ARIZONA DEPARTMENT OF HEALTH SERVICES

ARIZONA STATE HOSPITAL

Clinical Improvement and Human Resource Plan

Submitted Pursuant to Laws 2022, Chapter 359, Section 3

September 1, 2023

Jennie Cunico, MS
Director - Arizona Department of Health Services

Michael R. Sheldon, MPA
Chief Executive Officer - Arizona State Hospital
Deputy Director - Arizona Department of Health Services

[This Page Left Intentionally Blank]

ARIZONA DEPARTMENT OF HEALTH SERVICES

ARIZONA STATE HOSPITAL

September 1, 2023

The Honorable Katie Hobbs, Governor - State of Arizona;
The Honorable Warren Peterson, President - Arizona State Senate;
The Honorable Ben Toma, Speaker - Arizona House of Representatives;
The Honorable Thomas "T.J." Shope, Chair - Senate Health and Human Services Committee;
The Honorable Steve Montenegro, Chair - House Health and Human Services Committee.

Transmitted herein please find a clinical improvement and human resource plan ("Plan") developed by the Arizona Department of Health Services, Arizona State Hospital pursuant to Laws 2022, Chapter 359, Section 3.

Per the authorizing legislation, this Plan provides a series of recommendations, with budget estimates, for potential enhancements to the programs, facilities and staff at the Arizona State Hospital to improve services for patients in the Civil and Forensic Hospitals and residents of the Arizona Community Protection and Treatment Center (ACPTC). As part of this effort, the Hospital solicited input from various community stakeholders - specifically, the state's Independent Oversight Committees (IOC), community-based treatment facilities, guardians, families, and representatives of patients, as well as clinical and administrative leaders from multiple health plans under contract for the provision of behavioral health services to qualified individuals.

The Department of Health Services appreciates the opportunity to provide this information for your review and consideration and will make our subject matter experts available to address any clarifying questions you may have.

Sincerely,

Michael R. Sheldon, MPA
Chief Executive Officer - Arizona State Hospital
Deputy Director - Arizona Department of Health Services

[This Page Left Intentionally Blank]

ARIZONA DEPARTMENT OF HEALTH SERVICES

ARIZONA STATE HOSPITAL

Pursuant to Laws 2022, Chapter 359, Section 3, the Arizona Department of Health Services ("ADHS" or "the Department"), Arizona State Hospital ("ASH" or "Hospital") has developed a clinical improvement and human resource plan (the "Plan") focused on addressing several areas critical to Hospital operations including admissions, discharges, clinical programming and staffing levels.

Per the authorizing legislation, the Hospital solicited input from various community stakeholders in developing this Plan - specifically, the State's Independent Oversight Committees (IOC), community-based treatment facilities, guardians, families and representatives of patients, as well as clinical and administrative leaders from multiple health plans under contract with the Arizona Health Care Cost Containment System (AHCCCS) for the provision of behavioral health services to qualified individuals.

The Plan detailed herein provides a series of recommendations, with budget estimates, for potential enhancements to the programs, facilities and staff at the Arizona State Hospital to improve services for patients in the Civil and Forensic Hospitals and residents of the Arizona Community Protection and Treatment Center (ACPTC). The Department has structured this document in such a manner as to permit the Governor's Office, members of the State Legislature and other policymakers the opportunity to decide which priorities may result in the maximum return on investment for Arizona, should they elect to pursue Hospital-specific and/or statewide enhancements in the future.

While there are always opportunities for improvement, it is critical for all parties to recognize that the Hospital is only one of hundreds of interdependent entities providing critical services in the State's comprehensive psychiatric system of care, and any perception that the Hospital is not functioning optimally is indicative of a larger set of systemic deficiencies within that care continuum. The Hospital's dedicated team of medical, clinical, and administrative professionals stand ready to assist the State however necessary to improve care, promote transparency, and better serve our fellow Arizonans in need of intensive psychiatric support and inpatient treatment.

Sincerely,

Michael R. Sheldon, MPA
Chief Executive Officer - Arizona State Hospital
Deputy Director - Arizona Department of Health Services

[This Page Left Intentionally Blank]

Table Of Contents

[This Page Left Intentionally Blank]

Background

The Arizona State Hospital (ASH or "Hospital") is a Division of the Arizona Department of Health Services (ADHS or "the Department"), and serves all counties and tribal communities within the State of Arizona. Patients and residents are admitted only on an involuntary basis pursuant to a court order due to the severity of their mental illness or behavioral disorder and an inability to be successfully treated in a community facility, as a result of their involvement in the criminal justice system, and/or their propensity pose an imminent risk to public safety should they be released to the community. Treatment at ASH is considered the highest and most restrictive level of inpatient care in the State.

ASH consists of three separately-licensed facilities located at 24th Street and Van Buren Street in Phoenix, Arizona: the Civil Hospital, the Forensic Hospital, and the Arizona Community Protection and Treatment Center (ACPTC). Regardless of the admitting facility, patients or residents are provided with clinical and administrative programs designed to meet their individualized needs. This includes psychiatric care, psychosexual education (ACPTC), medical and nursing services, pharmacotherapy management, rehabilitation, social work, psychological services, dietary services, and nutritional care.

The Civil Hospital and Forensic Hospital are each licensed as a *Special Hospital* pursuant to Arizona Administrative Code (A.A.C.) R9-10-101.218 and are authorized to provide psychiatric services to individuals admitted for inpatient treatment with a primary diagnosis of a mental disorder, a personality disorder, or a significant psychological or behavioral response to an identifiable stressor per A.A.C. R9-10-225(A)(2).[1] As such, any individual whose clinical needs cannot be met by the facility shall not be admitted to the Arizona State Hospital for treatment (A.A.C. R9-10-225(A)(4)).

The **Civil Hospital** (117 licensed beds) is certified by the Centers for Medicare and Medicaid Services (CMS) and operates in accordance with the requirements outlined in CMS' Hospital Conditions of Participation (CoPs), despite being largely unable to bill Medicaid or Medicare for services (see below). The Civil Hospital is also accredited by The Joint Commission and adheres to its Hospital Accreditation Program (HAP) standards, and is further regulated by the state in accordance with healthcare institution (HCI) licensing rules. Civil Hospital patients are adults who are civilly-committed pursuant to Arizona Revised Statutes (A.R.S.) §36-201 et. seq., as a danger to self (DTS), danger to others (DTO), gravely disabled (GD) and/or persistently and acutely disabled (PAD). Per Title 36, and in accordance with various legal decisions, including the U.S. Supreme Court's ruling in *Olmstead v. L.C.*, civilly-committed individuals must be treated in the least restrictive environment that can safely meet their needs.

[1] Pursuant to ARS §36-501 a "Mental disorder" means a substantial disorder of the person's emotional processes, thought, cognition or memory. Mental disorder is distinguished from: (a) Conditions that are primarily those of drug abuse, alcoholism or intellectual disability, unless, in addition to one or more of these conditions, the person has a mental disorder. (b) The declining mental abilities that directly accompany impending death. (c) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder.

Whereas the Civil Hospital is classified as an Institution for Mental Disease (IMD; see 42 CFR Ch. IV §435.1010), Federal Medicaid and/or Medicare funding is not provided for inpatient psychiatric services beyond 15 days of a patient's admission.[2] However, Medicaid-eligible Civil Hospital patients determined to have a Serious Mental Illness (SMI) retain physical health (medical) benefits and enrollment with an Arizona Health Care Cost Containment System (AHCCCS) health plan throughout the duration of their treatment at ASH. Hospital staff coordinate with outpatient treatment teams to optimize medical and behavioral health care, with the goal of recovery, successful discharge and reintegration into a community-based setting.

Figure 1

Civil Patient Demographics - State Fiscal Year (SFY) 2023					
Civil Campus			**Total Unique Patients Served: 137**		
Gender	***Percent***	***Race***	***Percent***	***Length of Stay***	***Percent***
Male	69%	American Indian	6.2%	< 1 year	24.8%
Female	31%	Asian	<1%	1 to 2 years	19.0%
Age Group	***Percent***	African American	14.6%	2 to 5 years	31.4%
18-21	<1%	Caucasian	57.7%	5 to 10 years	10.2%
22-29	20.4%	Other / Unknown	20.4%	10+ years	14.6%
30-39	30.7%	***County of Origin***	***Percent***	***Admission Status***	***Percent***
40-49	27.0%	Maricopa	67%	First Admission	48.9%
50-59	8.0%	Pima	22%	Readmit to ASH	29.9%
60+	13.1%	Other	11%	Discharged in SFY	18.2%

Primary Diagnostic Categories - Civil Campus	
Diagnostic Category	**Percent of Population Served**
Schizophrenia Spectrum & Other Psychotic Disorders	88.7%
Neurocognitive Disorders	3.8%
Personality Disorders	3.0%
Bipolar & Related Disorders	2.3%
Depressive Disorders	1.5%
Disruptive, Impulsive-Control & Conduct Disorders	0.8%

Length of Stay (LOS) Analysis - Civil Campus (in years)			
Patient Status	**Count**	**Median LOS**	**Average LOS**
Discharged in SFY 2023	25	1.69	2.89
Inpatient as of SFY 2023 Year End	112	2.31	4.59

[2] With the exception of enrolled and eligible individuals under the age of 21 or those over the age of 64.

The **Forensic Hospital** (143 licensed beds) is accredited by The Joint Commission and operates as a psychiatric hospital in accordance with state licensing rules. In contrast to patients admitted under a Title 36 civil commitment order, public safety and protection, rather than 'least-restrictive' criteria, is prioritized for Forensic patients. There are two distinct patient program classifications admitted to the Forensic Hospital:

> ***Pre-Trial Restoration to Competency (RTC)*:** These individuals are admitted for a short duration (approximately five months on average) to receive pre-trial evaluation and treatment with the goal of being restored to competency to stand trial for a criminal offense. Because the majority of restoration services are provided in county jails in Arizona, there are, on average, fewer than five (5) RTC patients admitted to the Forensic Hospital at any given time.
>
> ***Post-Trial Forensic Rehabilitation:*** This program provides treatment to adults serving a determinate sentence for committing a violent offense and subsequently entering into a *'Guilty Except Insane' (GEI)* plea agreement as detailed in A.R.S. §13-502. Pursuant to statute, these individuals are sentenced to the State Hospital for a treatment duration equivalent to the time they would have received under the Department of Corrections had they otherwise been found guilty of the criminal offense. While the GEI statute became effective in 1994, and the majority of Forensic patients are classified as such, there are a small number of individuals (<10) who were found *'Not Guilty by Reason of Insanity' (NGRI)* prior to the statutory change, were sentenced to the Forensic Hospital, and remain admitted inpatient as of this Plan's publication.

Due to their legal status, Forensic patients lose all eligibility for Medicaid-covered benefits for the duration of their admission and, therefore, their treatment is fully funded by state general fund monies. Guilty Except Insane (GEI) and Not Guilty by Reason of Insanity (NGRI) Forensic patients receive services at the Hospital pursuant to a Title 13 criminal court order for treatment and are under the jurisdiction of the Superior Courts for the term of their confinement. Release of a GEI or NGRI patient to the community prior to sentence expiration, e.g. *Conditional Release,* is ordered by the courts and coordinated with an AHCCCS health plan for post-release monitoring.

Figure 2

Forensic Patient Demographics - State Fiscal Year (SFY) 2023					
Forensic Campus			Total Unique Patients Served: 139		
Gender	***Percent***	***Race***	***Percent***	***Length of Stay***	***Percent***
Male	85.6%	American Indian	3.6%	< 1 year	17.2%
Female	14.4%	Asian	2.9%	1 to 2 years	10.1%
		African American	9.4%	2 to 5 years	20.2%
Age Group	***Percent***	Caucasian	68.3%	5 to 10 years	31.0%
18-21	<1%	Other / Unknown	15.8%	10+ years	21.6%
22-29	11.5%	***County of Origin***	***Percent***	***Admission Status***	***Percent***
30-39	28.1%	Maricopa	32%	First Admission	59.0%
40-49	22.3%	Pima	25%	Readmit to ASH	17.3%
50-59	19.4%	Yavapai	9%	Readmit CR	7.2%
60+	18.7%	Other	34%	Discharged in SFY	15.8%

Primary Diagnostic Categories - Forensic Campus	
Diagnostic Category	**Percent of Population Served**
Schizophrenia Spectrum & Other Psychotic Disorders	71.8%
Bipolar & Related Disorders	14.5%
Personality Disorders	4.6%
Depressive Disorders	3.1%
Neurodevelopmental Disorders	3.1%
Substance-Related & Addictive Disorders	2.3%
Disruptive, Impulsive-Control & Conduct Disorders	0.8%

Length of Stay (LOS) Analysis - Forensic Campus (in years)**			
Patient Status	**Count**	**Median LOS**	**Average LOS**
Discharged in SFY 2023	13	2.44	3.54
Inpatient as of SFY 2023 Year End	113	5.58	7.08

***LOS Analysis does not include Forensic Restoration to Competency (RTC) patients.*

The **Arizona Community Protection and Treatment Center (ACPTC)** (131 licensed beds) is a state-funded Behavioral Health Specialized Transitional Facility mandated by the Arizona Legislature in 1997 per A.R.S. §36-3701 et. seq., and operates under the terms specified in A.A.C R9-10-1301 through R9-10-1317. ACPTC is a Title 36 civil commitment program that provides supervision, care or treatment to those individuals adjudicated as Sexually Violent Persons (SVP). All admissions and discharges from ACPTC are court-ordered. Services are provided to residents who are 18 years of age or older. Since the program began in 1997, no females have been admitted to ACPTC. Residents enter psychosexual treatment immediately following their commitment to the program and are statutorily required to be evaluated annually. Recommendations are made to the court regarding the resident's progress and whether they would benefit from continued treatment in a 'Total Confinement' setting or within a 'Less Restrictive Alternative' (LRA) setting.

Figure 3

ACPTC Resident Demographics - State Fiscal Year (SFY) 2023					
ACPTC			**Total Unique Residents Served: 103**		
Gender	***Percent***	***Race***	***Percent***	***Length of Stay***	***Percent***
Male	100%	American Indian	<1%	< 1 year	7.5%
Female	-	Asian	<1%	1 to 2 years	6.5%
Age Group	***Percent***	African American	13.9%	2 to 5 years	4.7%
18-21	0%	Caucasian	70.4%	5 to 10 years	17.6%
22-29	1.9%	Other / Unknown	14.8%	10+ years	63.9%
30-39	9.3%	***County of Origin***	***Percent***	***Admission Status***	***Percent***
40-49	11.1%	Maricopa	67%	First Admission	83.3%
50-59	38.0%	Pima	17%	Readmit to ASH	9.2%
60+	39.9%	Other	16%	Discharged in SFY	6.5%

Primary Diagnostic Categories - ACPTC	
Diagnostic Category	**Percent of Population Served**
Pedophilic Disorders	53.3%
Paraphilic Disorders	35.5%
Personality Disorders	4.7%
Schizophrenia Spectrum & Other Psychotic Disorders	1.9%
Other	4.7%

Length of Stay (LOS) Analysis - ACPTC (in years)			
Patient Status	**Count**	**Median LOS**	**Average LOS**
Discharged in SFY 2023	7	4.98	6.60
Admitted as of SFY 2023 Year End	96	13.13	12.78

Per Senate Bill 1444, adopted during the 2022 Second Regular Session of the Fifty-Fifth Arizona State Legislature, and codified in Laws 2022, Chapter 359, Section 3, the Arizona State Hospital has developed a clinical improvement and human resource plan ("the Plan") focused on addressing several areas critical to Hospital operations, including admissions, programmatic needs, staffing levels, and discharges as they relate to all three independently-licensed facilities managed by the Hospital's administration. As part of this effort, the Hospital solicited input from various community stakeholders - specifically, the state's Independent Oversight Committees (IOC), community-based treatment facilities, guardians, families, and representatives of patients, as well as clinical and administrative leaders from multiple health plans under contract with AHCCCS for the provision of behavioral health services to qualified individuals.[3]

Additionally, per the authorizing legislation, the Hospital has included budgetary estimates based on historical costs, market-specific reviews, and/or industry standards, for use as a *general guidance* for policymakers in determining which priorities may result in the maximum return on investment for Arizona, should they elect to pursue hospital-specific and/or statewide systemic enhancements in the future.

[3] Public input was collected via an anonymous online survey between March 6, 2023 and April 28, 2023. All survey feedback is included in Appendix B of this document.

Options for Enhancement and/or Expansion

Legislative Requirement: [the Plan shall] Identi[fy] the necessary enhancements to the services, facilities and staff at the Arizona State Hospital to provide statutorily required treatment and services to patients in the Forensic and Civil hospitals and the Arizona Community Protection and Treatment Center (ACPTC), including treatment and services for secondary diagnoses, such as substance use disorder, autism spectrum disorder, personality disorders and developmental disabilities.

The Arizona State Hospital provides for the care and treatment of persons with mental disorders and persons with personality disorders or emotional conditions who will benefit from care and treatment as required by A.R.S. 36-202. In order to do so, the Hospital must have adequate facilities and qualified professionals to meet the treatment needs of its patients and residents. Prior to this Plan's development, the Hospital has experienced internal limitations specific to staffing, bed capacity, physical environment, and clinical programming. The Hospital is also intimately aware of larger, systemic limitations impacting Arizona's public behavioral health system. Stakeholder input solicited for the development of this Plan suggests more community-based resources are necessary to meet the behavioral health needs of specific patient populations - which may subsequently reduce the utilization of, and the dependency on, the Arizona State Hospital.

In recent years, the Hospital has faced considerable external pressure to not only increase available bed capacity on the Civil campus and admit more patients with acute psychiatric conditions, but to also expand the service array to accommodate individuals with needs beyond what is currently authorized per licensure designation and admission criteria. Additional needs have been identified as long-term inpatient care for persons with *primary* Developmental Disabilities and/or Intellectual Disabilities (DD/ID), autism, severe substance use disorders, personality disorders, and severe neurocognitive disorders, including dementia. As required by Title 36, this Plan includes proposals with consideration of the rights of such individuals to receive services in the most appropriate level of care.[4]

The Hospital is firmly committed to enhancing its existing clinical model and expanding its permissible scope of services, permitted it has the legal authority and the available resources to safely do so. The State has multiple options available should it elect to augment the Hospital's programs in the future, ranging from adding clinical staff with the expertise to provide additional evidence-based treatment modalities to the existing patient population, increasing the allowable bed capacity to accommodate more psychiatric patients on the Civil campus, and building a separate free-standing facility on the Hospital's campus specifically designed to address patients with DD/ID, dementia, autism and/or significant personality disorders, as well as those with severe substance abuse and addiction disorders.

While this Plan includes data from the Hospital to support proposals contained herein, it does not include quantitative data from the health plans for patients experiencing DD/ID, dementia,

[4] see CMS Proposed Rule, *Nondiscrimination in Health Programs and Activities*

autism, significant personality disorders, or substance addiction, and for whom the health plans are seeking admission at the Arizona State Hospital due to insufficient resources in the community. A thorough analysis of the needs for these patient populations should include comprehensive data on provider network sufficiency, service utilization, access to care metrics, and costs of behavioral health and physical health care services.

The Plan detailed herein provides a series of recommendations, with budget estimates, for potential enhancements to the services, facilities and staff at the Arizona State Hospital to provide appropriate treatment and services to patients in the Civil and Forensic hospitals and residents of the Arizona Community Protection and Treatment Center (ACPTC). The following table (Fig. 4) summarizes the estimated funding and headcount revisions necessary for each recommendation's adoption, and further information can be found in the subsequent narrative. Finally, detailed budget estimates for each recommendation are included in Appendix A of this document.

