



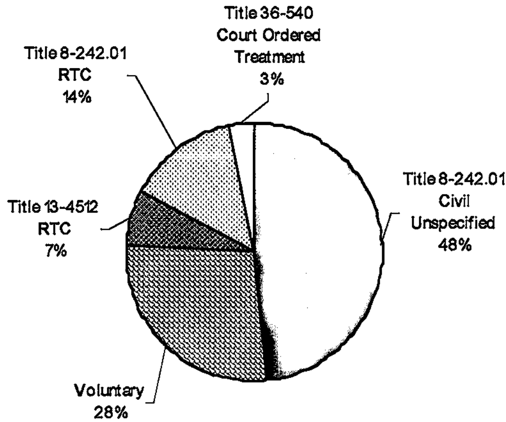
ADMISSIONS AND DISCHARGES

EXHIBIT #3:

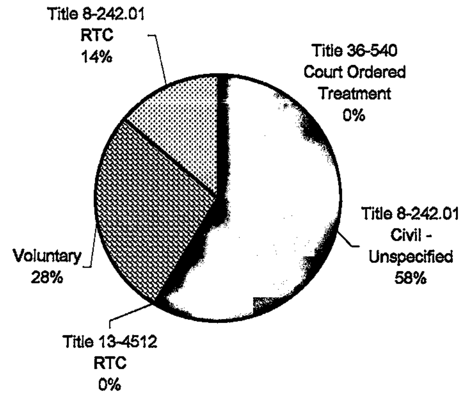


ARIZONA STATE HOSPITAL – STATE FISCAL YEAR 2007

Adolescent Admissions



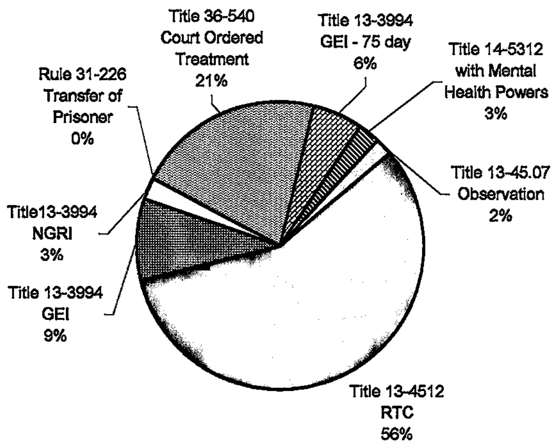
Adolescent Discharges



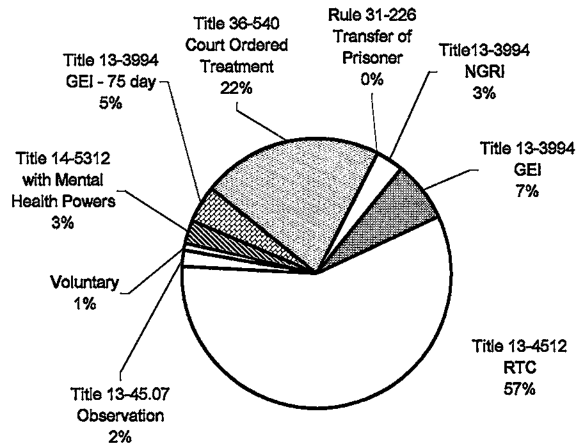
Admission Legal Status	
Title 13-4512 RTC	2
Title 36-540 Court Ordered Treatment	1
Title 8-242.01 Civil - Unspecified	14
Title 8-242.01 RTC	4
Voluntary	8
Total	**29**

Discharge Legal Status	
Title 13-4512 RTC	0
Title 36-540 Court Ordered Treatment	0
Title 8-242.01 Civil - Unspecified	17
Title 8-242.01 RTC	4
Voluntary	8
Total	**29**

Adult Admissions



Adult Discharges



Admission Legal Status	
Rule 31-226 Transfer of Prisoner	0
Title 13-3994 GEI	24
Title 13-3994 GEI - 75 day	15
Title 13-45.07 Observation	5
Title 13-4512 RTC	153
Title 13-994 NGRI	7
Title 14-5312 with Mental Health Powers	7
Title 36-540 Court Ordered Treatment	56
Voluntary	0
Total	**267**