Figure 4

State Hospital - Estimated Funding and Headcount Additions per Expansion Option				
Description	**Needed Headcount Increase**	**Estimated Time To Implement**	**Estimated Cost (Initial)**	**Estimated Cost (Ongoing)**
Additional Resources Needed to Meet Current Obligations[5]	117 FTE	-	-	$10,730,933 /yr
Option A - Enhance Clinical Model for Existing Patients and Residents	10 FTE	+6 Months	-	$1,667,021 /yr
Option B - Increase Civil Bed Capacity with No Changes to Clinical Model	169 FTE	+36 Months	$5,604,500	$20,709,953 /yr
Option C - Increase Civil Bed Capacity *and* Enhance Clinical Model	185 FTE	+36 Months	$5,604,500	$23,197,253 /yr
Option D - Create Civil Reintegration Unit	30 FTE	+36 Months	$8,064,000	$4,151,967 /yr
Option E - Develop a Special Needs Unit for ACPTC	24 FTE	+12 Months	$2,500,000	$2,737,273 /yr
Option F - Expand Service Model Beyond Primary Psychiatric Care	259 FTE	+60 Months	$61,635,000	$37,375,153 /yr

Figure 5

State Hospital - Estimated Funding Costs for Needed Systems Enhancements			
Description	**Estimated Time To Implement**	**Estimated Cost (Initial)**	**Estimated Cost (Ongoing)**
Replace Staffing Management System	18 Months	$898,000 over 2 years	$213,000 /yr

[5] This line item is specific to meeting the Hospital's current operational needs and will not accommodate any expansion or enhancement suggestions in Options A through F of this Plan.

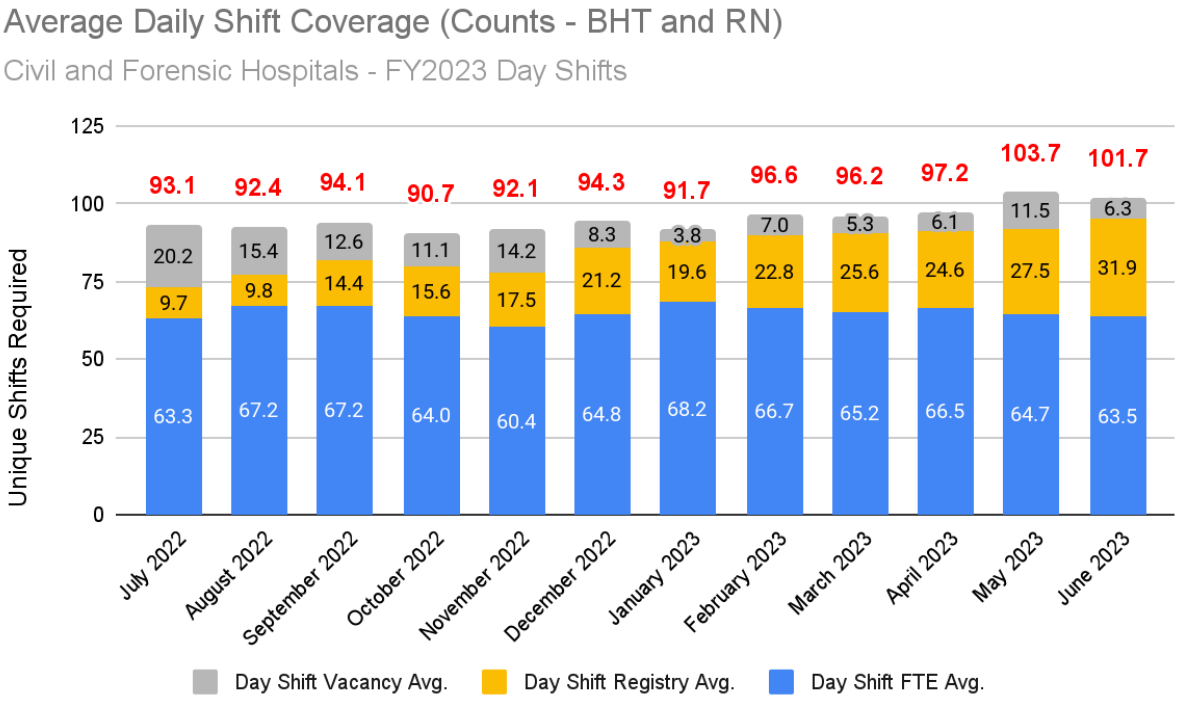
[This Page Left Intentionally Blank]

Additional Resources Needed to Meet Current Obligations

Based on the current demand for services as noted in the previous section of this document, and then further enumerated herein, the Hospital requires 846 full-time equivalent (FTE) positions to provide services in volume to meet the community standard of care; however, at present, the Hospital is permitted to hire up to 729 FTE positions, as outlined in the SFY2024 Appropriations Report.[6] Of those 729 positions, the Hospital receives the funding necessary to account for approximately 715 FTE positions, of which 629 are filled as of June 30, 2023.

In order to address this staffing shortfall, the Hospital relies on employees working overtime shifts on a voluntary basis, as well as contracted registry vendors to provide supplemental Registered Nurses (RN) and Behavioral Health Technicians (BHT), to maintain safety and patient care throughout the facility. These individuals carry the same qualifications, certifications, and licensure (where applicable) as full-time employees. Although the Hospital strives to reduce its reliance on both overtime and contracted staff, the ongoing dynamics of the healthcare labor market, specifically an industry-wide labor shortage across multiple disciplines, are making this exceedingly difficult for all healthcare institutions and has caused other psychiatric inpatient facilities in Arizona to reduce available capacity.[7]

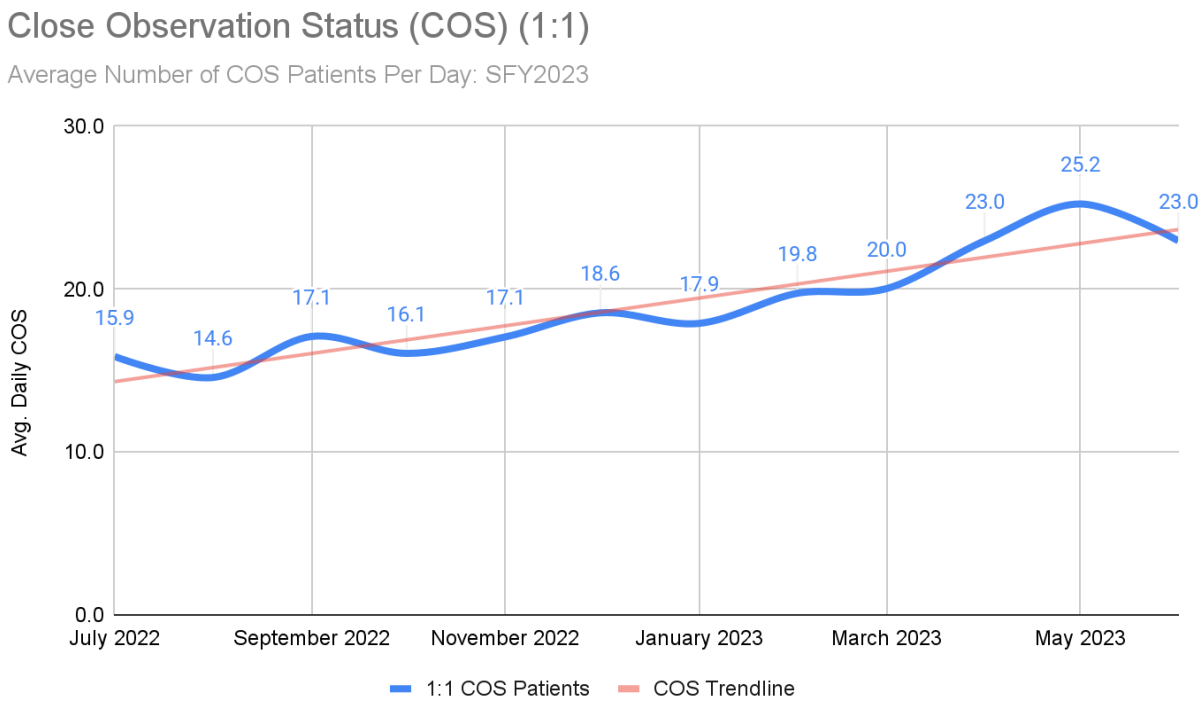
Figure 6



[6] Please see https://www.azjlbc.gov/24AR/dhs.pdf
[7] Innes, Stephanie. "'I've got the space and I can't use it': Why psychiatric beds in Phoenix area remain empty". Arizona Republic via AzCentral.com; published May 22, 2023.

The chart above (Fig. 6) illustrates the number of FTE and registry staff members (BHT and RN) that provided day shift coverage at the Hospital during SFY2023 per day, per month on average, as well as the average number of shifts that went unfilled per day, per month in that same time period.[8] As of June 2023, one-third (33%) of all day shifts are covered by temporary registry personnel, and this number has increased over time, as the Hospital has required more staff to meet the growing census and clinical needs of its patients, but has been unable to proportionately recruit qualified full-time employees in response. As detailed in Figure 6, the Hospital requires approximately nine (9) additional BHTs per day shift on average to operate as of June 2023 in comparison to what was needed in July 2022. This is primarily due to an increase in overall behavioral acuity and the number of patients requiring a heightened level of observation status (a physician's order for close observation is to mitigate a patient's harm to self, harm to others, or other adverse outcomes). Close Observation Status (COS) requires at least one dedicated staff member and may require additional staff (i.e., 2:1), depending on the physician's order. As indicated in the chart below (Figure 7), in June 2023, there were 23 patients on COS per day, on average, while in July 2022 there were 16 patients on COS per day, on average. Importantly, the number of shift vacancies has decreased substantially since the beginning of SFY2023, and the Hospital is presently able to cover 94% of all needed daily shift work using a combination of full-time employees and registry staff.

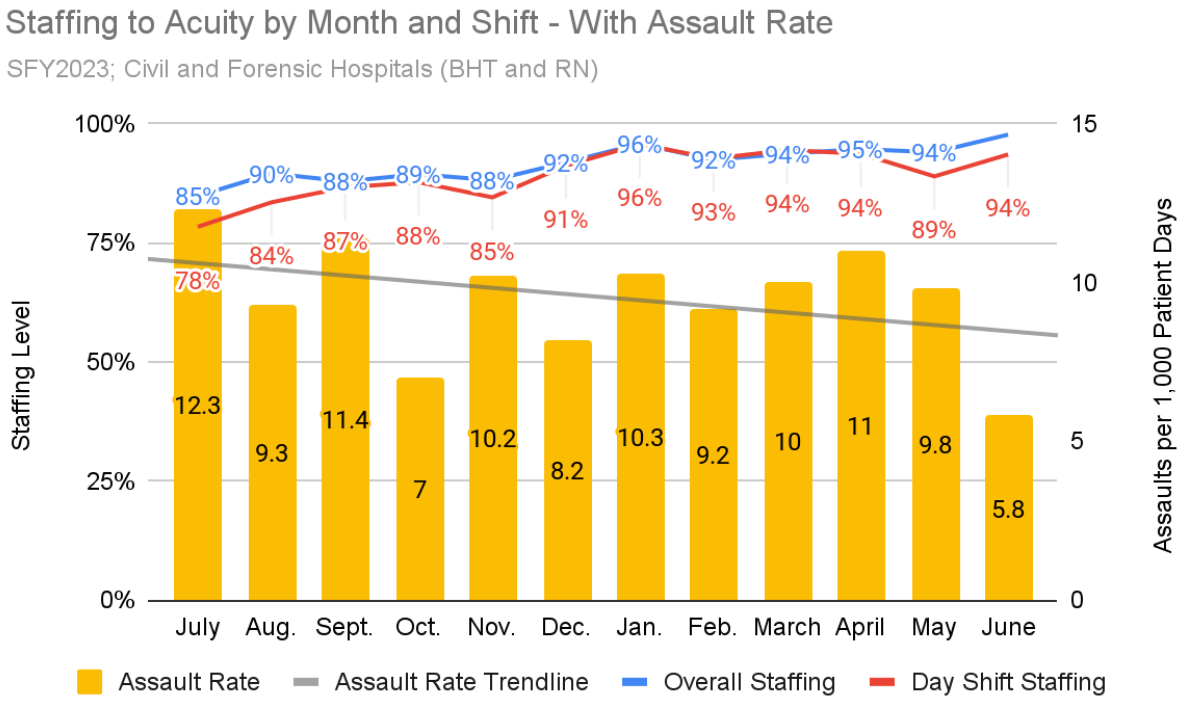
Figure 7



[8] The Civil and Forensic Hospitals utilize 12-hour shifts for all Behavioral Health Technicians and Nursing staff. The labor activity data reflected in Figure 6 is specific to day shifts, which are from 6:00 AM to 6:00 PM. On average, approximately 15 additional staff are required during this shift as opposed to that of the 6:00 PM to 6:00 AM overnight shift.

The importance of adequate staffing, in both quantity and quality, in an inpatient psychiatric setting where patients are admitted under an involuntary court order for treatment, cannot be overstated. Because the Hospital serves the most acutely ill individuals in the State, many of whom are prone to highly aggressive and assaultive behavior in response to auditory and/or visual hallucinations symptomatic of their mental illness, it is imperative that the Hospital has sufficient staff present on the treatment units to manage the milieu and maintain safety. The chart below reflects the relationship between staffing levels and patient assault rates during SFY2023. The Hospital defines an assault as '*any unwanted physical contact between parties with the intent to cause harm*', and the vast majority of assaults (>85%) result in no injuries. As the Hospital has been able to increase staffing levels over time, assault rates have gradually decreased.

Figure 8



It should also be noted that, due to the legal status and extensive lengths of stay of the admitted patient population, the Hospital does not have the flexibility to rapidly downscale its operations in response to staffing limitations. For example, unlike other inpatient healthcare facilities, the Hospital can not transfer patients to another location, refuse or delay admissions for prolonged periods of time, close treatment units or otherwise reduce available capacity - as the legal status of the patients dictates they remain at ASH for the duration of their inpatient care and, at present rates of attrition, the Hospital would require approximately 18 months to discharge the volume of patients needed to effectively close a single treatment unit. Therefore, the Hospital must meet the needs of the existing patient census at all times with the staffing resources presently available.

Figure 9, below, details the current staff availability relative to the Hospital's maximum allowable headcount and the facility's actual need for several critical positions. In addition to an increase in the hireable number of Behavioral Health Technicians and Registered Nurses, which are instrumental in maintaining the safety of patients throughout the campus, there is also an unmet need in other disciplines critical to providing care to our existing patient/resident populations including Psychology, Social Services, and Rehabilitation, among others.

Figure 9

FTE Adjustment Necessary to Meet Current Obligations[9]				
Position / Discipline	**Hired Headcount[10]**	**Maximum Allowable Headcount**	**Actual Needed Headcount**	**Potential Adjustment**
Behavioral Health Technicians	201	237	314	77 FTE
Registered Nurse	57	83	88	5 FTE
Psychology	18	20	29	9 FTE
Social Services	18	23	26	3 FTE
Rehabilitation	44	51	59	8 FTE
Residential Program Specialist (ACPTC)	63	67	80	13 FTE
Health Records	8	9	11	2 FTE
All				**117 FTE**

Psychology: The Psychology department consists of 20 employee positions that serve all three campuses of the Hospital. There are ten licensed psychologists, two doctoral-level staff members who are studying for their licensing exam, five masters-level therapists, one ACPTC program/project specialist, and two interns that are paid hospital employees. Additionally, there are currently two interns and two practicum students that are not paid through the state. In recent years, Psychology staff have taken on an increasingly larger role in the hospital. Along with providing assessment and therapy services, they are the leaders of treatment teams on three Forensic Hospital units; prepare reports and provide testimony for court hearings; offer training to staff hospital-wide; develop comprehensive plans to address self-injury and assaultive behaviors; and provide specialized services, such as therapy groups and assessments conducted in Spanish and a Healthy Sexual Boundaries educational program provided to patients on all Hospital units.

Recent legislative changes regarding the jurisdiction of Forensic patients has led to an increased demand for the Hospital's Psychology department to provide extensive reports

[9] Please see Appendix A for further details
[10] As of June 30, 2023

detailing the patient's clinical history and treatment progress, along with an assessment of risk for violence, to the Superior Courts for use in their legal proceedings in determining a Forensic patient's progress toward conditional release.[11] As a result of this change, the Hospital requires two (2) additional psychologists to ensure all necessary reports and assessments are completed and supplied to the courts in a timely manner. Additionally, in order to provide the appropriate volume of services to Forensic patients, two (2) additional therapists are needed to offer treatment that addresses issues contributing to patients' criminal offenses; these services would include group therapies focusing on areas such as trauma, symptom management, and interpersonal/relationship functioning.

The ACPTC's psychology staff provides psychosexual and psychological services for all ACPTC residents. According to the Sex Offender Civil Commitment Program Network (SOCCPN) 2018 and 2019 Annual Surveys, the national average for treatment hours for SVP programs is 6 hours per week, per resident. Currently, ACPTC averages approximately 2.6 hours of treatment per week, per resident, with a range from 1 to 5.5 hours of psychotherapy per week, per resident. ACPTC's clinical staffing ratio is 1:22 or more, on average, with a range of 1:20 to 1:24 depending on the caseload, yet according to SOCCPN, the accepted standard ratio to effectively provide the care for and experience needed to effectively treat this population is 1:16. Therefore, ACPTC requires at least one (1) additional psychologist and four (4) additional master's level therapists to increase service hours, provide legally-mandated treatment consistent with the national average, and reduce the clinical staffing ratio. This increase in staff would allow the ACPTC to provide an approximate average of 7.26 hours of psychotherapy a week to each resident, meeting and slightly exceeding the national average according to the SOCCPN survey.

Social Services: The Social Services team of 23 employees facilitates the admissions, benefit enrollment, treatment planning, care coordination, community reintegration and discharges for Civil and Forensic Hospital patients. The department also attends to the spiritual/pastoral needs of patients, conducts individual and group therapy sessions, and provides clinical supervision and continuing education to Master of Social Work interns and Social Work professionals. The members of the ASH Social Services Department collaboratively focus on patient recovery and treatment, from pre-admission to discharge. As such, the psychiatric social workers (all of whom have Masters level degrees and are licensed as masters of social work or clinical social workers by the Arizona Board of Behavioral Health Examiners) provide clinical care, and coordinate with the interdisciplinary team and guardians and other community stakeholders to promote recovery, community reintegration opportunities, and continuity of care.

As with all clinical disciplines, the Social Services Department requires essential personnel to maintain an acceptable, adequate, ethical, and equitable standard of care. At this time, the Social Services Department is functioning with fewer staff than necessary to meet current needs. The admission workflow has increased significantly, requiring increased attention to administrative tasks, coordination, and communication with external partners. In addition, the discharge process, with an aging and more diverse patient population, continues to present

[11] Please see Senate Bill 1839

greater community reintegration barriers and coordination complexities. As a result, though astutely adept at addressing all admissions and discharge challenges, the role of psychiatric social worker is, through necessity, focused less on clinical care and more on case management/coordination.

In addition to the admission and discharge complexities, there are other expanding administrative responsibilities requiring the attention of psychiatric social workers. Administrative responsibilities include developing and updating each patient's Inpatient Treatment and Discharge Plan (ITDP) in the electronic health record (EHR), providing real-time notification to patient guardians and other entities for patient incidents, documenting all notifications in the EHR, collecting and reporting data, conducting audits, and participating in a number of Hospital committees. While these functions are important, they limit the psychiatric social worker's ability to augment clinical services at a level commensurate with patient needs. In order to address this, the Hospital recommends adding three (3) Masters Level social workers to the existing team - with one specifically assigned to the ACPTC, which currently does not have a dedicated social worker to assist the resident population.