Discharge Legal Status	
Rule 31-226 Transfer of Prisoner	0
Title 13-3994 GEI	19
Title 13-3994 GEI - 75 day	12
Title 13-45.07 Observation	5
Title 13-4512 RTC	149
Title 13-994 NGRI	8
Title 14-5312 with Mental Health Powers	7
Title 36-540 Court Ordered Treatment	56
Voluntary	2
Total	**258**

SUMMARY OF ADMISSIONS AND DISCHARGES FY 2007

	Total Admissions	Total Discharges
Adolescents:		
Forensic	6	4
Civil	23	25
Subtotal	**29**	**29**
Adult:		
Forensic	204	193
Civil	63	65
Subtotal	**267**	**258**
Total for FY 2007	**296**	**287**

Admission Statistics

The Hospital admitted 296 patients this fiscal year. Individuals admitted to the Hospital for the first time accounted for 214 or 72 percent of all admissions during FY 2007. Admissions by diagnostic grouping indicated that patients diagnosed with schizophrenic disorders accounted for 32 percent of all admissions during FY 2007, which is a 9 percent decrease from the previous fiscal year. During FY 2007, patients diagnosed with polysubstance abuse (18%), psychotic disorders (18%), affective disorders (18%), personality disorders (7%), and cognitive disorders (6%) comprise the major diagnostic groupings for patient admissions to the Hospital. The remaining 1 percent of the admission diagnosis was deferred. Of the 296 patients admitted this fiscal year, 130 (44%) were determined to be Seriously Mentally Ill (SMI). This is a 15 percent increase over the previous fiscal year.

Admission Averages

The average monthly admission rate for FY 2007 was 25 patients, ranging from a low of 14 admissions in December 2006 to a high of 34 admissions in May 2007. This was an 8 percent increase from the FY 2006 average monthly admission rate of 23 patients.

Admission by County

Pima County had the highest number of admissions during FY 2007 with 127 patients or 43 percent of all statewide admissions. This was an increase of 35 percent from last fiscal year's 94 Pima County admissions. Maricopa County accounted for 23 percent of

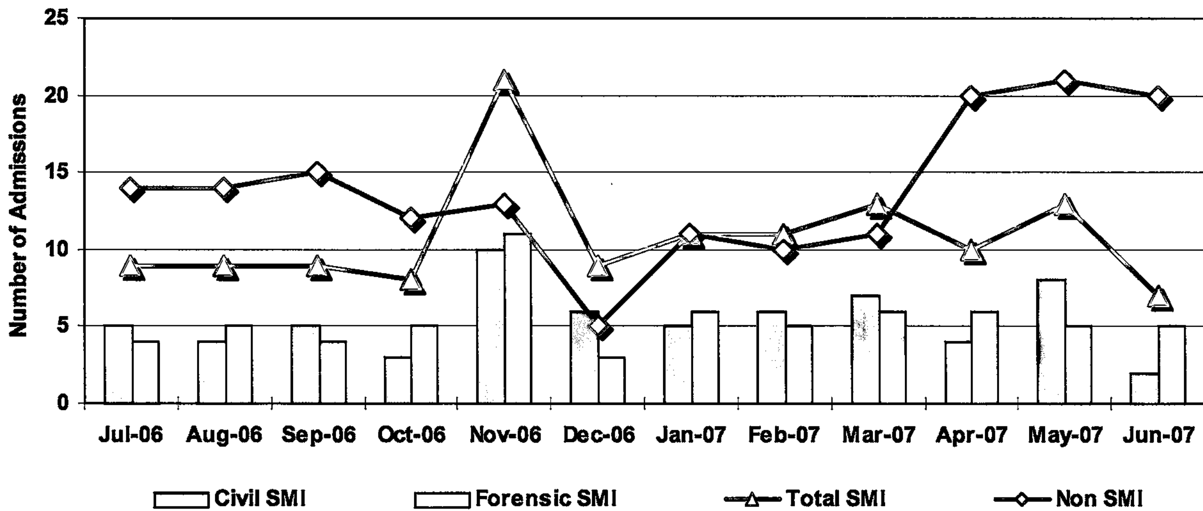
the admissions in FY 2007, an increase of 21 percent from the previous year's total of 56 admissions. The remaining thirteen counties accounted for 99 or 34 percent of the state admissions during the period July 2006 to June 2007.