Rehabilitation: The Rehabilitation Department provides various programming opportunities for all three campuses and manages the therapeutic work program. Groups offered by the Rehabilitation Department include vocational training programs, social skills, life skills, arts and crafts, ceramics, various sporting activities, fitness groups, music groups, creative writing, and computer skills. The Rehabilitation Department also facilitates services including patient cafes, a gift shop, two swimming pools, barber services, special events, and a library.

The Rehabilitation Department consists of 51 employee positions including recreation therapists, occupational therapists, therapy technicians, vocational leaders, a librarian, and three rehab managers. Additionally, there is a part-time barber and a part-time physical therapist. The Rehabilitation Department contributes to patient care and coordinates and oversees all community reintegration outings for the Civil and Forensic campuses - which is critical to helping patients move to community discharge or conditional release. Similar to other disciplines, this department has struggled to remain fully staffed and, as a result, has not been able to provide services at the desired volume. Ideally, the Hospital would like to expand the service hours and opportunities for outings provided by the Rehabilitation Department to include programming during the evenings and weekends to keep all patients and residents fully engaged in treatment - doing so would require the addition of eight (8) recreation therapists who would be assigned to either the Forensic Hospital or ACPTC.

Residential Program Specialists: The Residential Program Specialists (RPS) are the unit staff for the ACPTC. The RPS provide care and supervision for the ACPTC residents, including day-to-day health and welfare, management of the unit, room safety compliance checks, and facilitation of visitation with family, friends, and legal representation. The RPS staff also provide oversight of statutorily mandated annual evaluations and transportation to and supervision of community reintegration activities, as well as medical or legal appointments.

As of June 30, 2023, ACPTC had 63 RPS staff and, on average, these individuals worked a total of approximately 882 hours of overtime per pay period in SFY2023 - or 14 hours per employee, per pay period. Due to difficulty recruiting and retaining staff to work with this unique population, RPS are frequently requested to work overtime to provide mandated care and supervision to ACPTC residents. Without overtime or additional staff, court ordered privileges, such as community reintegration outings, are often canceled. The hospital is requesting 13 additional RPS staff to reduce overtime costs and ensure court-ordered aspects of treatment remain consistent with the goal of assisting residents with community reintegration and discharge planning.

Health Records: The Health Records Department at the Hospital consists of a Release of Information (ROI) Specialist, seven (7) Medical Record Specialists, and a supervisor. The Director has direct oversight of the day-to-day operations of the Health Records Department, and additionally serves as the Privacy Official for the Hospital. The Department staff support the thirteen (13) total inpatient treatment units of the Civil and Forensic hospitals. This support includes, but is not limited to, maintaining the hybrid records (electronic and hard copy) for each patient, scanning files for import into the electronic health record (EHR), and auditing records to verify completion of records, as required for meeting regulatory requirements. Medical record staff and service requirements are outlined in the CMS Hospital Conditions of Participation (CoPs).[12]

Additional staff are necessary for the Health Records Department due to the need to shift medical record documentation into the EHR and to meet the demand of requests for medical records. In accordance with the Hospital's Imaging Plan filed with the Arizona State Library, Archives, and Public Records, the Hospital is obligated to transition health records to the EHR rather than maintaining a hybrid system of patient health records. This requires significant resources to scan and import documents into the EHR and modify the Hospital's existing EHR to include all necessary patient health information. One additional dedicated, full-time staff member is necessary for supporting the responsibilities of scanning and importing documents into the EHR and auditing documentation in the EHR to verify completion of required documentation.

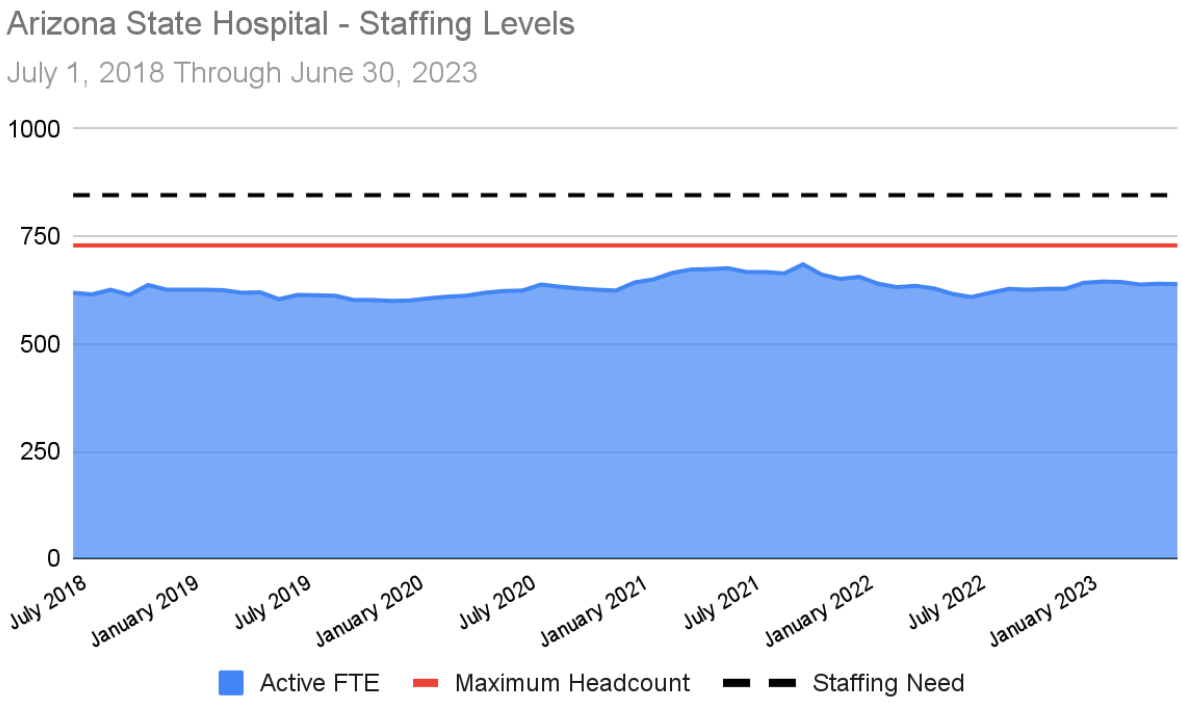
Effective January 1, 2023, the management of Guilty Except Insane (GEI) cases for Forensic patients shifted from the Psychiatric Security Review Board (PSRB) to the Arizona Superior Courts. This change has resulted in a significant, increased demand for patient health records from attorneys filing motions with the Superior Courts. Such requests may include the totality of the patient health record for multiple years of admission. The Health Records Department has proposed the creation of a secure portal to manage these requests and to ensure the release of patient records only to those individuals who are authorized to receive this highly-confidential information. Regardless of whether a secure portal is developed to manage this process, an additional full-time staff member would be necessary to support this increased demand to produce patient health records in a timely manner.

[12] 42 CFR 482.24, *Medical record services*; 42 CFR 482.61, *Special medical record requirements for psychiatric hospitals*

Workforce Analysis: At present, there are no vendors under contract with the Hospital to provide supplemental staff for Psychology, Social Services, or Rehabilitation; however, those programs routinely offer internship opportunities to individuals preparing for a professional career in the field. While interns provide both a significant number of direct service hours to patients/residents and an inherent recruiting pool from which these disciplines hire, adequate oversight resources are required to administer internship programs. Additionally, the Hospital has noticed a shift in the preferences of potential internship candidates in recent years, as more individuals are opting for paid internships, or opportunities that provide either varied (atypical) hours and/or remote work - unfortunately, the Hospital is largely unable to accommodate this due to our funding model and the complexity of our patient/resident population.

As depicted in Figure 10, the Hospital has consistently operated with less full-time staff than that determined necessary to provide comprehensive therapeutic services to patients and residents at volume to meet the community standard of care. During the period beginning July 1, 2018 and ending June 30, 2023, the Hospital had an average hired headcount of 631 full-time employees - 98 less than the Hospital's maximum permitted headcount and 215 less than the actual number needed.

Figure 10



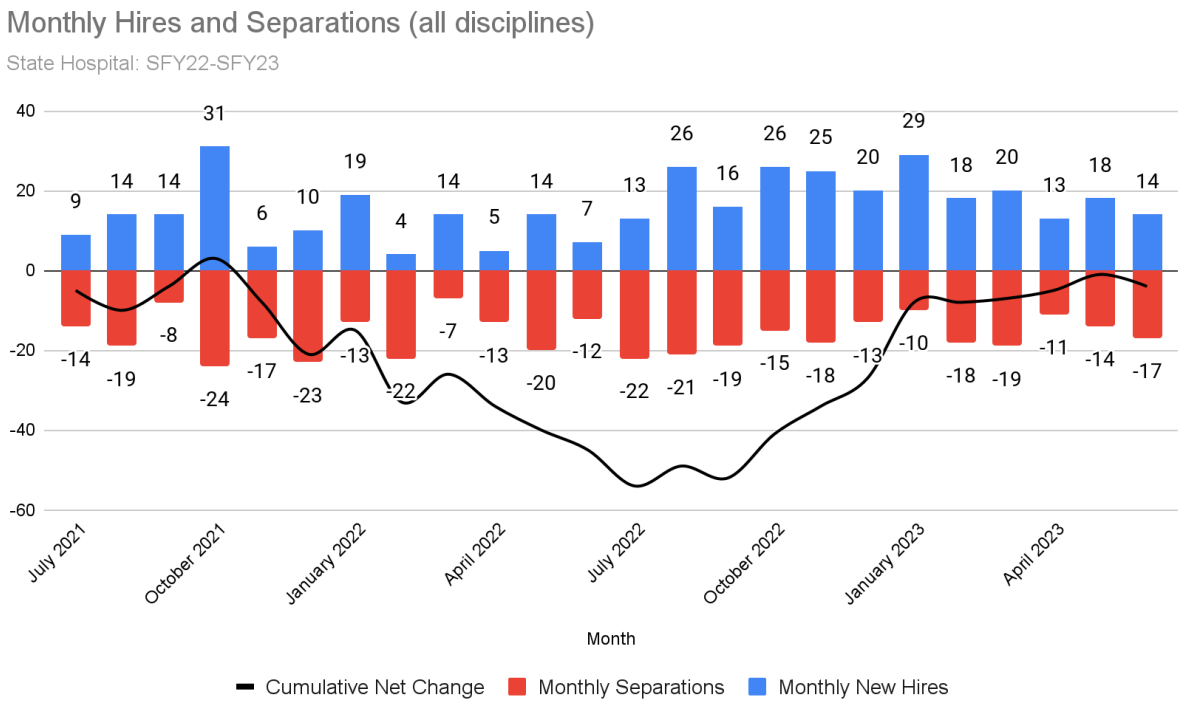
The Department of Health Services has dedicated considerable resources to the Hospital in an effort to expand outreach to various educational programs, attend job fairs, and network directly with career services organizations. Additionally, the Hospital has taken several administrative actions in recent years to increase recruitment and retention in an attempt to stabilize the workforce:

- As of November 19, 2021, the weekend hourly shift differential for employees working Saturday and Sunday increased from 5% to 10%.
- Beginning on the November 27, 2021 pay period through the end of the fiscal year (June 30th, 2022), staff providing direct patient care (most positions except for security and administration) received a 10% critical services premium pay stipend (**Discontinued July 28, 2022**).
- The Hospital offered a $500 incentive per holiday to each employee required to work Thanksgiving (November 25, 2021), Christmas Eve (December 24, 2021), Christmas Day (December 25, 2021), New Year's Eve (December 31, 2021), and New Year's Day (January 1st, 2022) (**Not carried over past SFY2022 due to funding**).
- Effective January 8, 2022, the following classifications received a $5,000 hiring incentive to be paid out in three payments ($500 at month three, $1,000 at month six, and $3,500 after one-year): Registered Nurses, Licensed Practical Nurses, Behavioral Health Technicians, Therapy Technicians, Residential Program Specialists, Occupational Therapists, Rehab Therapists, Recreational Therapists, and Social Workers.
- As of January 18, 2022, requirements were updated to make it easier for clinical staff at ASH to request an annual leave payout for COVID-related hardships. The update removed the minimum number of annual leave hours a clinical employee must have used in the previous 12 months from 40 to zero hours.
- As of February 17, 2022, ADOA approved a new “Call-Back Pay Incentive”. This incentive offers staff the opportunity to receive Double-Time for responding to a call to work any additional shift beyond their normal workweek required shifts. All staff (hourly and salary), minus certain disciplines and administrators, are eligible to participate and receive double-time for working an additional shift. (**Discontinued in its entirety October 14, 2022**).
- On June 15, 2022, the Hospital amended its contracts with the five Registry Staffing agencies to increase the payable rate for services and come into alignment with market salaries, subsequently increasing the number of registry staff willing to accept placement at ASH. The final adjustment was approximately 33%.
- On July 9, 2022, employees who scored a 3.25 or higher on their annual assessment were provided a salary increase of 2% - 4% (depending on the overall score). Unlike previous years, this was a fixed change to the employee’s annual base pay and not a one-time payout.
- On July 28, 2022, employees received a pay increase of at least 10% to their base salary per the SFY2023 budget. All positions in recruitment were refreshed to reflect the increased pay rate.
- The State implemented a Behavioral Health Loan Repayment Program in SFY2023 that prioritized awards to qualifying State Hospital employees whereby the individual could receive a maximum of $25,000 per year to assist with repaying student loan debt.

Unfortunately, these efforts have not had the anticipated positive impact on staffing levels. To the contrary, as depicted in the chart below (Figure 11), in the time period covering SFY2022 and SFY2023 (July 1, 2021 through June 30, 2023), on average the Hospital onboarded 16 new employees each month, while simultaneously losing 16.2 employees monthly due to separation from state service - resulting in an overall *negative net change* of -0.2 FTE per month on average.

The black line in Figure 11 represents the cumulative net change in the Hospital's employed headcount during this time period. As reflected in the diagram, the Hospital experienced a substantial decrease in full-time employees in SFY2022, during which the Hospital went from 672 employees (July 2021) to 618 employees (July 2022), a net loss of 54 FTE. This was largely driven by turnover in two key position classifications: Behavioral Health Technicians (31% annual turnover) and Nursing staff (26% annual turnover), as the economy stabilized towards the end of SFY2021 and other healthcare facilities offering notably higher salaries than ASH began hiring at an unprecedented rate. The Hospital has only recently begun to see its overall staffing numbers rebound, yet the facility still remains significantly below both its maximum allowable headcount, and the actual needed headcount, due to difficulties recruiting and retaining qualified staff in the current hyper-competitive healthcare labor market.[13]

Figure 11



[13] According to the most recent data from the National Library of Medicine, the overall turnover rate for Nursing nationwide was 27.1% in 2021 - which closely mirrors that of the State Hospital.

The SFY2024 budget included a line-item appropriation requiring the Arizona Department of Administration to conduct a compensation analysis of all State position classifications to determine market competitiveness with respect to the private sector, and to finalize that report no later than October 1, 2024. There are no specific details available at this time for how extensive this review will be, but it is likely to provide valuable insight to policymakers when determining the potential costs for expansion efforts at the State Hospital, specifically regarding employee salaries necessary for attracting and retaining qualified staff and stabilizing future operations. Importantly, the budget estimates included in this Plan specific to staffing costs **do not account for a market increase** - as that potential rate change is unknown at the time of this Plan's publication; therefore, labor budget estimates should be interpreted as a minimum baseline adjustment only.

If the Hospital's allowable headcount was proportionately adjusted to account for service demand, *and all positions were both adequately funded at or above market rate and fully staffed,* current spending on third-party registry contractors could be largely eliminated and overtime spending would decrease significantly, as more staff would be available to cover needed shifts.[14]

An additional 117 FTE would need to be added to the Hospital's maximum allowable headcount to accommodate the need for 846 employees, and an increase in $10.7 million in annual funding would be required to fully staff the Hospital under current conditions. In addition, annual salary adjustments would help maintain competitiveness with the healthcare labor market and increase recruitment and retention efforts.

Even with an adjustment to both the allowable headcount and associated funding appropriations, the Hospital has considerable concerns that the aforementioned issues with industry-wide labor shortages will undoubtedly prevent it from achieving full staffing levels across all disciplines in the immediate future.

Please Note: The above-cited adjustments to existing staffing levels are specific to meeting the Hospital's current operational needs and will NOT accommodate any expansion or enhancement suggestions in Options A through F below.

[14] A key requirement of SB1444 specifically tasks the Hospital with determining optimal staffing levels by emphasizing the use of regular employees and reducing the reliance on temporary staff.

[This Page Left Intentionally Blank]

Option A - Enhance Clinical Model for Existing Patients and Residents

Due largely to past funding priorities targeted to emphasize milieu management and safety, specifically a focus on Behavioral Health Technicians and Security Officers, clinical services have not been provided the necessary resources to accommodate the changing and increasingly complex needs of the patient population, including specialized therapies and evidenced-based behavioral modification procedures. This section of the Plan seeks to address these deficiencies and propose solutions that will allow the Hospital to provide more expansive psychiatric care to our existing patient and resident population, as well as meet their secondary or tertiary behavioral health needs beyond that of a primary psychiatric disorder. Respondents to the public survey soliciting feedback for this Plan believed this to be the action likely to result in the most long-term benefit for the State as a whole.

As previously indicated, individuals with a Neurocognitive Disorder (i.e., Dementia, Traumatic Brain Injury, etc.) or a Neurodevelopmental Disorder (i.e., Autism Spectrum Disorder or an Intellectual Disability) require specialized treatment due to the complexity of the behaviors and symptoms that are associated with these disorders. Furthermore, when these disorders are combined with a Serious Mental Illness, the need for specialized care is compounded and oftentimes leads to longer hospitalizations and difficulty discharging to a less-restrictive setting. While preparing this Plan, the Hospital reviewed the prevalence of Neurocognitive Disorders and Neurodevelopmental Disorders across its existing patient population. It should be noted that for both the Civil and Forensic campuses, individuals that had either a Neurocognitive Disorder, a Neurodevelopmental Disorder, or a combination, have been hospitalized for a significantly longer time period than their peers. Specifically, 32.5% of Civil patients and 12.2% of Forensic patients had at least one of these diagnoses and have an average length of stay 2.9 years longer than their peers without a Neurocognitive or Neurodevelopmental Disorder.

Figure 12

Prevalence of Top Non-Psychiatric Disorders Among Existing Hospital Population[15]				
Disorder Category	**Percent of Civil Patients**	**Percent of Forensic Patients**	**Percent of ACPTC Residents**	**Percent of ASH Population**
Neurocognitive Disorder	20.18%	4.35%	1.03%	***8.90%***
Neurodevelopmental Disorder	12.28%	7.83%	14.43%	***11.35%***
Personality Disorder	23.68%	18.26%	68.04%	***34.97%***
Substance Related Disorder	32.46%	61.74%	50.52%	***48.16%***

[15] Data as of June 21, 2023

In order to adequately address the high prevalence of comorbidity amongst the Hospital's current patient population, the Hospital will need to recruit specialists with training and extensive experience in clinical modalities that best serve its patient's needs.

First, a neuropsychologist is needed, as impairments in attention, memory, processing speed, and problem-solving ability are common cognitive deficits found in patients with schizophrenia, depression, and bipolar disorder. These individuals typically score below the general population on cognitive tests and have some impairment in cognitive functioning. A psychologist with expertise in neuropsychology would be instrumental in both assessing and then treating this large segment of our patient population.

Second, psychologists with expertise in the assessment and treatment of personality disorders are needed to serve our population of patients who display significant interpersonal struggles, emotional regulation difficulties, and severely dangerous behaviors that are impacted by their personality functioning.

Additionally, a psychologist with a background in working with people with developmental and intellectual disabilities - and, in particular, a knowledge of applied behavioral analysis - is needed for their specific expertise in the development and implementation of treatment plans best suited to address the factors contributing to behavioral issues of this population.