EXHIBIT #5

Admissions by County FY 2007

County of Admission	Total	Percentage
Pima	127	42.9%
Maricopa	68	22.9%
Yavapai	18	6.2%
Pinal	14	4.8%
Yuma	11	3.7%
Cochise	10	3.4%
Gila	10	3.4%
Mohave	10	3.4%
Navajo	7	2.4%
Santa Cruz	7	2.4%
Coconino	6	2.0%
Graham	3	1.0%
La Paz	3	1.0%
Apache	2	0.7%
Greenlee	0	0.0%
Total Admissions FY 2007	**296**	**100.0%**

EXHIBIT #6



Discharge Statistics
The Hospital discharged 287 patients during this fiscal year. The average monthly discharge rate for FY 2007 was 23.9 patients, ranging from a low of 11 discharges in December 2006 to a high of 31 discharges in January 2007 (Exhibit #3). This was a 7 percent increase from the FY 2006 average monthly discharge rate of 22 patients. Of the 287 patients discharged this fiscal year, 123 (43%) were Seriously Mentally Ill. This is a 1.7 percent increase from the previous fiscal year.

The number of non-forensic patients discharged during FY 2007 with a length of stay less than 365 days was 64 or 71 percent, which is 23 percent higher than last fiscal year. This data continues to support the premise that the Hospital, the ADHS/Division of Behavioral Health Services and the Regional Behavioral Health Authorities are committed to the concept that non-forensic patients are to be admitted to the Hospital for intensive treatments and shorter durations rather than for extended hospitalization periods. During FY 2007, 16 patients were discharged with a length of stay of greater than 3 years including 5 patients hospitalized for over 7 years, and 1 patient hospitalized for over 17 years. These patients require extensive treatment and discharge planning coordination between the Hospital and the community providers, who will provide follow-up services.

Adult Discharges
Of the 287 patients discharged during this fiscal year, 258 or 90 percent were adults. Overall, the average length of stay for this age group was 210.1 days. During FY 2007, 65 civil patients had an average length of stay of 562.3 days: 56 patients were discharged from the Title 36 Court Ordered Treatment program with an average length of stay of 495.2 days; 7 patients under Title 14 with Mental Health Powers were discharged in an average of 1175.7 days; and 2 Voluntary patients were discharged in an average of 816.5 days. During the same time period, 193 forensic patients were discharged with an average length of stay of 212.7 days: 149 patients were discharged from the Title 13 Restoration to Competency program with an average length of stay of 79.7 days; 19 Title 13 Guilty Except Insane patients were discharged in an average of 1227.1 days; 12 Title 13 Guilty Except Insane – 75 Day patients were discharged in an average of 47.3 days; 8 patients were discharged from the Title 13 Not Responsible for Criminal Conduct by Reason of Insanity treatment in an average of 640.4 days, and 5 patients were discharged from Title 13-45.07 Observation with a length of stay of 35.2 days.

Adolescent Discharges
Of the 287 patients discharged during FY 2007, 29 or 10% were adolescents. Overall, the average length of stay for this age group was 134.2 days. The 25 non-forensic patients stayed an average of 100.7 days during FY 2007: 17 patients were discharged from Title 8 Juvenile Commitment after an average of 71.2 days; and 8 Voluntary patients were discharged in an average of 161.8 days. The 4 Title 8 Juvenile Restoration to Competency patients– were discharged this fiscal year with an average length of stay of 84.8 days.

EXHIBIT #7

FY07 SMI and Non-SMI Discharges

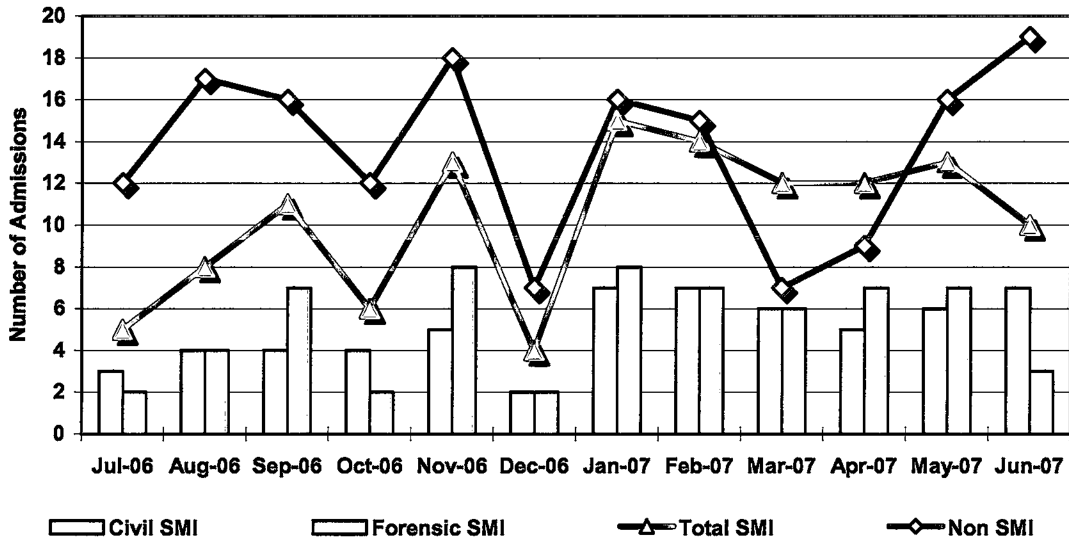


EXHIBIT #8

Patients were discharged to the community to the following placements:

Patients Discharged during FY 2007

Living Arrangements after Discharge	Adult	Adolescent	Total	Overall %
CORRECTIONAL FACILITY	164	19	183	63.8%
GROUP HOME	51	3	54	18.8%
FAMILY	8	6	14	4.9%
INDEPENDENT LIVING	7	0	7	2.4%
NURSING HOME	6	0	6	2.1%
PSYCH HEALTH FACILITY	4	0	4	1.4%
OTHER	4	0	4	1.4%
RES. SAP/SMI-DUAL DIAGNOSIS	3	0	3	1.0%
PSYCH HSP/WARD	2	0	2	0.7%
RTC 24 HOUR NOT PHF	2	0	2	0.7%
RTC SEMI-SUPV. NOT PHF	1	0	1	0.3%
HOMELESS	1	0	1	0.3%
NON PSYCH HOSP/WARD	1	0	1	0.3%
SPONSORED BASED HOUSING	1	0	1	0.3%
LICENSED SUPERVISORY CARE	1	0	1	0.3%
NONE	1	0	1	0.3%
UNKNOWN	1	0	1	0.3%
FOSTER HOME	0	1	1	0.3%
Total	**258**	**29**	**287**	**100.0%**

Discharge by County

Pima County had the highest number of discharges during FY 2007 with 119 patients or 42 percent of all statewide discharges. This was an increase of 53 percent from last fiscal year's 78 Pima County discharges. Maricopa County accounted for 63 or 22 percent of the FY 2007 discharges, a decrease of 22 percent from the previous year's total of 81 discharges. The remaining thirteen counties accounted for 105 or 36 percent of the state discharges during the period July 2006 to June 2007.

EXHIBIT #9

Discharges by County FY 2007

County	Total	Percentage
PIMA	119	41.5%
MARICOPA	63	22.0%
YAVAPAI	22	7.7%
PINAL	16	5.6%
YUMA	13	4.5%
COCHISE	11	3.8%
COCONINO	10	3.5%
MOHAVE	9	3.1%
GILA	8	2.8%
NAVAJO	6	2.1%
SANTA CRUZ	5	1.7%
APACHE	2	0.7%
LA PAZ	2	0.7%
GRAHAM	1	0.3%
GREENLEE	0	0.0%
Total Discharges	**287**	**100.0%**