Finally, the majority of admitted patients and residents have a history of substance abuse issues and nearly half (48%) are clinically diagnosed with substance-related and addictive disorders. Substance-related issues can exacerbate patients' psychiatric symptoms and negatively affect psychosocial functioning, interfere with treatment progress, and are a common reason for readmission to inpatient care once discharged. For these reasons, clinicians specializing in the treatment of substance-related disorders are needed to provide optimal service to patients. To best meet patient needs, the Hospital requires two (2) Licensed Independent Substance Abuse Counselors (LISACs) and two (2) additional Licensed Associate Substance Abuse Counselors (LASACs) who can work under the LISACs' supervision. These staff would be members of the Psychology department, providing both individual and group therapy treatments, along with assessment services.

Additionally, there are numerous evidence-based procedures considered standard care for acute psychiatric patients that the Hospital is currently not equipped to provide in-house due the lack of staff with these particular qualifications. This includes Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS) and Vagus Nerve Stimulation (VNS):

> ***Electroconvulsive Therapy (ECT)*** is a medical treatment most commonly used in patients with severe major depression or bipolar disorder that have not responded to other treatments. Extensive research has found ECT to be highly effective for the relief of major depression. Clinical evidence indicates that for individuals with uncomplicated, but severe major depression, ECT will produce substantial improvement in approximately 80 percent of patients. It is also used for other severe mental illnesses, such as bipolar disorder and schizophrenia.[16]

[16] https://www.psychiatry.org/patients-families/ect

Transcranial Magnetic Stimulation (TMS) is an FDA-approved procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of major depression. It's called a "noninvasive" procedure because it's done without using surgery or cutting the skin and is used only when other depression treatments have not been effective.[17]

Vagus Nerve Stimulation (VNS) is a procedure that involves using a device to stimulate the vagus nerve with electrical impulses. The device works by sending stimulation to areas of the brain that lead to seizures and affect mood. The FDA has approved vagus nerve stimulation for the treatment of depression in adults who have long-lasting, hard-to-treat depression, known as treatment-resistant depression, and/or haven't improved after trying four or more medicines or electroconvulsive therapy (ECT), or both.[18]

These are standard procedures for the treatment of refractory illnesses, or those patients whose psychosis is so severe and prevalent that they are unable to experience symptomatic relief and stabilization via pharmacotherapy (medication) and other recognized therapeutic services. This is common amongst the patient population at ASH. For this reason, interventional psychiatry is needed to produce symptom reduction for these individuals.

It is estimated that pursuing Option A would require a headcount increase of 10 FTE, and an annual appropriation increase of $1.67 million to the Hospital's operating budget (please see Appendix A for more details).

Figure 13

Option A - Clinical Model Enhancement FTE Additions	
Position	**Required Adjustment**
Specialist - Neuropsychologist	1 FTE
Specialist - Psychologist with an Expertise in the Treatment of Personality Disorders	2 FTE
Specialist - Psychologist with an Expertise in Development / Intellectual Disabilities and Applied Behavior Analysis	2 FTE
Specialist - Substance Addiction	4 FTE
Nurse Anesthetist	0.5 FTE
ECT Nurse	0.5 FTE
Total	**10 FTE**

[17] https://www.mayoclinic.org/tests-procedures/transcranial-magnetic-stimulation/about/pac-20384625
[18] https://www.mayoclinic.org/tests-procedures/vagus-nerve-stimulation/about/pac-20384565

[This Page Left Intentionally Blank]

Option B - Increase Civil Bed Capacity with No Changes to Clinical Model

The Civil Campus comprises three (3) separate treatment units each capable of supporting approximately 37 patients, for a total licensed capacity of 117 funded beds. Two of those buildings, however, have second floors that are currently vacant, as the Hospital historically has not been funded to staff and operate those areas. Past litigation also placed a restriction on the number of patients the Civil Hospital can admit from Maricopa County.

Arizona has the fewest number of state-operated psychiatric beds reserved for individuals under a civil commitment order, per capita, in the nation. As displayed in Figure 14 below, and as of the most recent census, Arizona has 117 total inpatient civil psychiatric beds for its approximate 7.2 million residents, or 1.6 beds per 100,000 residents. Despite this, in the period spanning State Fiscal Years (SFY) 2020 through SFY2023 (July 1, 2019 - June 30, 2023), the Civil Hospital had an average daily occupancy of 105 patients, or an 89.7% bed utilization rate, and the patient census fluctuated modestly from a low of 95 in January 2021, to a high of 112 in June 2023. As such, the Civil Hospital has typically operated below maximum capacity and only recently has experienced bed availability issues. That being said, should the State determine it necessary and financially tolerable, and if the legal restrictions specific to Maricopa County admissions were to be relaxed or eliminated, the Civil Hospital could be expanded to admit an additional seventy-five (75) individuals in need of involuntary long-term inpatient psychiatric care. Doing so would increase the total Civil capacity by 64% to 192 funded beds, or 2.7 beds per 100,000 Arizona residents.

Figure 14

State Operated Civil Commitment Inpatient Beds per 100k Residents (Psychiatric Only)						
	AZ	**MN[19]**	**CT**	**NM**	**WA**	**MT**
Population	7.2M	5.6M	3.6M	2.1M	7.8M	1.1M
Adult Civil Beds	117	110(206)	132	121	531	117
Beds per 100k	**1.6**	**2.0 (3.7)**	**3.7**	**5.8**	**6.8**	**10.6**

In order to accommodate this expansion, the Hospital would require an initial one-time appropriation of approximately $5.6 million to renovate the two vacant units as necessary to comply with present day Life Safety Code, physical plant, and environment of care standards enforced by The Joint Commission and the Centers for Medicare and Medicaid Services. This would include retrofitting each patient bedroom, restroom, and all common areas with ligature resistant fixtures and furniture, upgrading the fire safety and HVAC systems, securing the nursing stations, purchasing all necessary medical and IT equipment, office furniture, and installing a closed circuit audio/video security surveillance system, among other requirements.

[19] Minnesota closed all but one large state hospital a few years ago. MN (1) reflects the main remaining MN state Hospital. MN (2) is the main MN state Hospital plus six, 16 bed, state-operated psychiatric treatment facilities in local communities opened after they closed 10 of the 11 large state facilities.

Subsequent annual appropriations of an additional $20.7 million would be required to staff and operate the two additional units and the Hospital would require a headcount adjustment of 169 FTEs to provide all necessary services to this population, as detailed in the below Figure and outlined in detail in Appendix A.

Figure 15

Option B - Civil Capacity Expansion FTE Additions	
Position	**Required Adjustment**
Behavioral Health Technician	104 FTE
Registered Nurse	28 FTE
Psychiatrist	4 FTE
Psychologist	4 FTE
Physician (Medical)	1 FTE
Recreational Therapist	8 FTE
Medical Records	2 FTE
Social Worker	4 FTE
Transportation Staff	2 FTE
Misc. Unit Support Staff[20]	12 FTE
Total	**169 FTE**

Given the challenges experienced in recent years with recruitment efforts, it should be expected that the Hospital will encounter considerable difficulty locating and hiring qualified personnel to adequately staff these additional units and provide sufficient patient care. Importantly, respondents to the public survey soliciting feedback for this Plan believed that, of all options presented, solely expanding the Civil Hospital's bed capacity would be least likely to provide long term benefit to the State as a whole.

It is critical for all parties to recognize that the Hospital is only one entity in a comprehensive psychiatric system of care and, in order for the Hospital to function optimally, the care continuum must be capable of readily transitioning patients into and out of the Hospital based on their clinical need. Barriers to efficient patient throughput should first be mitigated prior to investing in any significant physical expansion efforts at the State Hospital. The most expedient method of increasing capacity for civil patients is not necessarily adding more beds, but rather increasing discharge rates to maximize the utilization of existing capacity. Accordingly, the Hospital strongly urges against pursuing any expansion of civil bed capacity without the State first addressing the

[20] Includes 2 Nurse Unit Managers, 2 Unit Clerks, and 8 Psychiatric Nurse Shift Supervisors

larger, systemic, deficiencies prevalent in the continuum of care that have resulted in delays discharging patients to less-restrictive environments. These concerns are further discussed in subsequent sections of this Plan.[21]

[21] Please see Option D - Create a Civil Reintegration Unit and the section titled Patient Discharges and Care Transition

[This Page Left Intentionally Blank]

Option C - Increase Civil Bed Capacity *and* Enhance Clinical Model

If the State elects to fund Option B and expand the bed capacity of the Civil Hospital, future admissions will also require a higher volume of additional services than the Hospital is readily able to provide. Therefore, it would be appropriate to enhance the clinical programs at a rate commensurate to meet the needs of the expanded civilly-committed population. **Option C** would fully encompass the recommendations identified in Options A and B and require a headcount increase of 185 FTE, as outlined in the Table below:[22]

Figure 16

Option C - Civil Capacity Expansion and Clinical Program Enhancement FTE Additions	
Position	**Required Adjustment**
Behavioral Health Technician	104 FTE
Registered Nurse	28 FTE
Psychiatrist	4 FTE
Psychologist	4 FTE
Physician (Medical)	1 FTE
Recreational Therapist	8 FTE
Medical Records	4 FTE
Social Worker	4 FTE
Transportation Staff	2 FTE
Specialist - Neuropsychologist	2 FTE
Specialist - Psychologist: with an Expertise in the Treatment of Personality Disorders	3 FTE
Specialist - Psychologist with an Expertise in Development / Intellectual Disabilities and Applied Behavior Analysis	3 FTE
Specialist - Substance Addiction	4 FTE
Nurse Anesthetist	1 FTE
ECT Nurse	1 FTE
Misc. Unit Support Staff[23]	12 FTE
Total	**185 FTE**

[22] A complete budgetary assessment for Option C is available in Appendix A of this Plan
[23] Includes 2 Nursing Unit Managers, 2 Unit Clerks, and 8 Psychiatric Nurse Shift Supervisors

[This Page Left Intentionally Blank]

Option D - Create a Civil Reintegration Unit

Many states utilize an onsite, state hospital-operated facility that functions as a transitional unit for Civil patients approaching discharge, or that have been “difficult to discharge” for reasons related to previous history of placement issues in the community. A separate reintegration unit for the Civil Hospital would programmatically focus on a "Whole Person Care" model of structured residential living that approximates the stability of a hospital setting, but also introduces the benefits of a community based treatment environment. This would be done using integrated care principles of physical health, mental health, psychosocial health and substance use disorder treatment. ASH presently does not have a facility designated for Civil patient reintegration - although, there is a separate reintegration unit on the Hospital’s campus for Forensic patients.

The Civil reintegration program would allow for the application of evidence-based pharmacotherapies combined with individualized psychosocial interventions and development of treatment plans that can be tested and adjusted in the approximate community setting. It would also allow for a more creative treatment environment which would extend into community residential placement after completion of the reintegration program. Additionally, the Hospital would encourage outpatient case managers to visit the unit and interact with their members on a routine basis to establish the rapport necessary to mitigate discharge anxieties. Finally, the Hospital will also establish on-site support from Peer Service Providers/Peer and Recovery Support Specialists (PRSS) to supplement the recovery-oriented care provided to the patients in the reintegration program.

The program goals are geared to help patients with psychiatric symptoms related to transition acclimate to changes in the world that may have occurred over the (often) many years they have been on a secured unit, and gain or regain important independent living skills. This is best accomplished in a separate setting with less visible security and a physical environment that more closely resembles a residential facility, rather than an institution, to reduce overstimulation and promote self-directed engagement. The unit would legally be licensed as part of the existing Civil Hospital to ensure that, should a patient begin to clinically decompensate while receiving treatment at the reintegration unit, they could be quickly transferred back to the main Civil campus to receive a heightened level of psychiatric care as needed for their safety.

This physical design of the reintegration unit would allow for personal creative space; opportunities for social interactions; tension easing spaces, and; access to greenspace and outdoor areas. It is the Hospital’s expectation that building a facility such as this will reduce aggressive behaviors on the primary Civil campus; permit ASH to admit more Civil patients to the primary campus, as those patients deemed discharge-ready would be placed on the transitional unit; and reduce the likelihood of Civil patients decompensating post-discharge.

Furthermore, whereas the program would place a high degree of importance on secondary prevention measures and symptom awareness, patients will undergo substantial reintegration activities to expose them to the community and give them a sense of confidence that they can

safely live outside of the Hospital - which should reduce the likelihood of readmission to the hospital, or another inpatient setting, in the future.

The Hospital would request a small, 16-bed building for such a facility. Ideally, it would have seven (7) double rooms, as many patients will have to have a roommate in a group home situation post-discharge, and two (2) single rooms. It would have a large, home-like living room space, patio, computer room, a kitchen area that patients could use under observation, and a staff station area. It is also particularly important that this facility has ample outdoor greenspace under shade canopies, preferably in a courtyard setting, to allow patients and staff to hold individual or group therapy sessions in a calm, non-institutional environment. The projected costs to design and construct the necessary facility would be an estimated $8 million.[24] The Hospital would require an additional annual appropriation of $4.15 million, and 30 additional FTEs, to staff and operate this transitional facility.

Figure 17

Option D - Civil Reintegration Unit FTE Additions	
Position	**Required Adjustment**
Behavioral Health Technician	12 FTE
Registered Nurse	4 FTE
Psychologist Supervisor	1 FTE
Psych. Nurse Practitioner	1 FTE
Psychologist	1 FTE
Occupational Therapist	1 FTE
Recreational Therapist	4 FTE
Medical Records	1 FTE
Social Worker	1 FTE
Nurse Shift Supervisor	4 FTE
Total	**30 FTE**

[24] The size of the facility is calculated based upon 1,000 square feet per patient with a patient population of 16. Construction costs are based on the First Quarter 2022 North American Quarterly Construction Cost Report (https://s31756.pcdn.co/americas/wp-content/uploads/sites/4/2022/03/Q1-2022-QCR.pdf).

Option E - Develop a Special Needs Unit for ACPTC

The Arizona Community Protection and Treatment Center (ACPTC) is the State's only secured civil confinement facility for the treatment of Sexually Violent Persons. This program originated in 1997 with the adoption of A.R.S. §36-3701 et.seq. and has been in continuous operation since. As detailed in the Background section of this Plan, nearly 80% of ACPTC's residents are over the age of 50, and approximately two-thirds of the residents have been admitted for at least 10 years, with the average length of stay nearing 13 years. ACPTC was never programmatically intended, nor was the facility structurally designed, to serve a geriatric population. Due to various system limitations and legal restrictions dictating the confinement of Sexually Violent Persons in Arizona, the residents at ACPTC continue to age and the Hospital experiences the unique challenges that come with serving an aging population.

ACPTC residents are court ordered and civilly committed due to their risk of danger to others if released to a less restrictive alternative or community living. With a lack of an Arizona Forensic Nursing Home, ACPTC is unable, or at the very least limited, in its ability to place elderly and medically compromised residents in outside care facilities, given their legal status. Additionally, if ACPTC were legally able to place a resident in an outside care facility, many facilities are wary of accepting a "sexually violent person" into their care as this could pose a risk to other care home residents. Furthermore, given state laws, many (if not all) ACPTC residents placed in care homes would require the surrounding neighborhood to be notified that a registered sex offender lives in the assisted living facility.

The Hospital recommends the creation of a new 15-bed special needs unit, within the ACPTC grounds, for aging residents and those with acute medical needs. Ideally, this unit would consist of larger bedrooms to accommodate wheelchairs, ambulatory devices, and medical beds as well as an ADA-approved restroom. A larger dayroom would allow for residents who utilize wheelchairs to move around more freely and independently and a larger staff office would include a closet for medical supplies to be readily available if needed. A "medical bay" with the option for negative airflow consisting of three medical beds is also requested to provide a space for sick or medically compromised residents to reside temporarily before or after visits to the Emergency Department for more efficient triaging and treatment of medical ailments. This would also assist in preventing the spread of any communicable diseases. Currently, ACPTC does not have any areas with negative airflow capabilities.

Additional staff needed to operate this unit and provide care would consist of one (1) psychologist, one (1) rehabilitation therapist, and one (1) nurse per shift (six (6) total). Additionally, this unit would need five (5) Residential Program Specialists per shift (fifteen (15) total) and one (1) Residential Program Manager to operate safely and efficiently (please see Figure 18, next page). Psychiatric and physical medical support could be accommodated by the ACPTC's existing staffing capabilities. It is estimated developing this unit would cost an estimated $2.5 million and annual ongoing operational would total approximately $2.73 million (please see Appendix A for more information).

Figure 18

Option E - Develop a Special Needs Unit for ACPTC FTE Additions	
Position	**Required Adjustment**
Psychologist	1 FTE
Rehabilitation Therapist	1 FTE
Registered Nurse	6 FTE
Residential Program Specialist	15 FTE
Residential Unit Manager	1 FTE
Total	**24 FTE**

Option F - Expand Service Model Beyond Primary Psychiatric Care

Beyond the above-cited issue with the Hospital's current licensure restrictions, the Hospital is not able to meet the needs of patients with Autism, DD/ID, dementia/neurocognitive disorder, or substance use disorder as primary diagnosis. Appropriately meeting the needs of these populations takes whole teams with specialized training. The Hospital's current allocation meets its needs for the treatment of severe general primary psychiatric illnesses (such as schizophrenia, bipolar disorder, depression, etc.). ASH can address other issues mentioned if they are *secondary* conditions, as all clinical staff have basic abilities to address these issues when minor or secondary. Antisocial personality disorder (which is a disqualifying diagnosis for Title 36 court ordered treatment and has no evidence-based treatments for the diagnosis), cannot be treated by ASH regardless of the specialized staff hired.

There is a second, equally important, issue for patients with Autism, DD/ID, Dementia/ Neurocognitive Disorders, severe personality disorders, or substance use disorders as a primary component of their behavioral issues. These patients require specialized and separate patient care environments for optimal treatment and to mitigate disruption for patients with primary general psychiatric illness. The Hospital does not currently have sufficient or appropriate facilities to provide such varied and specialized treatment.

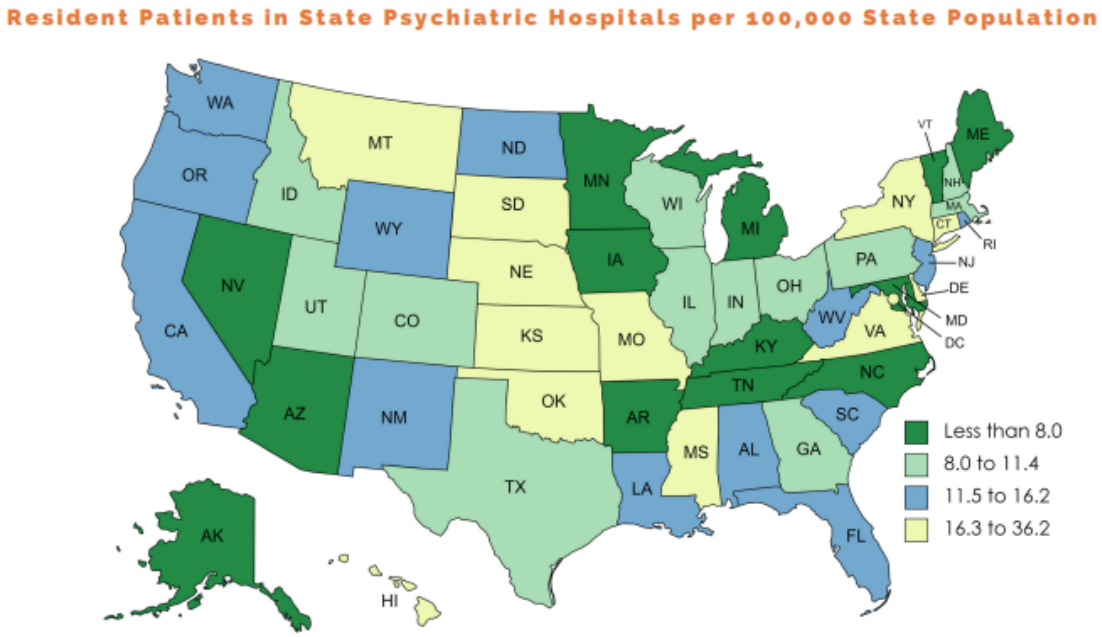
States that are currently treating all of these diagnoses (Autism, DD/ID, Dementia/ Neurocognitive Disorders, or substance use disorders) as primary presentations of behavioral issues typically do so in separate facilities, or in dedicated and separately licensed units. For example, New Mexico, Connecticut, New York, Massachusetts, Washington, and many other states treat patients with significant behavioral issues due to Autism/DD/ID, in separate dedicated inpatient facilities. Many also have separate, dedicated state nursing homes for patients with dementia and co-occurring severe behavioral issues that cannot be managed elsewhere. Some states also operate long-term substance-use rehab facilities. Having a State Hospital ***System*** that can meet all of these diverse needs requires significant physical structure and programmatic enhancements beyond that of ASH's existing Civil facility.