EXHIBIT #10

Discharge Length of Stay FY 2007

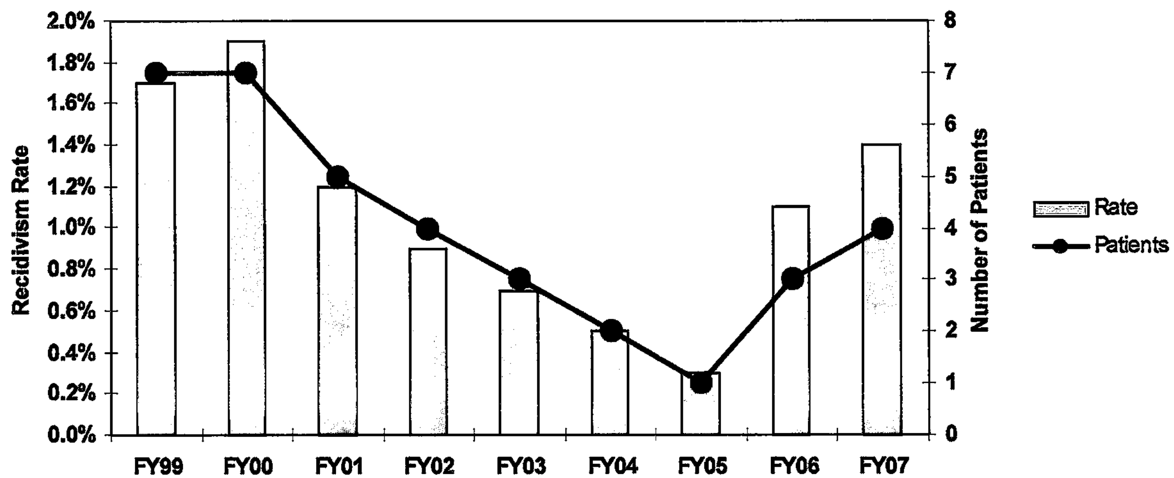
Length of Stay	Civil		Forensic		Total	
	Patients	%	Patients	%	Patients	%
0-6 Months	45	15.7%	168	58.5%	213	74.2%
6 Months – 1 Year	19	6.6%	10	3.6%	29	10.2%
1-2 Years	9	3.2%	5	1.7%	14	4.9%
2-3 Years	11	3.9%	4	1.4%	15	5.3%
3-5 Years	3	1.0%	4	1.4%	7	2.4%
5-7 Years	0	0%	3	1.0%	3	1.0%
7-10 Years	2	0.7%	2	0.7%	4	1.4%
10-15 Years	0	0%	1	0.3%	1	0.3%
15-20 Years	1	0.3%	0	0%	1	0.3%
20+ Years	0	0%	0	0%	0	0%
Total	**90**	**31.4%**	**197**	**68.6%**	**287**	**100.0%**

Recidivism

Recidivism is defined as the readmission of a patient within 30 days from their previous discharge date. The FY 2007 overall recidivism rate was 1.4 percent (n=4) of the 287 discharges for the year. Recidivism rates for prior fiscal years vary from a low of 0.3 percent in FY 2006 to a high of 1.9 percent in FY 2000. In total, there were 32 readmissions during FY 2007 with a median community stay of 93 days before the subsequent readmission to the Hospital.

EXHIBIT #11

Recidivism Rates FY 1999 through FY 2006



EMPLOYMENT AND PERSONNEL

EMPLOYMENT STATISTICS
Current Number Employed

The Hospital is authorized 700.7 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	2
Social Worker	12	5
Health Planning Consultants (Treatment Plan Coordinators)	8	2
Licensed Practical Nurse	13	2
Psychiatric Nurse II	77	29
Psychiatric Nurse Shift Supervisor	30	1
Psychiatric Nurse Unit Manager and Psychiatric Nurse Coordinator	14	0
Mental Health Program Specialists	190	39
Recreation Therapists	23	6
Occupational Therapists	4	0
Therapy Technicians	8	2
Security Officers	71	20
Managerial Staff	49	7
Administrative Support	81	3
Total	**596**	**119**