According to data collected by NRI (Figure 20, below), Arizona has the lowest number of dedicated state-run Civil psychiatric beds per capita (1.6 per 100k residents) in the nation.[25] The limited number of dedicated psychiatric beds per capita, along with the lack of State-operated beds for other types of patients that may be in need of longer term hospitalization, is problematic. A dedicated psychiatric environment is not conducive to the care of patients with significant dual-comorbidities, as well as patients with primary diagnoses of neurocognitive disorders (dementia, Traumatic Brain Injuries, etc). Similarly, patients with primary DD/ID/Autism, and primary diagnosis with severe personality disorders that can be treated (such as Borderline Personality Disorder), require specialized and dedicated treatment environments in order to properly meet their behavioral needs that are distinct from those that a primary psychiatric facility can properly address.

[25] NRI - 2020-2021 State Profiles

Each state varies with regard to the operation and structure of facilities intended to meet the behavioral healthcare needs of their communities. However, a comparison of state data is still helpful to review, to better understand approaches in serving complex and varied populations.

Figure 19



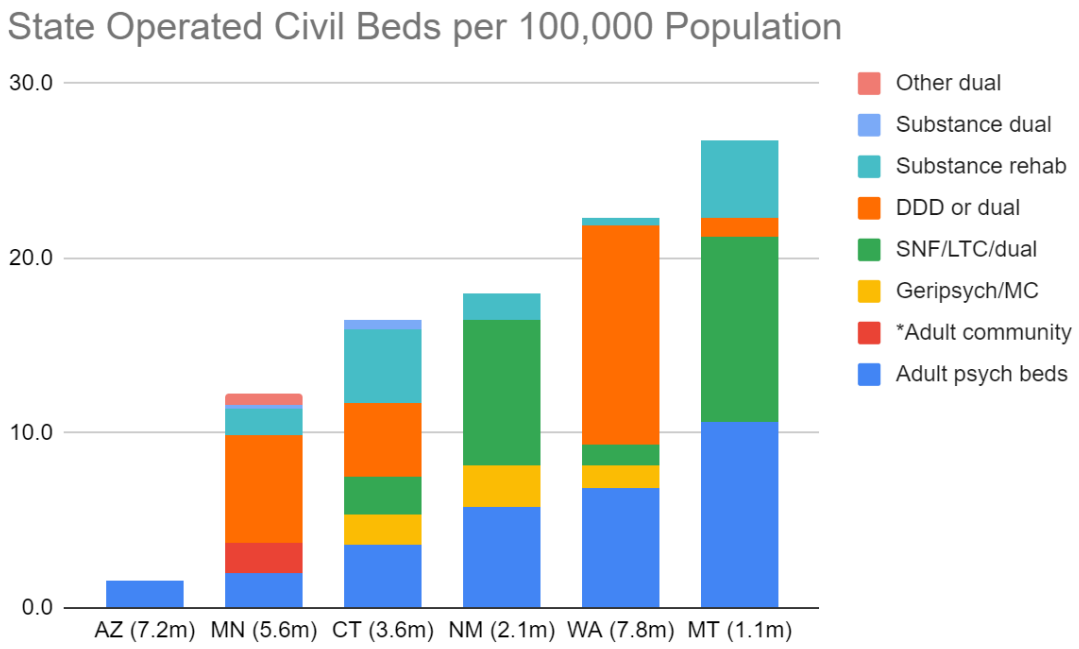
While the inclusion of Forensic beds in this data (Figure 19, above) is not directly relevant to the proposals herein, the data demonstrates that, even with the Forensic beds included, Arizona ranks last per population in bed availability. Below is a multi-state comparison without the Forensic beds included. (Minnesota- also near the bottom with Arizona in total psychiatric state hospital beds per capita; New Mexico - Southwestern state similar in land area and in the middle range in total state hospital beds per capita; Washington - similar population and in the middle range for total state hospital beds per capita; Montana - a mountain west state and higher in total state hospital beds per capita; and Connecticut - top 5 for meeting the needs of its mentally ill community overall):[26]

Figure 20

State Operated Civil Commitment Inpatient Beds per 100k Residents (All Disorders)						
	AZ	**MN**	**CT**	**NM**	**WA**	**MT**
Civil Beds per 100k	1.6	12.2	16.5	18.0	22.3	26.7

[26] https://mhanational.org/issues/2022/ranking-states#overall-ranking

Figure 21



Although there is no definitive consensus, various experts place the number of state-run beds necessary to meet the long term care needs of the general population at anywhere from 12.4 to 50 beds per 100,000 residents.[27] This suggests that Arizona is severely lacking in state-operated beds to meet the varied and wide spectrum of behavioral health needs for our population, in comparison to other states.

It is important to note that having the most beds does not correlate to ranking highest in meeting community needs; however, there appears to be some relationship between having an appropriate set of diversely and uniquely allocated, and appropriately staffed beds, and better outcomes for patients.

In order to meet the needs addressed in this section, an additional facility could be developed on the Hospital's campus. This facility would consist of a new building with five (5) units, each with approximately 25 beds per unit. Some units of this facility would not fall under Title 36 involuntary commitment, and patients would need to either enter voluntarily or, more likely, be signed in by a guardian.

This proposed facility would be a start to meet the variety of needs of the community that currently do not exist. Each unit would be based on the specific clinical need for the patient population, and have a unique milieu and treatment programming structure tailored to their needs. Based on the Hospital's best *estimate* as of this Plan's date of publication, developing this new free-standing facility would cost approximately $62 million, with ongoing operational costs, including staff salaries, contractual services, overhead and utilities totaling approximately

[27] AMA Journal of Ethics; Yohanna, D.

$37.5 million per year. An additional 259 employees would be required to successfully operate this facility (please see Option F - Budgetary Analysis).

Figure 22

Option F - Expand Service Model Beyond Primary Psychiatric Care			
Unit Speciality	**Unit Capacity**	**Treatment Focus**	**Patient Legal Status**
Neurocognitive Disorders	25 Beds	Dementia, Traumatic Brain Injuries or other neurological conditions with severe behavioral issues that cannot be managed in a Skilled Nursing Facility (SNF) Serious Mental Illness (SMI) with Dementia where the dementia is severely complicating the ability to treat and manage their psychiatric illness SMI with severe comorbid medical issues that would currently prohibit admission to ASH due to lack of appropriate facilities that can manage medical care needs in the community.	Involuntary
DD/ID Unit	25 Beds	Adults with Developmental Disability (DD), Intellectual Disability (ID), or Autism Spectrum Disorders and a co-occuring SMI diagnosis wherein the DD/ID and/or Autism is a significant contributor to problematic behaviors and severely complicate factors of recovery.	Involuntary
Personality Disorders	25 Beds	Severe Borderline Personality Disorder who are a danger to themselves or others and require inpatient care. Other Personality Disorders, including those who demonstrate severe deficits in interpersonal functioning and emotion regulation such that they are a danger to self/others or interfere with the ability of others to benefit from treatment.	Involuntary or Per-Guardian
Dual-Diagnosis	25 Beds	Individuals with a severe and chronic mental illness, and a co-occurring treatment-interfering substance use disorder that impedes their ability to remain stable post-discharge.	Involuntary
Substance Use / Abuse	25 Beds	Individuals where substance use is the primary or only condition requiring mid- to long-term inpatient substance use residential rehabilitation.[28]	Voluntary or Per-Guardian

[28] Individuals in Arizona cannot be civilly committed for treatment solely due to a substance use disorder pursuant to Title 36.

Figure 23

Option F - Expand Service Model Beyond Primary Psychiatric Care FTE Additions	
Position	**Required Adjustment**
Psychiatrist - Geriatric	1 FTE
Psychiatrist - Autism Disorders	1 FTE
Psychiatrist - Psychodynamic or Psychoanalytic	1 FTE
Psychiatrist - Addictions	1 FTE
Psychiatrist - Dual Diagnosis	1 FTE
Psychologist - Neuropsychologist	1 FTE
Psychologist - Neurodevelopmental	1 FTE
Psychologist - Personality Disorders	1 FTE
Psychologist - Substance Addictions	2 FTE
Social Worker - LMSW on Unit	5 FTE
Social Worker - LMSW; Discharge Specialist	2 FTE
Behavioral Analyst	1 FTE
Therapist	1 FTE
Physical Therapist	1 FTE
Occupational Therapist	2 FTE
Substance Abuse Specialist	1 FTE
Vocational Specialist	2 FTE
Therapy Technician	5 FTE
Medical - MD/DO (Neurologist)	1 FTE
Medical - MD/DO (Generalist)	1 FTE
Nurse Unit Manager	5 FTE
Nurse Shift Supervisor	20 FTE
Registered Nurse	48 FTE
Behavioral Health Technician	142 FTE
Medical Assistant	2 FTE
Unit Coordinator	2 FTE
Unit Clerk	5 FTE
Appointment Scheduler	1 FTE
Transportation	2 FTE
Total	**259 FTE**

Deinstitutionalization, or the process of shifting care from large state-run hospitals to smaller, community-based settings gained momentum in the U.S. in the 1950's and, in conjunction with various court decisions, gradually led to the closure of multiple state hospitals across the country. For example, *Lake v. Cameron* (1966) established the concept of the "least restrictive setting" for care, which required hospitals to discharge patients to an environment less restrictive if possible, and in *O'Connor v. Donaldson* (1975), the U.S. Supreme Court declared that a person had to be a danger to him or herself, or to others, for confinement to be constitutional.[29] As such, the appropriate use of, and preference for, long term inpatient treatment for a severe mental illness or a behavioral disorder, particularly under involuntary commitment in lieu of community-based care is a highly-volatile topic of debate amongst advocates on all sides of the mental health care service efficacy spectrum. One particular respondent to the Hospital's public survey alluded to this very point when asked if there were any additional observations or insight they would like to provide:

"ASH should not increase bed capacity or build additional facilities because both of these strategies would encourage the involuntary commitment of people with disabilities without ensuring that the community based healthcare system receives needed reforms."

It is crucial that all parties are involved in the planning and development of any programmatic expansion activities at the State Hospital that may add inpatient capacity, specifically with respect to the scope of practice(s) of a new facility, the criteria for admission and discharge, and legal confinement restrictions. A balance must be achieved between developing a sufficient network of community-based resources to provide needed care to individuals with Serious Mental Illnesses, while still ensuring that long term facility-based care is available in both scope and volume to act as a safety net and meet the needs of individuals that have not been able to be successfully treated in those community settings - providing those long term care facilities are expected to treat with the intent to discharge patients back into the community when clinically appropriate. Doing so will help ensure the Hospital tailors its programs and scales operations to provide effective care while never infringing upon an individual's constitutional rights.

Please Note: Although this recommendation is expansive in both scope and cost, pursuing this option would also meet the objectives outlined in Options A, B, C and E of this Plan, by allowing the Hospital to redirect existing patients and residents to this new facility based on their primary non-psychiatric needs, resulting in increased bed availability on the Civil Campus, Forensic Campus and ACPTC, as well as expediting patient throughput for Civil psychiatric patients. At the time of this Plan's development, the Hospital estimates it could justifiably transfer as many as 35 Civil patients, 13 Forensic patients, and 15 ACPTC residents presently in need of a heightened level of medical or behavioral (non-psychiatric) care to this proposed facility, and an unknown number of individuals currently receiving care in other facilities across Arizona would meet medical criteria for admission.

[29] AMA Journal of Ethics; Yohanna, D.

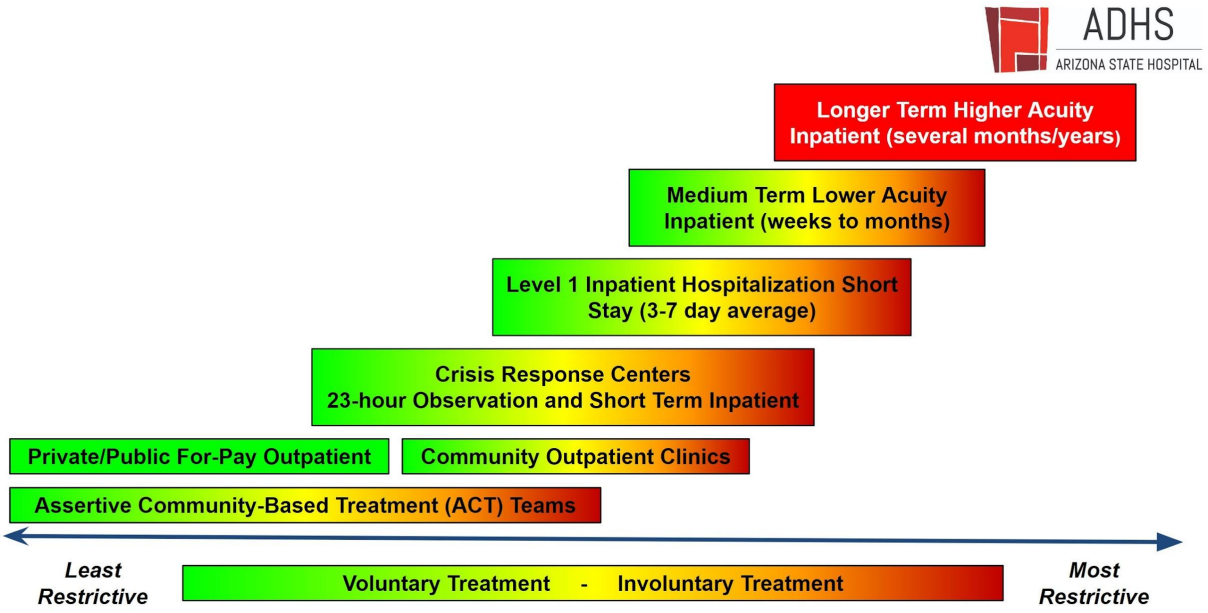
Admission Volumes and Wait Times

Legislative Requirement: [the Plan shall] [Provide] options and recommendations to reduce the number of patients statewide who are seeking admission to the Arizona State Hospital and to reduce the waiting time to be admitted to the Arizona State Hospital.[30]

The Civil Hospital is one of approximately 90 inpatient psychiatric facilities operating in Arizona, and is the last resort for inpatient treatment in the state's psychiatric continuum of care (please see Figure 24, below).[31] Individuals are admitted to the Civil Hospital due to the innate severity of their mental illness, a documented prior history of treatment resistance, and the inability of other treating providers to successfully stabilize the patient and meet their psychiatric and behavioral health needs.

About 1 in 25 U.S. adults lives with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression, and approximately 46% of Americans will experience a mental illness during their lifetime.[32] Serious mental illnesses, including schizophrenia, schizoaffective disorder, and bipolar disorder are chronic conditions and, as with all chronic conditions, early detection, intervention and consistent treatment are critical to preventing severe medical complications and subsequent inpatient hospitalizations. Because the Hospital operates within a larger care continuum, external factors, whether structural or functional in nature, can often cause inappropriate admissions and result in significant discharge barriers.

Figure 24



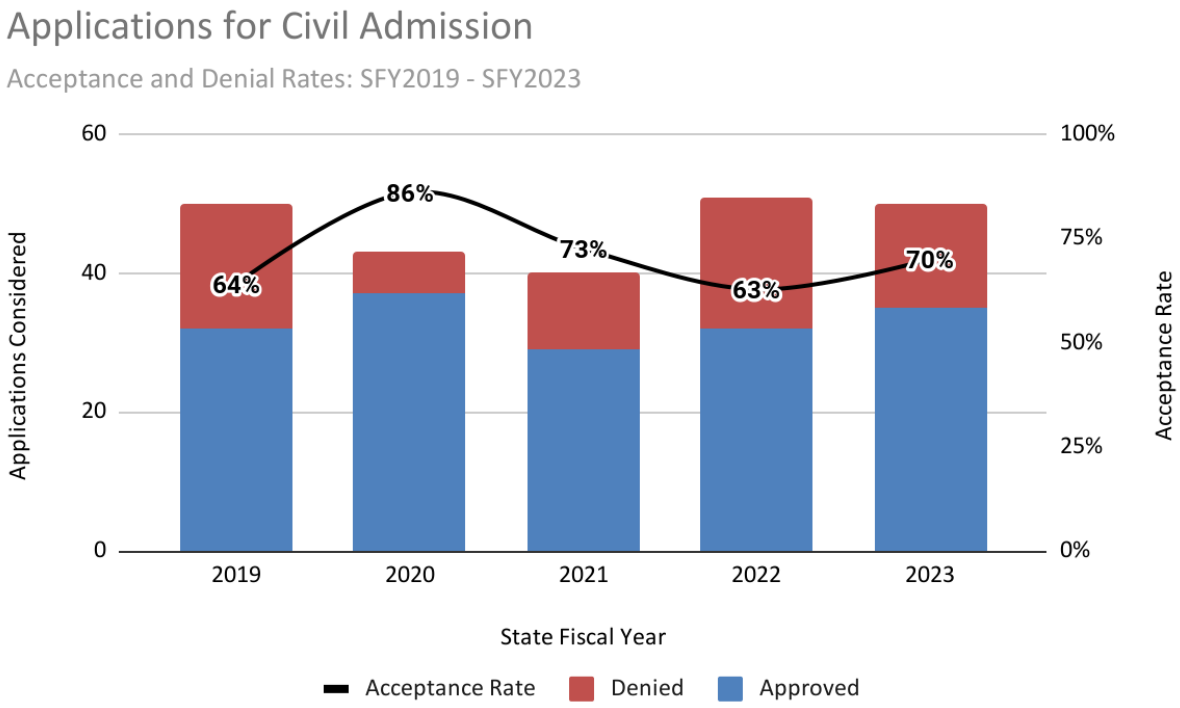
[30] There is no formal admission application process for the Forensic Hospital or the ACPTC, as the courts and various legal proceedings ultimately dictate patient and resident confinement to those facilities. Therefore, this section is specific to the Civil Hospital and patients admitted under a Title 36 court order for treatment.

[31] Number is current as of February 22, 2023 and includes facilities licensed as either a Behavioral Health Inpatient Facility or as a Psychiatric Hospital. It does not include hospitals that may provide psychiatric care under a general hospital license, as those facilities are not readily identifiable within the state's active provider licensee database.

[32] https://www.cdc.gov/mentalhealth/learn/index.htm; https://mhanational.org/mentalhealthfacts

Neither the Department, nor the Hospital, are responsible for providing oversight of the statewide behavioral health system of care and ensuring the network adequacy or sufficiency thereof. This responsibility was transferred from the Arizona Department of Health Services to the Arizona Health Care Cost Containment System (AHCCCS) in 2016; therefore, the Hospital's ability to address the requirement(s) in this section of the authorizing legislation is limited to community input and feedback, and a presentation of three recent patient admissions in which the Hospital's medical staff firmly believe the individual did not require an inpatient admission and could have been successfully treated in a less-restrictive environment, had the proper community supports been more readily available and/or accessible.