Turnover

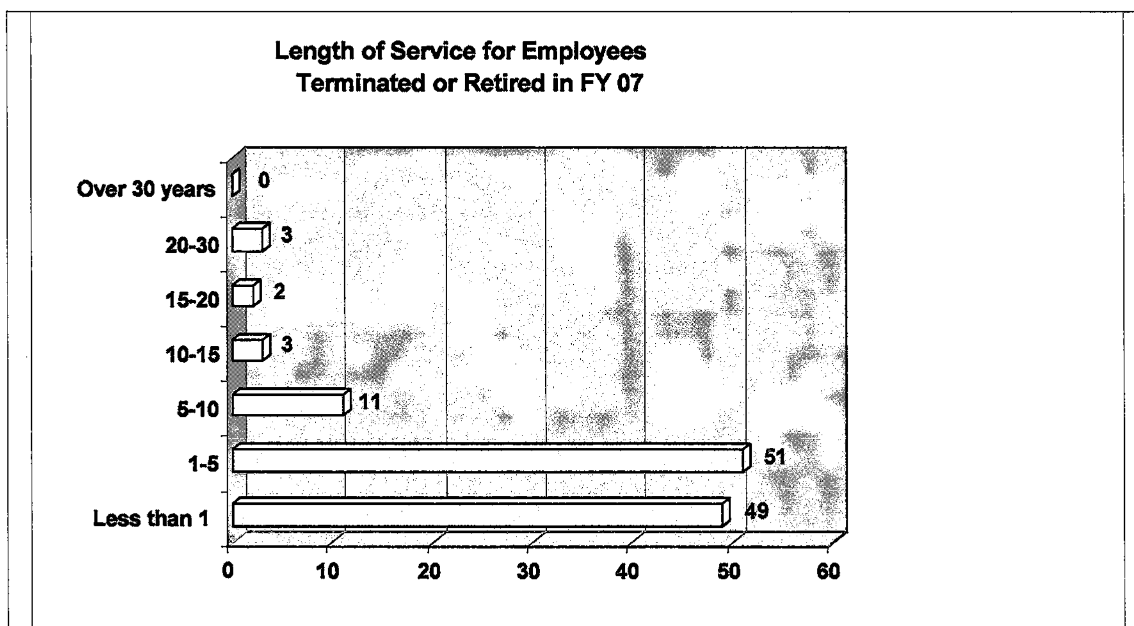
Hospitals have a difficult time retaining staff, particularly those with critically needed skills. The Arizona State Hospital is no exception, particularly with critical shortages in classes like registered nurse. The nature of the State Hospital's patient population also poses an additional challenge to recruitment. 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. Although there are many challenges in working at Arizona State Hospital, we had a reduction of 24 percent in the number terminated, due in part to the measures created and established for this fiscal year. To continue to recruit key staff that is truly prepared to support the special needs of the State Hospital, the hospital has taken these steps:

- Continue to offer the referral bonus, which provides a department employee $300 for assistance in recruitment of the RN. Certain exclusions are in place to avoid abuse.
- Hospital recruiters are still utilizing expanded tools to advertise, such as the state's azstatejobs.gov web site and job fairs; Internet based sites specific to the recruited occupations and accompanying trade publications, and industry management association web sites.
- An alternate pay tier plan for nursing was implemented in June 2007 to include a stipend into their base pay, with the hope to continue recruitment and retention successes.

Direct care RNs are a vital position for the Hospital. There are continuous efforts to recruit and retain them. 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 Actual
31%	30%	31%	8%

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 percent of the Arizona State Hospital campus. The remaining buildings represent 74 percent of the campus. This condition report can be divided into two categories: needs maintenance and major repair (48 percent) or needs renovation (26 percent).

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. While conducting scheduled facilities inspections, water leaks from the showers ware identified. Further investigation indicated that plastic pans under the floor tile were missing. McCarthy (General Contractor) with the assistance of ADOA agreed to repair the showers throughout the civil hospital under warranty at no direct expense to the Hospital. Additionally, the building movement created roof cracks at the plastic membrane resulting in roof leaks. As a result, rainwater has damaged the walls, ceiling tiles, and at times, furniture and equipment. A new roof was installed this year by the contractor under the 10 year warranty.

The **Old Forensic** portion of the hospital was built in the 1950s. It was designed to care for a geriatric 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 50s for construction. The majority of the galvanized water piping is corroded, causing 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** (future PSRB-Psychology building) was identified as the structure that required the least amount of work to bring it up to occupancy standards and to provide a safe work environment to the staff. The old commissary reconstruction to replace offices for the displaced personnel was delayed due to financial constraints. A new air handler was installed, the interior is abated and the restrooms are finished. To complete this project

the interior needs to be finished. However, the hospital has lacked capital funds to complete this project.

The Van Buren entrance **Guard Building** was in disrepair. The building was replaced with a new secure modular building. Features of this new building are a bullet proof widow at the south side, a new electrical system, a new data communication system, replacement of the remote controls, new floor, vehicle access electronic control gate 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.

In the **Dietary Building**, repairs this year included the following: repair to the collapsed sewer lines, repair lift station and upgrade the seismic system.

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 ultimately wil create a safety 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 fire system will be relocated to the forensic security control to obtain 24/7 fire coverage and ACTPC will be incorporated into the centralized system.

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's **public address system** is very old and in need of replacement. It was recently expanded to each building on the civil hospital, forensic hospital and Arizona Community Treatment and Protection Center.

Hospital Technology Services
Over the past several years, technology has taken several forms at the Arizona State Hospital. The Hospital has had both ITS employees from the Department of Health Services and Hospital employees performing technology functions. Additionally, both groups had different reporting chains. This past year we consolidated all of the technology resources at the hospital under one umbrella. Mark Moyle now serves as the Chief Technology Officer for the Arizona State Hospital Complex and is responsible for all technology related issues. He serves as a member of the Hospital Executive Management Team and represents the hospital at the Department of Health Services ITS executive management team. This new department is called Hospital Technology Services. Since there are staff from both the hospital and ADHS ITS in the new department, Mr. Moyle reports to both John C Cooper, CEO, Arizona State Hospital (50%) and David Spitzer, CIO, ADHS (50%).

Hardware

During FY2007 some aging switches that control the computer connectivity on the Hospital campus have been replaced. In addition, one of the older servers was changed and is now a development server. This allows our software developers to work on a separate server away from our production system. Also, many of our desk top computers and monitors were replaced with newer computers and flat screen monitors. The Hospital was also part of a larger project to upgrade our common servers and add new common storage.

Software

Software development has been haphazard in the past. To better organize and promote needed development this Fiscal Year, we established the Electronic Medical Record Steering Committee. This committee is comprised of decision makers from each area of the hospital. We identified several projects in various stages of development. Through the committee, we prioritized these projects and developed controls, allowing us to complete these projects in a timely manner. In addition, we brought the Avatar system current by applying the fixes as provided by Netsmart. We also completed a solicitation for a new Time and Attendance system that will be installed in FY2008. Lastly, the hospital was part of a Department of Health Services conversion from Novell to Active Directory and from GroupWise email to Microsoft Outlook.

2007 LEGISLATIVE CHANGES IMPACTING THE ARIZONA STATE HOSPITAL

New Forensic Hospital

During FY 2007, the Legislature authorized the issuance of $32,2 million in Certificates of Participation (COP) for the lease purchase financing for the design and construction of a new 200 bed Forensic Hospital.

Hospital Staff have met with ADOA Capital Construction Staff to discuss the building project and identify first steps. As agreed, the Hospital has developed a Building Advisory Group to organize various recommendations for the new construction from a programmatic prospective. ADOA is in the process of hiring an Architect and Contractor for the project.

Guilty Except Insane (GEI), Statutory Change

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:

- No longer mentally ill, and not dangerous (RELEASED)
- Mentally ill, and still dangerous (REMAINS CONFINED)
- Mentally ill, and no longer dangerous (CONDITIONALLY RELEASED)

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

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

This past year A.R.S. § 13-3994 was amended to address this difficult population. Pursuant to the amended statute, a person who is found to be guilty except insane will receive a presumptive sentence to the Arizona Department of Corrections but will be remanded to the Arizona State Hospital for a period of treatment. Those individuals who are found to be no longer in need on ongoing mental health treatment but still dangerous or having a propensity to reoffend may be remanded to the Arizona Department of Corrections for the remainder of the sentence. The statute is prospective only and does not operate retroactively to individuals already at the Arizona State Hospital prior to the effective date of the statute.

The State Hospital will continue to work with the community and courts to ensure that those involved in the commitment process are aware of the admission criteria (which does not include sociopathic behavior or those who are primarily substance abusers).