Figure 25



As demonstrated in Figure 25, above, the Hospital reviews approximately 47 applications for Civil admission each year and, on average, approves 70% of applications presented for consideration.[33] Applications are reviewed independently by three (3) Hospital psychiatrists for a suggestion to approve or deny admission. These recommendations are compiled by the Hospital's Chief Medical Officer, and an admission determination is made. The Hospital may request further information if the application is unclear before making this determination.

In the uncommon case wherein the application is denied, the opportunity to request reconsideration is offered to the referring agency. In accordance with State law, there are three primary reasons why the Hospital may deny an application for admission, those being: the

[33] Data presented will not directly equal the number of civil admissions in a fiscal year due to instances of the Hospital receiving more than one application request for the same individual during the year, applications being withdrawn by the submitter, and/or a patient beginning treatment at ASH in the fiscal year following the year of application submission.

applicant has not undergone at least 25 days of local mandatory treatment in the community as required by A.R.S. §36-541; the applicant was determined to not have a behavioral health condition that can be treated by the Hospital per A.R.S. §36-202; or, based on the individual's clinical presentation, the Hospital is not the most appropriate and/or least restrictive placement for the applicant (A.R.S. §36-501.22).

The following information, while anecdotal, may provide some justification for the development of other community-based resources to individuals necessary to forgo their need to seek services at ASH.[34]

Admission Case Study 1	
Admission Time frame	**Total Length of Stay (Days)**
2021	36

Case Study 1: *A 49 year old Native American male was admitted in the spring of 2021 with a primary diagnosis of Major Depressive Disorder, with mood congruent psychotic features and a history of substance use. He was directly court ordered (civil commitment) to ASH from the Tribal Department of Corrections, where he had been detained after an incident with police. He had a history of difficulty managing his mood, reported episodes of irritability followed by depressive episodes, and suicidal ideation.*

Prior to admission he did not have an SMI designation, but was General Mental Health (GMH) and was Title-19 (Medicaid) eligible. He had received limited mental health treatment in the community, and reportedly had no previous psychiatric hospitalizations, other than one 90-day residential treatment program for substance use. Additionally, he had a history of involvement with the criminal justice system including past incarcerations for various offenses related to substance use, domestic violence, burglary, and aggravated robbery.

Upon admission, the ASH clinical team quickly determined that he could be successfully treated in a less-restrictive environment. The team requested an SMI determination, and the individual met the requirements for an SMI designation. Outpatient services were arranged and follow up appointments were scheduled. The ASH team initiated an application for SSI benefits and provided extensive education to the patient and his family regarding his diagnosis, need for follow up treatment, and the services available to him in the community. He was able to be discharged to his family home after approximately one month.

The proactive steps of initiating the SMI evaluation, applying for SSI benefits and coordinating with the family could have occurred in the community had the appropriate resources been engaged, likely preventing this individual's subsequent admission to the State Hospital.

[34] Please see the section specific to Patient Discharges and Care Transition for more examples of systemic factors impacting operations at the Hospital.

Admission Case Study 2	
Admission Time frame	**Total Length of Stay (Days)**
2021	206

Case Study 2: *A 47 year old Caucasian male was admitted in 2021 with a primary diagnosis of Schizoaffective disorder bipolar type. He was directly court ordered (civil commitment) to ASH from a County Jail, where he had been detained for assault. This direct order bypassed the requirement for local mandatory treatment and the ASH application process.*

Prior to admission, he had a history of several suicide attempts, assaults, criminal justice involvement, and substance use. It was unknown the extent of prior hospitalizations, but family reported that he was at his best when living in a behavioral health residential facility. The patient was a poor historian and previous records were limited. It appeared that he was designated SMI and had previously received services in the community. He was not in active treatment with his health plan at the time of admission.

Upon admission, the ASH clinical team re-engaged the outpatient treatment provider and health plan. The patient was receptive to treatment offered and required very little pharmacological intervention. The ASH team was able to establish his AHCCCS eligibility, enroll him with a health plan, and assist him in starting his SSI claim. Throughout his hospitalization the patient was engaged and non-threatening, and the ASH Clinical team began discussing discharge planning very early on in his stay. He was determined to be ready for discharge in early 2022, but remained at the hospital for an additional 74 days until the outpatient provider could arrange an appropriate placement for him.

Although ASH provided exemplary care, the patient could have been reengaged with, and served by, his health plan/outpatient provider without being ordered to the State Hospital. He was discharged successfully to a group home with community services engaged and follow up appointments scheduled after approximately seven months.

Admission Case Study 3	
Admission Time frame	**Total Length of Stay (Days)**
2019	115

Case Study 3: *27 year-old Lebanese American male, was admitted with a designation of SMI, and a diagnosis of Bipolar Affective, Manic, severe, with psychotic symptoms and a history of marijuana, prescription painkiller, and alcohol use. He had a history of two psychiatric hospitalizations, but a long period of stability between hospitalizations during which he maintained his own home, employment, and family relationships. When not stable, he presents with mania, suicidal ideation/attempts, aggressive/assaultive behavior, paranoia, and with delusional thought content.*

Prior to his ASH admission, he stopped taking medications and became aggressive, psychotic, and was reportedly researching buying guns. His family assisted him seeking inpatient psychiatric treatment in his county of residence. While hospitalized, he was aggressive, manic, paranoid, and delusional. Within days of that admission, the treatment facility began pursuing admission to ASH. After just 14 days of treatment, the facility requested that he be court ordered to ASH without the mandatory 25 days of local treatment as required by statute. Records indicate that the local psychiatric hospital cited his 'explosiveness', staff resignations, and the opinion that he wouldn't stabilize in 25 days as reasons to directly order him to ASH. Additionally, the local psychiatric hospital reported their opinion that he would be best served, and "would pose the least danger to others in ASH" as they believed ASH to be better suited to treat him due his "security needs" and "extreme nature of his psychopathology". The local facility further stated that ASH has "far more staff, and far more resources available" than the local hospital. As a result he was directly court ordered (civil commitment) and admitted to ASH only 17 days after family helped him seek inpatient treatment.

Once he was admitted to ASH, the clinical team provided aggressive pharmacological intervention, no different than what could have been administered at the local inpatient facility. He was quickly stabilized and no longer aggressive or assaultive, and actively engaged with his Behavioral Health Medical Provider to adjust medication as needed. His insight quickly improved and he was able to verbalize the need for increased medication to help control his symptoms. The ASH clinical team worked collaboratively with the patient, health plan, and family to arrange follow up care and a comprehensive discharge plan. The ASH clinical team did require assistance from the health plan in engaging the outpatient provider, as there was a lack of communication/timely response, which prolonged the patient's stay. ASH ensured that the patient was on a continuing court order for outpatient treatment and then he was able to be discharged home to his family after 115 days of treatment at ASH.

Based on these cases, as well as many other similar experiences, the Hospital has noticed a consistent and pervasive trend of limited early engagement for those needing care, as well as outpatient providers often losing contact with patients resulting in either a failure to initiate treatment, or subsequently poor treatment retention. Additionally, too often providers opt to elevate patients to the State Hospital out of a sense of desperation because they believe they do not have the resources to meet the individual's needs, to mitigate their own risk, and/or a fear that the individual's needs are so extensive that caring for them is cost-prohibitive.

Furthermore, there seems to be a recurring phenomenon of providers not beginning the AHCCCS enrollment process or fully assessing the individual's potential medical benefits, especially pursuing an SMI determination - which would quickly expand the array of services available to the individual. Although this may be due to the patient disengaging during the process, it may be worthwhile for the system to invest in or expand the use of care navigators at outpatient facilities, jails, crisis psychiatric centers, walk-in health clinics, schools, or other community-based locations to expedite enrollment and promptly establish care connections; however, if the community-based system of care is indeed overwhelmed, as many respondents to the Hospital's public survey noted, taking this action would only further exacerbate the demand for already scarce resources while not necessarily increasing the availability of said services in the community.

In addition, when asked what changes they believed were necessary to reduce the number of individuals requiring involuntary admission at the Arizona State Hospital, multiple respondents to the Hospital's public survey cited the need for additional community-based services including integrated care, housing services, supportive residential treatment, outpatient treatment, and pharmacotherapy (medication) monitoring. The following comments perfectly encapsulate this sentiment:

"There needs to be a broader network of assertive community treatment providers, supported housing, and supported employment. The caseload for case managers is also too large and results in case managers who are not responsive to their clients. Workforce retention strategies need to be employed to increase the number of qualified case managers."

"Law-enforcement and the behavioral health systems need to collaborate more to assist individuals in mental health crises to be diverted away from involuntary commitment. The behavioral crisis system needs to be integrated with law-enforcement, so behavioral health providers arrive at a scene of a potential mental health crisis. Nonviolent crisis intervention also needs to be applied more often to help individuals access voluntary treatment."

"There needs to be more outpatient services available for treatment and resources. Our state lacks the behavioral health resources needed."

Meanwhile, others specifically referenced deficiencies within the network for individuals with a Developmental Disorder or an Intellectual Disorder that are currently directed to ASH for care:

"DDD needs to have behavior health group homes for members who are dual diagnosed that have high level of behaviors."

"Having a specialized inpatient setting for adults with intellectual disability, including autism, and behavioral disturbance requiring an inpatient level of care; ideally such a setting would be paired with a step-down residential treatment center. [and] Having DD group homes specifically intended for patients with ID and comorbid psychiatric conditions, at which the typical DD staff have additional training and supports to address the psychiatric symptoms."

Conversely, some respondents provided feedback suggesting that reducing involuntary admission rates for ASH was simply not feasible and/or encouraged the State to admit more individuals to the State Hospital:

"Increased community services but reducing involuntary admissions may not be an appropriate goal given the lack of current behavioral health services."

"Actually, there needs to be an increased bed capacity for admission to ASH, or a 2nd state hospital to be opened. Currently there's a backlog of very symptomatic individuals waiting for ASH beds in level 1 hospitals. I work for a psychiatric hospital as a psychiatric nurse practitioner, and we have patients waiting months to be admitted to ASH."

The Department recommends the State solicits an independent third-party consultant to conduct an end-to-end sufficiency analysis of the continuum of care and quantify the unmet treatment needs of the population. In order to develop tangible recommendations that include potential expansions to community-based care settings, and due to cross-contracting, this analysis must be based at the provider level to assess the State's true capacity for treatment services.[35]

[35] It is common practice for a single provider to contract with multiple health plans as an "in-network" resource. Doing so, if not deduplicated prior to analysis, will result in an inflated interpretation of available bed / resource capacity for the State as a whole.

[This Page Left Intentionally Blank]

Optimal Staffing Levels

Legislative Requirement: [the Plan shall] Identi[fy] optimal levels of acuity-based staffing at the Arizona State Hospital with full-time employees and minimal use of contract staff and ways to increase the number of forensically trained clinical staff at both the management and staff levels.

Please see the section titled *Additional Resources Needed to Meet Existing Obligations* and Option A for a detailed analysis of the Hospital's existing staffing levels relative to its actual need.

Since 2015, the Arizona State Hospital has utilized an acuity based staffing (ABS) tool to determine the minimum number of staff members necessary to meet the needs of each treatment unit and maintain a safe environment. The ABS tool is capable of calculating, monitoring, and adjusting staffing needs dynamically based on multiple variables, including unit census levels, patient behavioral patterns and/or patient needs for physical assistance, special outings or scheduled off-site medical appointments, among others.

Although the Hospital's present system meets the minimum needs of the facility, it has several notable limitations. First, because Acuity Based Staffing is a unit-based analysis, rather than a facility-based assessment, staffing numbers are specific to Nurses and Behavioral Health Technicians only and do not account for the facility's need in regards to other disciplines, including Social Work, Psychology, Rehabilitation, and Medical Services. These functions are maintained outside of ABS and typically adhere to a standardized schedule in order to establish a general daily routine for the patients. Furthermore, the Acuity Based Staffing system was designed to capture the needs of the Civil and Forensic Hospital campuses, and does not determine or monitor staffing levels for the Arizona Community Protection and Treatment Center (ACPTC).

By far, the most significant limitation of the Hospital's current system is the considerable amount of manual intervention and data entry that is consistently required to balance work schedules across the units and then retrospectively validate that each unit had the expected staff on hand at any given time. For example, ABS is not capable of interfacing with the Hospital's Electronic Medical Record (EMR). This system is the point of record for key information used in calculating patient acuity such as:

- Complex Procedures
- In-Person Visitations
- Transports
- Admissions / Discharges
- Patient Transfers
- Telemed Visits and Medical Appointments
- Offsite Care Needs
- Line of Sight (LOS) \ Close Observation (COS)
- Total Care \ ADL
- Scheduled Outings

Each of these patient care needs must be manually entered into the system in order to calculate incremental acuity which aggregates to the total unit acuity. Staff must therefore manually gather this information from the EHR and enter into ABS at the start of every shift, across every unit, leading to significant cost investment in staff labor to support accurate scheduling.

Additionally, ABS cannot communicate with other personnel data systems, including timekeeping; therefore, the Hospital's staffing office must manually confer with each unit and verify which staff members were physically present during the shift. Sick calls and unexpected leave for FMLA, or other unscheduled time off must be managed and updated manually, as the main schedule is not connected to the acuity calculations, requiring staff to duplicate entry into the system in order to maintain accurate reporting of staffing actuals.

Because of the above, the Hospital is in need of procuring a comprehensive scheduling and staffing module that will integrate with existing data systems to maximize the effectiveness and efficiency of facility-wide acuity-based staffing. This integration will enable a new level of accuracy and timeliness to acuity calculations which will generate an estimated **cost savings of $420k annually** in staff labor costs for data entry and IT maintenance. As of July 1, 2023, the Hospital is preparing a Request For Proposal (RFP) for public solicitation to select the staffing platform that will best meet its needs. It is anticipated that this solicitation should be finalized, and an awardee selected, by the end of calendar year 2023, with an estimated 18-month implementation window to follow due to the complexities of interfacing this system with the Hospital's Electronic Medical Record system and the State's payroll / timekeeping system.

The new system is expected to expand the Hospital's administrative capacity for real time labor management, as well as extend new features such as:

- System data driven acuity calculations
- Mobile device support for staff schedule management
- Automated support for draft schedules
- Integration of staff scheduling preferences
- Leave and sick time request routing and management
- Staff notification of schedule changes in real time

The total five year implementation cost is estimated to be $1.5 million dollars, with an initial investment of $200k for vendor implementation, $250k in staffing costs to support implementation and migration, as well as an ongoing annual cost of $215k for adjusted staff needs, and software support as detailed in the following tables:

Figure 26

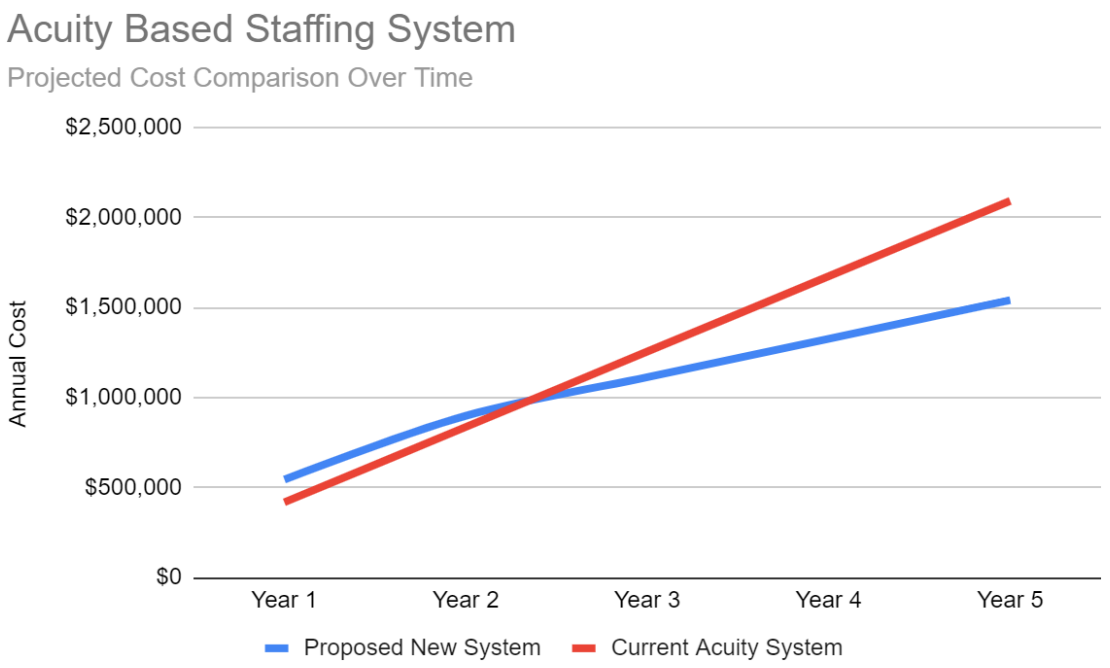
Expected 5-Year Cumulative Costs - New Staffing System					
Cost Area	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Implementation	$131,472	$65,736			
Annual Maintenance	$164,000	$164,000	$164,000	$164,000	$164,000
Staffing	$249,148	$124,574	$49,830	$49,830	$49,830
Total	$544,620	$354,310	$213,830	$213,830	$213,830
Cumulative Total	**$544,620**	**$898,930**	**$1,112,760**	**$1,326,590**	**$1,540,419**

When compared to costs associated with maintaining the existing system, and the anticipated labor and maintenance savings for the same five year period, the expected return on investment period would begin within year three.

Figure 27

Expected 5-Year Cumulative Costs - Existing Staffing System					
Cost Area	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Staff Data Entry	$271,113	$271,113	$271,113	$271,113	$271,113
Maintenance	$147,251	$147,251	$147,251	$147,251	$147,251
Total	$418,365	$418,365	$418,365	$418,365	$418,365
Cumulative Total	**$418,365**	**$836,729**	**$1,255,094**	**$1,673,459**	**$2,091,823**

Figure 28



[This Page Left Intentionally Blank]

Patient Discharges and Care Transition

Legislative Requirement: In collaboration with community-based treatment facilities, [the Plan shall] Identi[fy] levels of service that assist in transitioning patients out of the Arizona State Hospital into clinically appropriate settings, which may include secure or less restrictive settings than the Arizona State Hospital, and ways to increase the number of patients who successfully transition into the community with no readmission to the Arizona State Hospital or another inpatient psychiatric facility.

In the time period beginning July 1, 2019 and ending June 30, 2023, the Hospital discharged 116 Civil patients to another level of care. As detailed in the table below (Figure 29), the majority (78.5%) of these individuals transitioned from the State Hospital to a supervised group home in the community. Of those 116 patients discharged, eleven (11) were eventually readmitted to the State Hospital after medically decompensating in the community - importantly, each of those individuals had been discharged to a supervised group home.[36] Unlike hospitals or inpatient facilities, group homes / Behavioral Health Residential Facilities (BHRF) are not required to have a Registered Nurse physically present at all times. Instead these facilities tend to be monitored by a Behavioral Health Technician (BHT) or equivalent and a rotating staff of clinical professionals provide services to residents per their treatment plan.

Figure 29

Civil Discharge Dispositions - SFY2020 through SFY2023			
Discharge Placement	**Count**	**Average Length of Stay (Days)**	**Percent of Total**
External Medical Facility	5	787	4.3%
Group Home	91	750	78.5%
Home to Family	3	134	2.6%
Incarceration	3	3,581	2.6%
Independent Living	1	115	0.9%
Skilled Nursing Facility	9	2,516	7.8%
Other	4	607	3.4%
All	**116**	**935**	**100%**

It could be inferred that, had more robust community resources been available, specifically a facility with a regimented clinical program and proper continuous oversight, these individuals would have maintained clinical stability and not required subsequent inpatient readmission.

[36] Once an individual is formally discharged from the State Hospital they are no longer considered a patient of the facility and the Hospital cannot engage in their aftercare due to HIPAA patient confidentiality restrictions. Therefore, ASH is only aware of the current status of the 11 patients that readmitted, and cannot speak to the adequacy of the medical care being provided to the others, the behavioral/psychiatric stability thereof, or whether they have been admitted to another inpatient facility for treatment after clinically decompensating.

Alternatively, readmissions such as these could have been avoided if the individual had first been transferred to a step down unit on the Hospital's campus, as outlined in Option D of this Plan - as this program would have provided comprehensive reintegration activities to give the patients the necessary confidence and better prepare them for independent or communal living in a less-rigorous group home setting.

Another clearly apparent reality presented in this data (Figure 29) is the impact that a pre-existing support structure with robust and cooperative clinical engagement can have on expediting discharges from the State Hospital, as well as how rare these relationships appear to be for patients. For example, of the 116 Civil patients discharged during the reporting timeframe, only three (3) were discharged home to their family. Although a relatively small sample size, these individuals had an Average Length of Stay (ALOS) 93% less than the other patients that were discharged in the same period (134 days versus 935 days). All too often, patients receive minimal, if any, ongoing support from their families and/or legal guardians during their ASH admission. Rather, it has been the Hospital's experience that guardians for Title 36 Civil patients present barriers to discharge rather than advocating for the patient's transition to a less-restrictive environment when clinically appropriate - which is in violation of the 'General powers and duties of [a] guardian' established in Title 14 of Arizona Revised Statutes.[37]

As detailed in the Background section of this Plan, the Civil Hospital is classified as an Institution for Mental Diseases (IMD) per 42 CFR Ch. IV §435.1010 and is, therefore, largely unable to bill payor sources (e.g., Medicare and Medicaid) for inpatient bed days. As a result, the care and treatment for the vast majority (>97%) of Civil patients is funded by state General Fund monies although, if enrolled with AHCCCS and determined to have a Serious Mental Illness, the Health Plan continues to receive funding for the member as part of their per-member-per-month (PMPM) capitation allotment throughout the duration of the patient's civil admission - as they are responsible for any physical health services their member may require during an ASH admission. If the individual were treated in another setting, including a smaller (≤16 bed) inpatient or residential facility, Medicare and/or Medicaid would cover the costs for their stay, providing the care is medically necessary. However, as a result of the court-ordered civil admission, costs for their psychiatric treatment are shifted entirely to the state taxpayer.

There are two unintended consequences of this funding paradigm: first, the State's care continuum has adopted an escalation mentality that quickly determines that if a patient's needs cannot be readily met by a provider's existing resources, or if the patient gives the appearance of being treatment resistant, the patient should be rapidly elevated to a more restrictive level of care, e.g. outpatient to involuntary inpatient - which contradicts the aforementioned reality that mental illness is a chronic condition that, if properly managed, can be treated successfully in the community. It is more cost-effective for outpatient providers to refer the patient for involuntary treatment at an inpatient facility, including ASH, than engage them at a lower level of care, as doing so removes high service utilizers from their rosters while simultaneously mitigating risks associated with caring for treatment-adverse patients.[38]

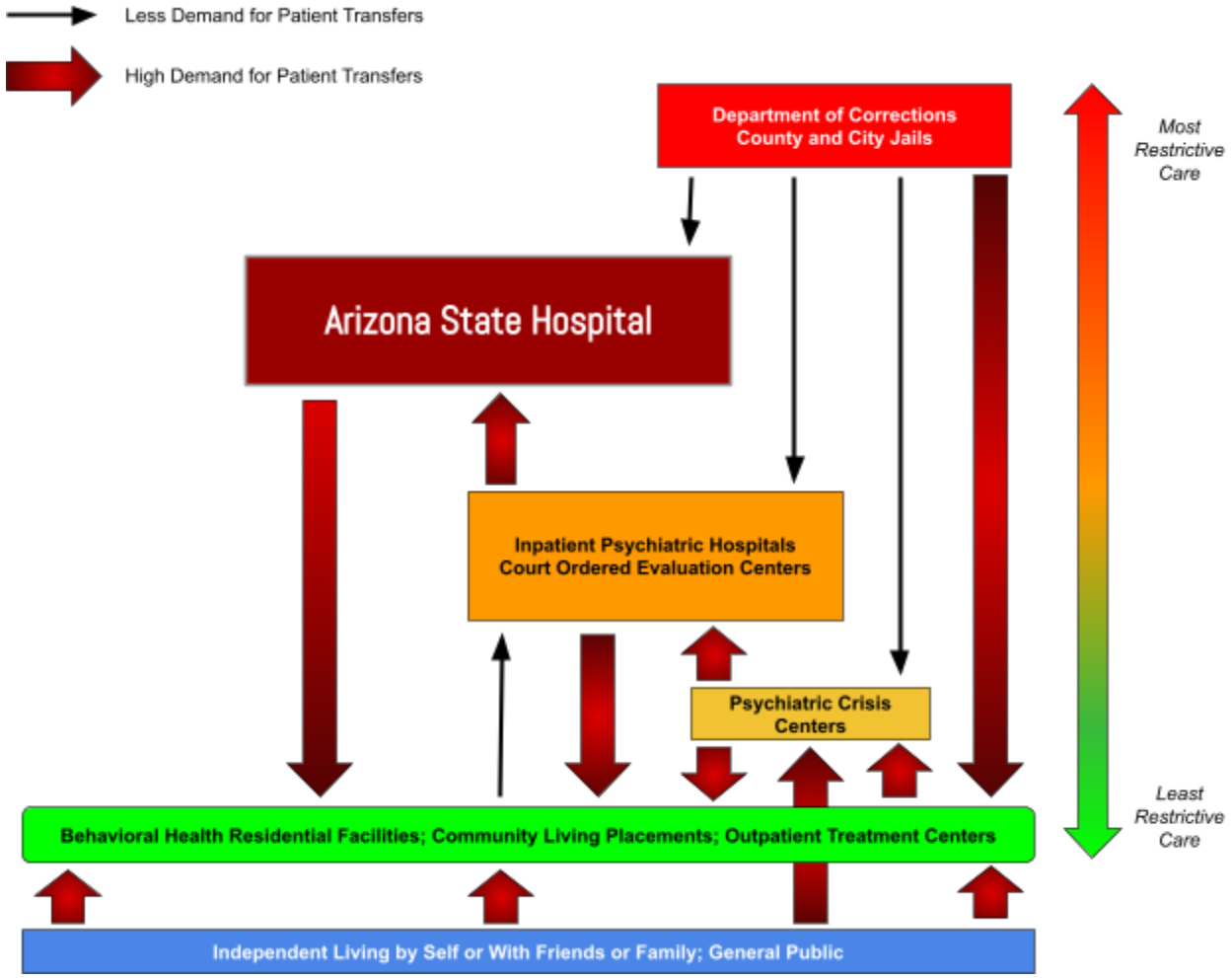
[37] Please see A.R.S. §14-5312(A)(8)

[38] Please see the section titled Admission Volumes and Wait Times for examples of how this funding model impacts admissions for the Hospital.

Second, and equally as concerning, is that the community-based treatment network, under the oversight of a health plan, is financially disincentivized from establishing an adequate service array for patients needing discharge from the State Hospital or another inpatient facility - as these patients are viewed as “too complex” and “difficult to manage” (i.e., high-cost and high-need). From a purely cost-containment perspective, the provider assumes significant financial risk by accepting these individuals into their program for ongoing care post-discharge.

In combination, these factors have reduced the availability of intermediary community-based care settings, significantly hampered bi-directional patient throughput across the entire system of care, and limited the Hospital’s ability to readily discharge Civil patients to a less-restrictive setting. The graphic below (Figure 30) illustrates how the demand for service places immense pressure on community-based providers (green rectangle) from individuals attempting to access care for the first time, as well as those presently being served in a more-restrictive setting requiring transition to a lower level of care.

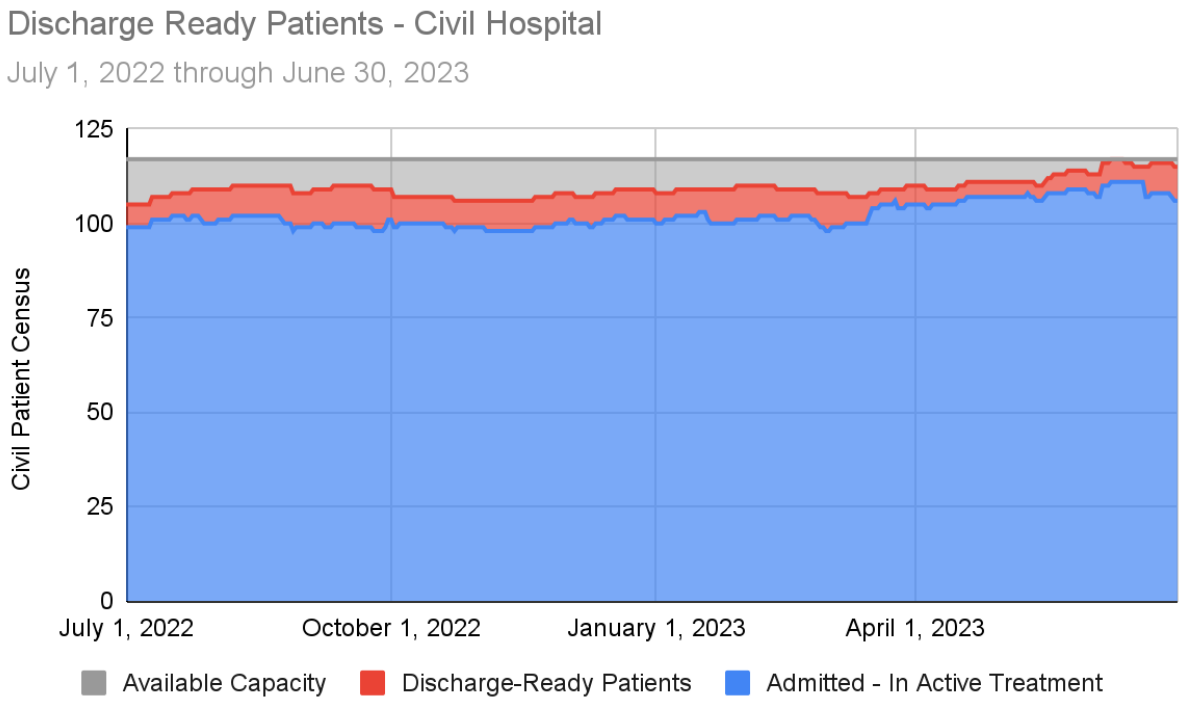
Figure 30



Unfortunately, this remains the case even for those Civil patients who have been determined psychiatrically cleared for discharge by the Hospital's medical staff (i.e. they no longer meet medical-necessity criteria for continued inpatient stay at ASH - please see Figure 31, below). Throughout State Fiscal Year 2023, there was a fluid population of seven (7) patients, on average, who were approved for discharge from the Civil campus, yet they remained at ASH for several months before discharging because no outpatient provider was ready, willing, and able to accept responsibility for their aftercare, they lacked financial eligibility for services, or their guardian objected to the community-based discharge options available for their ward.[39]

Because the individual remains under a court order for services, and as an ethical clinical practice, the Hospital is required to establish care continuity with another provider prior to initiating a discharge - and the guardian must sign the admission paperwork at the receiving facility. The Hospital cannot discharge a Civil patient to a shelter or similar setting solely because they no longer require inpatient-level care. Had the Hospital been able to promptly transition these individuals to a lower level of care based on their clinical presentation, others in need of services at ASH could have been readily admitted for treatment.

Figure 31



[39] The Hospital anticipates posting this data on its public website by the end of Calendar Year 2023.

Below are three (3) case studies that exemplify the difficulty the Hospital can experience when attempting to properly and safely discharge a Civil patient to a lower level of care. These scenarios are not isolated incidents and are, rather, largely indicative of all complex discharge cases.

Discharge Case Study 1			
Admission Time frame	**Total Length of Stay (Days)**	**Days Deemed Discharge Ready**	**Percent of Stay Discharge Ready**
2021	413	198	48%

Case Study 1: *A Native American male with diagnoses of Schizophrenia and Substance Use Disorder, was admitted to ASH for stabilization in the Spring of 2021. The patient had a history of Absent Without Leave (AWOL) from past placements, physically aggressive behaviors including Danger to Self / Danger to Others when not compliant on his medications, treatment non-compliance, and psychotic thought processes. Within six months of admission to ASH, the individual was stabilized and approved for discharge by the Hospital's medical team; unfortunately, he remained at ASH for another seven months before a placement could be secured. While waiting for a placement, there were several delays with discharge planning including the following: no availability at a Community Living Placement (CLP), ongoing communication breakdowns between various agencies and individuals involved in the discharge process external to the Hospital, identified housing needing to be cleaned and repaired, and inadequate supportive services put in place (i.e., lack of financial resources, no groceries, unfurnished apartment).*

Discharge Case Study 2			
Admission Time frame	**Total Length of Stay (Days)**	**Days Deemed Discharge Ready**	**Percent of Stay Discharge Ready**
2013	3,352	50	1%

Case Study 2: *In 2013, a 56-year-old Caucasian male with a primary diagnosis of Schizophrenia was admitted to ASH after a long history of mental health treatment and inpatient psychiatric hospitalizations. Throughout his stay at ASH, his psychosis made it difficult for him to engage in meaningful treatment. As he aged, his needs became more complex due to rising medical complications; eventually leading to his medical needs surpassing his psychiatric symptoms. This led to multiple emergency room visits and medical hospitalizations. Between 2020-2022, the patient was medically hospitalized fifteen (15) times and sent to the emergency room several other times out of medical necessity.*

The patient's treatment team at ASH, with agreement from the guardian and outpatient team, determined that the patient's needs would best be served at a Skilled Nursing Facility (SNF) and began applying for Arizona Long Term Care System (ALTCS) eligibility in 2020. The patient was denied ALTCS enrollment and, as a result, was denied consideration at every SNF that an

application was submitted to. From 2020-2022, ALTCS denied the patient twice despite having a qualifying medical score on the ALTCS eligibility because the ALTCS reviewing physician determined that the score was high due to the patient's psychiatric illness. The patient was finally approved for ALTCS after a prolonged medical hospitalization in 2022. Once approved, the patient was successfully discharged to a SNF directly from a medical hospital. ***In all, the patient remained hospitalized at ASH for two years after no longer being deemed appropriate for ASH due the lack of funding for an appropriate placement as a result of being denied ALTCS.***

Discharge Case Study 3			
Admission Time frame	**Total Length of Stay (Days)**	**Days Deemed Discharge Ready**	**Percent of Stay Discharge Ready**
2021	222	42	19%

Case Study 3: *A Latino male with diagnoses of Schizoaffective Disorder, Bipolar Type was admitted to ASH for stabilization in the Spring of 2021. The patient had a history of verbalizations of self-injury or suicidal ideation as well as difficulty with responding to internal stimuli that resulted in struggling to maintain safety for himself and others. By early fall of 2021, the patient had stabilized and ASH informed the health plan and outpatient team that the patient was nearing discharge. Once officially on the discharge list, there was decreased engagement from the health plan and outpatient team and they verbalized resistance to discharging to the recommended placement and services (a Behavioral Health Residential Facility [BHRF] with medication monitoring/ACT team) due to the patient's financial eligibility (Non-Title 19). Additionally, ASH was informed by the outpatient team that an ACT referral would take a month or more. ASH expressed concern about the unnecessary delay of discharge and informed the Office of Human Rights (OHR) of the patient's need for special assistance. OHR provided education to the health plan on options for funding of a BHRF and reminded the health plan of the patient's SMI rights. Funding and placement were secured shortly after OHR involvement. ASH had to re-engage OHR again when additional barriers were presented regarding discharge transportation and the outpatient team reportedly being unable to schedule a follow up PCP appointment for the patient's medical continuity of care. After OHR again provided education, the patient was discharged with appropriate transportation and a plan for his medical needs to be managed.*

The importance of properly preparing a patient for discharge, and then safely transitioning them to community was extensively referenced by respondents of the public survey developed as part of this Plan. Many survey respondents voiced concerns about network sufficiency and the availability of adequate post-inpatient care and wraparound services:

"Assertive community treatment needs to be expanded to provide services to all former ASH patients. This team approach to behavioral health care will ensure that former ASH patients receive all of the wraparound services they need to successfully reside in the community. Assertive community treatment should also identify and provide for all of an individual's needs, including physical health care and social determinants of health; such as housing, education, employment, and social supports [and] [a]lthough some of these wraparound services may not be covered by Medicaid, State policymakers have the authority to provide the services using State funding."

"DDD needs behavioral health group homes for members who are dually diagnosed. more community behavioral health supports for people with mental illness as a step down program to provide supports."

"Supported housing, residential treatment designed for transitioning patients, Transitional Housing, and post-AzSH teams to bring care to the persons where they are and as part of the transitioning, assess their ability to get to appointments, take the bus or other transportation, assess ability to live on their own, truly."

"Having a better and longer transition time for ASH patients - eg, able to go on pass to proposed placements and having outpatient team much more involved prior to ASH discharge. 2) Having many more community placements with 24 hour staff presence and house model. This type of setting is often more appropriate for patients with very severe symptoms even with optimal treatment and who will end up getting kicked out of a BHRF due to non-participation and then be homeless and then deteriorate. BHRFs discharge a patient if they are gone for 48 hours ,even if it is because they required urgent care treatment."

Respondents were also asked which resources would best ensure that a recently-discharged patient is able to remain in the community and not require readmission to the State Hospital or another inpatient facility. Similar to the answers received regarding discharge and care transitions, participants cited various concerns with the availability of resources for these individuals once discharged, as well as provided recommendations for additional actions ASH can take while the individual is still admitted for care:

"There should also be more of a focus on trauma informed care both within the community based behavioral health system and ASH. Upon admission, ASH should assess trauma history and include addressing trauma in its treatment plans. ASH should also continually assess patients for trauma throughout their stay, and address issues of trauma as they arise. Addressing this can avoid future mental health crises and re-admission."[40]

"[our] monitoring work has revealed that a number of ASH patients also have a history of substance use disorder, however ASH does not have programming or treatment to address substance use issues. Providing this type of treatment would assist patients after discharge by giving them the tools to prevent a relapse of their substance use, leading to a mental health crisis and readmission to ASH."[41]

[40] Note: The Hospital continuously assesses patients for their reactions to any traumatic experiences that have occurred prior to or during hospitalization, and provide treatment interventions (including individual therapy) as indicated and as the patient is able to tolerate.

[41] This need is also referenced by the Hospital under Option A of this plan

"Treatment at ASH is focused primarily on a medical model, but there is growing evidence that medicating a mental illness is not enough. Individuals need to be treated in a more holistic and integrated fashion to address social determinants of health. ASH should assist patients in acquiring some of these non-medical tools."[42]

"Being able to see outpatient psychiatrists and therapists and have a supportive team. Even if they can't be in person, utilizing technology to check in on them once they discharge so they feel supported and if they were declining someone would be able to tell sooner to get them in to see someone. More therapeutic housing options for those that are frequent readouts would help."

"Home health agencies local to the person would be needed to ensure they keep close tabs on the person and keep an eye out for decompensating. It's possible to head off an admission if proper intervention happens but the problem is that many agencies are overwhelmed and underpaid-until this is addressed at the community level, people will always be a danger of readmission."