ARIZONA STATE HOSPITAL FINANCIAL SUMMARY
FISCAL YEAR 2007

Item	Amount
Funding Sources (General Operations Based on Budget Allocations): *	
Personal Services and Related Benefits - General Fund	$40,631,882
All Other Operating - General Fund/Az State Hosp Fund	$13,631,013
Non-Title 36 Revenue	$65,927
Rental Income	$527,248
Endowment Earnings	$350,000
Patient Benefit Fund	$45,000
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	$62,029,370
Expenditures: *	
Personal Services and Related Benefits	$40,624,426
Professional and Outside Services **	$8,015,735
Travel (In-State)	$74,986
Travel (Out-of-State)	$7,862
Food	$0
Other Operating	$6,217,688
Capital Equipment	$141,070
Assistance to Others	$6,704,800
Total Cost of Operations	$61,786,567
Collections :	
Patient Care Collections to General Fund	$836,297
Patient Care Collections to Az State Hosp Fund - RTC	$2,880,127
Patient Care Collections to Az State Hosp Fund - Title XIX	$1,650,076
Non-Patient Care Collection to General Fund	$3,778
Total Collections	$5,370,278

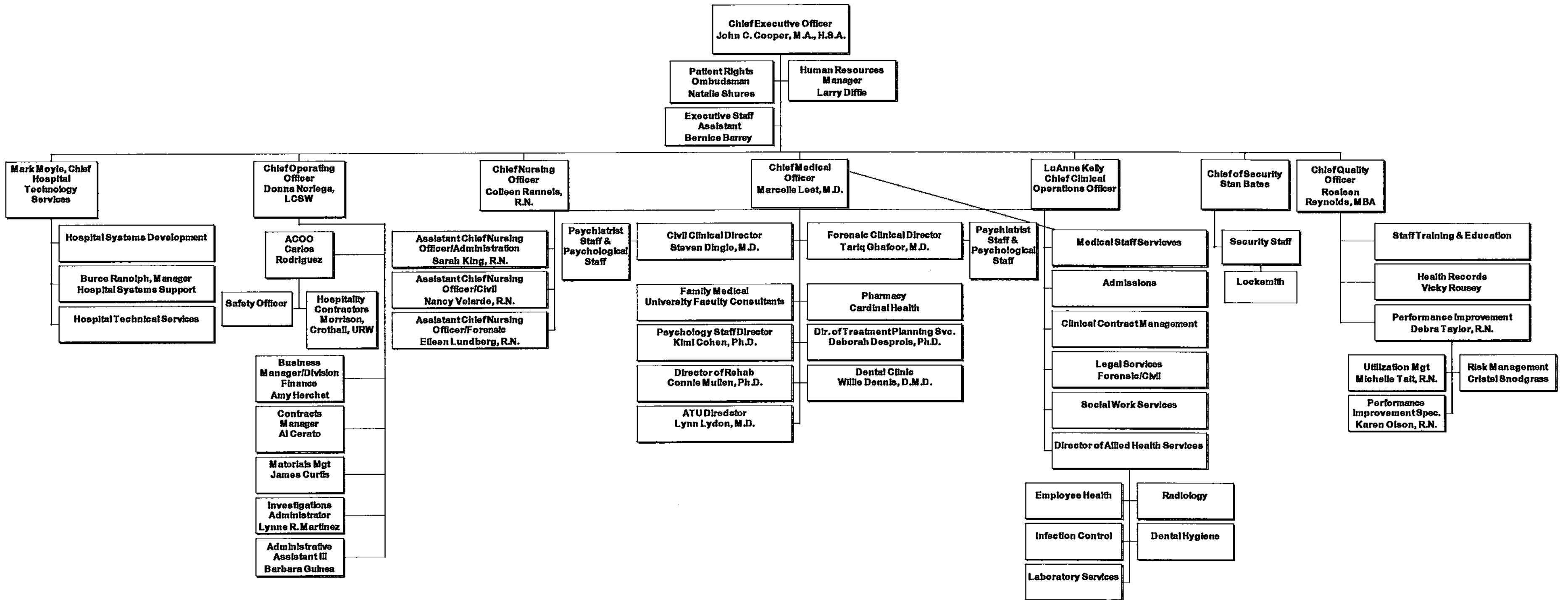
Excludes SVP Program.
Contract Physicians, Outside Hospitalization Costs, Outside Medical Services, and privatization of support services.

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.

ARIZONA DEPARTMENT OF HEALTH SERVICES
Arizona State Hospital with Arizona Community Protection & Treatment Center 2007

Organizational Chart



Designated Clinical Statutory Authority ____________