As noted in the previous section specific to admissions, the Hospital recommends the State solicit an independent third-party consultant to conduct an end-to-end sufficiency analysis of the continuum of care and quantify the unmet treatment needs of the population. In the meantime, there are multiple actions the State can take to properly affect the changes to the system of care, improve discharge performance, and reduce readmission rates. For example, Option D and Option F of this plan are specifically designed to expedite patient throughput across the system by developing facilities managed by ASH that would provide services to patients that are either not currently available, or are only offered in minimal capacity at the Hospital. Doing so will permit ASH to redirect existing patients into the new facility based on their discharge readiness, clinical stability or medical need, and ensure the Civil Hospital, Forensic Hospital, and ACPTC can focus on caring for individuals within their respective scopes of expertise, e.g., psychiatric and/or psychosexual rehabilitation.

Furthermore, as an incentive, the Legislature could consider amending statute to require AHCCCS to provide an increased reimbursement to the Health Plan for not less than 12-months for each enrolled Civil patient discharging from the State Hospital to better support their wraparound care in the community, provided that the individual actively engages in ongoing treatment and does not readmit to ASH or another inpatient facility within that 12-month period. Subsequently, as a penalty, the Legislature could consider amending statute to require the assigned AHCCCS Health Plan to reimburse the Hospital its published daily bed rate (currently $1,100 / day) for each day a Medicaid-enrolled member remains admitted to the Civil Hospital once medically cleared and approved for discharge to a less-restrictive level of care by the Hospital's medical staff and the patient's guardian (if applicable), and these monies should be deposited into the Hospital's non-appropriated fund to be used for *legislatively-directed* program expansion activities. Both actions would simultaneously create significant motivation to expand community-based resources and increase patient throughput, while substantially restricting the demand for inpatient services to only those patients who truly warrant that level of service based on their clinical presentation.

[42] Note: The Hospital does address social determinants of health. For example, we use treatment interventions that focus on interpersonal functioning, developing/maintaining relationships, and building social and support networks. Through community outings with staff, family/support members, and on their own, our patients get practice with navigating and participating in the communities to which they are going to discharge. And our work programs give the patients opportunities to learn how to acquire a job, practice job skills, and increase financial stability.

Pandemic Response and Operational Continuity

Legislative Requirement: [the Plan shall include] a pandemic response and preparedness plan that does the following:

- *Creates a set of clinical metrics to significantly mitigate the effects of the COVID-19 pandemic and staffing shortages on the Arizona State Hospital's implementation of each patient's individual treatment and discharge plan, including the patient's inability to achieve what is necessary to advance to conditional release.*
- *Ensures continuous operation of the Arizona State Hospital with minimal or no cessation or disruption of treatment services in the event of a new or recurrent epidemic or pandemic event.*

The State Hospital maintains multiple plans intended to dictate its response to emergency situations and ensure a baseline level of operational continuity of the facility regardless of external mitigating factors that may impact the Hospital's ability to function as designed. This includes an Emergency Operations Plan (EOP), a Pandemic Influenza, Epidemic, and Infectious Disease Outbreak Plan, a Continuity of Operations Plan (COOP) with an annual Hazard Vulnerability Analysis (HVA) assessment, as well as an Infection Prevention and Control Program plan.

These plans are designed in accordance with the requirements outlined by the Centers for Medicare and Medicaid Services, The Joint Commission, and state licensing rules, and are subject to regular review and revision as new standards are instituted by various regulators. Importantly, they are specifically intended to ensure continuity of operations with an emphasis on patient, staff and public safety, Although the plans include actions necessary to reallocate resources, adjust staffing levels and provide patient care, they do not prioritize patient clinical progression towards conditional release as a goal since, during an emergency scenario, this is determined to be secondary to safety. These plans are intended to meet CMS requirements for mitigating the impact of emerging infectious diseases by following federal and state authorities on infection prevention and control. Accordingly, the Hospital will follow Federal and State authority directives during public health emergencies, such as the COVID-19 pandemic, as a failure to do so would jeopardize approximately $28 million in Federal funding the State receives from CMS annually, permitting the State Hospital maintains compliance with Medicare regulations.

In calendar year 2024, the Hospital will begin tracking the number of outings and passes to the community being offered to patients on a monthly basis and, of that number, the percent that were canceled due to staff availability. Once this metric is finalized, the Hospital will establish a baseline goal and then begin to quantify the effect that staffing levels may have on patient progression to discharge (Civil) and/or conditional release (Forensic). Additionally, the Hospital currently tracks service utilization and patient engagement in services identified in their Inpatient Treatment and Discharge Plans (ITDPs). Patient engagement in treatment and services is crucial in progressing to the point of being able to participate in outings and passes to the community. The Hospital will implement action plans when it has identified that staffing levels have impacted the ability of patients to receive services necessary in meeting their ITDP goals.

[This Page Left Intentionally Blank]

Independent Investigations

Legislative Requirement: [the Plan shall] Identi[fy] an independent third-party that resides outside of the Arizona State Hospital to investigate incident reports and to whom patients, families and advocates may file complaints.

Similar to other inpatient facilities in the nation, the State Hospital is regulated by a number of external entities, and these entities have varying levels of authority to conduct investigations of incidents that occur at the Hospital and/or in response to complaints. Per the applicable regulation(s), the State Hospital is required to provide information to patients and staff of their ability and right to contact these entities directly and file complaints. ASH is one of the most heavily-regulated healthcare institutions in the State of Arizona, as is evident in the table below:[43]

Figure 32

Arizona State Hospital - Regulatory Entities[44]			
Name	**External to ADHS**	**Reviews Incident Reports[45]**	**Investigates Complaints**
Adult Protective Services (DES/APS)	Yes	Yes	Yes
Arizona Center for Disability Law (ACDL)	Yes	Yes	Yes
Arizona Department of Occupational Safety and Health (ADOSH - OHSA)	Yes	Yes	Yes
Bureau of Medical Facilities Licensing (ADHS/BMFL)	No	Yes	Yes
Centers for Medicare and Medicaid Services (CMS)[46]	Yes	Yes	Yes
Independent Oversight Committee (IOC)	Yes	Yes	Yes
Office of Behavioral Health Grievances and Appeals (AHCCCS/BHGA)	Yes	Yes	Yes
Office of Human Rights (AHCCCS/OHR)	Yes	Yes	Yes
The Joint Commission[47]	Yes	Yes	Yes
State of Oregon (pending)	Yes	TBD	TBD

[43] Applicable regulations/requirements: CMS (42 § CFR 482 et. al); The Joint Commission *Comprehensive Accreditation Manual for Hospitals (CAMH)*; A.A.C. R9-21-104, R9-21-105, 9 A.A.C. 21, Article 4; 9 A.A.C. 10, Article 2 and Article 13; ADHS/DES Memorandum of Understanding (MOU); 42 U.S.C. § 10803; 20 A.A.C. 5, Article 6

[44] List is not all-inclusive

[45] Entities are permitted to review incident reports as part of their complaint investigation activities. In some cases, incident reports may be redacted based on the entity's legal authority to access patient-specific information.

[46] The Civil Hospital is certified by the Centers for Medicare and Medicaid Services (CMS)

[47] The Civil and Forensic Hospitals are both accredited by The Joint Commission.

These entities include, but are not limited to, the Centers for Medicare and Medicaid Services (CMS), The Joint Commission, the AHCCCS Office of Human Rights (OHR), AHCCCS Behavioral Health Grievances and Appeals (BHGA), the ADHS Bureau of Medical Facilities Licensing (BMFL), the Independent Oversight Committee (IOC), Adult Protective Services (APS), the Arizona Center for Disability Law (ACDL), and the Arizona Department of Occupational Safety and Health (ADOSH).

The ADHS Bureau of Medical Facilities Licensing (BMFL) operates as the State Survey Agency in Arizona under a contractual arrangement with CMS to conduct surveys of healthcare institutions, including the State Hospital. Because of the numerous external regulatory entities involved in overseeing patient care, it is a common practice across the country for a State Hospital to be a part of a large state health department that also has licensing responsibilities. Nonetheless, as of July 1, 2023, the Department of Health Services is negotiating an 'in kind' agreement with the State of Oregon that would permit each State to conduct an annual survey of the other's State Hospital to assess compliance with CMS standards. Doing so will further alleviate the perception of an existing bias or conflict of interest inherent with the State Hospital and BMFL both operating under ADHS.

Additionally, the State could establish an independent entity with authority to act as a secondary reviewer of grievances investigated by the State Hospital and, following their own review of the facts, subsequently concur with, or override, the initial decisions made by the Hospital's internal investigation team, prior to the Hospital notifying the patient/resident of said determination. This individual, or entity, would act in a manner similar to that of a healthcare ombudsman. Should the patient or resident still not agree with the disposition of their grievance, they would maintain the right to appeal the decision to AHCCCS' Office of Behavioral Health Grievances and Appeals.

Arizona Administrative Code (A.A.C. R9-21-402 et. seq.,) outlines specific procedures for the investigation and determination of grievances, including required timeframes - as well as the process for appeals and hearings to an Administrative Law Judge. Establishing an independent entity to validate grievance decisions made by the State Hospital may, therefore, necessitate a change to Title 36, in order to grant the entity all legal privileges to access confidential patient information, define their scope, extend the grievance determination timelines for State Hospital investigations, and clarify the independent entity's role in future appeals and/or administrative hearings. Doing so will ensure that neither the Hospital, nor the independent entity, are procedurally determined to be in violation of Arizona Administrative Code. Furthermore, in order to maintain compliance with Centers for Medicare and Medicaid Services (CMS) standards, the Hospital's Governing Body would need to formally delegate final grievance decision making authority and liability to the independent entity.

Appendices

[This Page Left Intentionally Blank]

Appendix A - Detailed Budgetary Analysis

Additional Resources Needed to Meet Existing Obligations

Figure 33 - Behavioral Health Technician and Registered Nurse Needs per Shift and Unit

			Base Staff		Additional Staff For Acuity		
Campus	**Unit**	**Shift**	**Nurses (RN)**	**BHT (Base)**	**BHT (1:1)**	**BHT (ADL)[48]**	**RN Float**
Civil	Palo Verde	Front End Days	4	10	5	2	0
Civil	Palo Verde	Front End Nights	3	8	3	2	0
Civil	Palo Verde	Back End Days	4	10	5	2	0
Civil	Palo Verde	Back End Nights	3	8	3	2	0
Civil	Desert Sage	Front End Days	4	10	5	1	0
Civil	Desert Sage	Front End Nights	3	8	3	1	0
Civil	Desert Sage	Back End Days	4	10	5	1	0
Civil	Desert Sage	Back End Nights	3	8	3	1	0
Civil	Ironwood	Front End Days	4	10	5	1	0
Civil	Ironwood	Front End Nights	3	8	3	1	0
Civil	Ironwood	Back End Days	4	10	5	1	0
Civil	Ironwood	Back End Nights	3	8	3	1	0
Forensic	CRU	Front End Days	1	3	0	0	0
Forensic	CRU	Front End Nights	1	2	0	0	0
Forensic	CRU	Back End Days	1	3	0	0	0
Forensic	CRU	Back End Nights	1	2	0	0	0
Forensic	Saguaro	Front End Days	2	5	1	0	0
Forensic	Saguaro	Front End Nights	1	5	0	0	1
Forensic	Saguaro	Back End Days	2	5	1	0	0
Forensic	Saguaro	Back End Nights	1	5	0	0	1
Forensic	Cottonwood	Front End Days	2	5	0	0	0
Forensic	Cottonwood	Front End Nights	1	4	0	0	0
Forensic	Cottonwood	Back End Days	2	5	0	0	0
Forensic	Cottonwood	Back End Nights	1	4	0	0	0
Forensic	Sycamore	Front End Days	2	5	1	0	0
Forensic	Sycamore	Front End Nights	1	5	1	0	1
Forensic	Sycamore	Back End Days	2	5	1	0	0
Forensic	Sycamore	Back End Nights	1	5	1	0	1
Forensic	Mohave	Front End Days	2	5	1	0	0

[48] Assistance with “Activities of Daily Living” - including eating, dressing, mobility assistance, and personal hygiene.

			Base Staff		Additional Staff For Acuity		
Campus	Unit	Shift	Nurses (RN)	BHT (Base)	BHT (1:1)	BHT (ADL)[48]	RN Float
Forensic	Mohave	Front End Nights	1	5	0	0	0
Forensic	Mohave	Back End Days	2	5	1	0	0
Forensic	Mohave	Back End Nights	1	5	0	0	0
Forensic	Pinon	Front End Days	2	5	0	1	0
Forensic	Pinon	Front End Nights	1	5	0	1	1
Forensic	Pinon	Back End Days	2	5	0	1	0
Forensic	Pinon	Back End Nights	1	5	0	1	1
Forensic	Sago	Front End Days	2	5	1	0	0
Forensic	Sago	Front End Nights	1	5	0	0	0
Forensic	Sago	Back End Days	2	5	1	0	0
Forensic	Sago	Back End Nights	1	5	0	0	0

		RN	BHT	BHT+	BHT+	RN+
ASH	**All Shifts (Base Need)**	**82**	**236**			
ASH	**All Shifts (+ For Acuity)**			**58**	**20**	**6**
ASH	**Allocated FTE**	**83**	**237**			

Total RN Need	**88**
RN Allowable FTE	**83**
RN FTE Deficit	**-5**

Total BHT Need	**314**
BHT Allowable FTE	**237**
BHT FTE Deficit	**-77**

Figure 34

FTE Adjustment Necessary to Meet Current Obligations							
Position / Discipline	Hired FTE	Maximum Allowable Headcount	Actual Needed Headcount	Required Adjustment	Total Salary	Total ERE[49]	Est. Annual Cost Increase
BHT	201	237	314	77	$4,567,927	$1,955,183	$6,523,109
Registered Nurse	57	83	88	5	$567,864	$213,216	$781,080
RPS (ACPTC)	63	67	80	13	$803,859	$362,618	$1,166,478
Psychology	18	20	29	9	$807,342	$37 8,262	$1,185,605
Social Services	18	23	26	3	$202,706	$92,280	$294,986
Rehabilitation	44	51	59	8	$434,191	$223,858	$658,049
Health Records	8	9	11	2	$73,030	$48,596	$121,626
All	**409**	**490**	**607**	**117**	**$7,456,919**	**$3,274,013**	**$10,730,933**

[49] Employee Related Expenses (ERE) include the State's payable portion of benefits to employees.

Option A - Enhance Clinical Model for Existing Patients and Residents

Figure 35

Option A - Clinical Model Enhancement FTE Additions and Labor Expenses				
Position	**Required Adjustment**	**Total Salary**	**Total ERE**	**Estimated Annual Cost Increase**
Specialist - Neuropsychologist	1	$115,282	$46,113	$161,395
Specialist - Psychologist with an Expertise in the Treatment of Personality Disorders	2	$230,564	$92,226	$322,790
Specialist - Psychologist with an Expertise in Development / Intellectual Disabilities and Applied Behavior Analysis	2	$230,564	$92,226	$322,790
Specialist - Substance Addiction	4	$461,128	$184,451	$645,579
Nurse Anesthetist	0.5	$97,400	$38,960	$136,360
ECT Nurse	0.5	$56,786	$21,322	$78,108
Total	**10**	**$1,191,724**	**$475,297**	**$1,667,021**

[This Page Left Intentionally Blank]

Option B - Increase Civil Bed Capacity with No Changes to Clinical Model

Figure 36 - Additional Unit Staffing Needs for Civil Expansion (BHT and RN)

			Base Staff		Additional Staff For Acuity		
Campus	**New Unit**	**Shift**	**Nurses (RN)**	**BHT (Base)**	**BHT (1:1)**	**BHT (ADL)**	**RN Float**
Civil	Desert Sage 2	Front End Days	4	10	5	0	0
Civil	Desert Sage 2	Front End Nights	3	8	3	0	0
Civil	Desert Sage 2	Back End Days	4	10	5	0	0
Civil	Desert Sage 2	Back End Nights	3	8	3	0	0
Civil	Ironwood 2	Front End Days	4	10	5	0	0
Civil	Ironwood 2	Front End Nights	3	8	3	0	0
Civil	Ironwood 2	Back End Days	4	10	5	0	0
Civil	Ironwood 2	Back End Nights	3	8	3	0	0

		RN	BHT	BHT	BHT	RN
Civil	**All Shifts (Base Need)**	**28**	**72**			
Civil	**All Shifts (+ For Acuity)**			**32**	**0**	**0**

Total Additional RN Need	**28**		**Total Additional BHT Need**	**104**

Figure 37

Option B - Civil Capacity Expansion FTE Additions and Labor Expenses				
Position	**Required Adjustment**	**Total Salary**	**Total ERE**	**Estimated Annual Cost Increase**
Behavioral Health Technician	104	$6,169,667	$2,640,766	$8,810,433
Registered Nurse	28	$3,180,038	$1,194,008	$4,374,046
Psychiatrist	4	$926,213	$332,868	$1,259,081
Psychologist	4	$358,819	$168,117	$526,935
Recreational Therapist	8	$444,164	$187,978	$632,142
Medical Records	2	$73,030	$48,596	$121,626
Social Worker	4	$292,453	$132,223	$424,676
Transportation Staff	2	$118,647	$50,784	$169,431
Misc. Unit Support Staff	12	$788,631	$412,750	$1,201,381
Total	**168**	**$12,351,661**	**$5,168,091**	**$17,519,752**

Figure 38

Option B - Civil Capacity Expansion Estimated Unit Renovation Costs	
Project Task	**Cost**
Purchase and install 80 anti-ligature beds	$160,000
Retrofit 40 patient restrooms to anti-ligature	$500,000
Remove unsafe furniture/lockers from patient rooms; Remove miscellaneous items	$20,000
Retrofit 15 patient shower/tub rooms to anti-ligature	$150,000
Install anti-ligature hardware on all doors	$500,000
Purchase patient bathtubs	$20,000
Fire System Compliance Changes	$100,000
Purchase Day Room Furniture	$250,000
Renovate Nursing Stations	$500,000
Purchase IT Equipment	$100,000
Door Key Card System hardware and installation	$100,000
Install Wall Reinforcement - Safety Overlay Materials	$1,000,000
Install Audio/Video Security System	$750,000
Purchase Staff office furniture	$200,000
Upgrade HVAC Controls - Environmental Management System	$150,000
Door Replacement	$50,000
Purchase Additional food servicing equipment	$150,000
Upgrade Locking Assembly for doors	$50,000
Roof Repairs	$200,000
Purchase Conference Room furniture	$60,000
Purchase Seclusion and Restraint Furniture	$20,000
Purchase Physician exam room equipment	$20,000
Purchase Storage Supplies - Shelving, etc...	$10,000
Purchase Miscellaneous Appliances	$25,000
Miscellaneous Repairs (Unknowns)	$10,000
10% Contingency Buffer (Price Variations)	$509,500
Total Estimate	**$5,604,500**

Figure 39

Option B - Civil Capacity Expansion Development and Ongoing Operational Expenses (Non-Labor)		
Service	**Estimated One-Time Expense**	**Estimated Annual Expense**
Unit Renovations	$5,604,500	-
Housekeeping / EVS	-	$412,610
Food and Nutrition Service	-	$715,934
Medications and Pharmacy	-	$989,491
Facility Maintenance	-	$459,013
Utilities	-	$325,227
All	**$5,604,500**	**$2,902,275**

Option B Total Cost (Est.) -
Initial: $5,604,500
Ongoing Annual: $20,709,953 / yr

[This Page Left Intentionally Blank]

Option C - Increase Civil Bed Capacity and Enhance Clinical Model

Figure 40

Option C - Civil Capacity Expansion and Clinical Program Enhancement FTE Additions and Labor Expenses				
Position	**Required Adjustment**	**Total Salary**	**Total ERE**	**Estimated Annual Cost Increase**
Behavioral Health Technician	104	$6,169,667	$2,640,766	$8,810,433
Registered Nurse	28	$3,180,038	$1,194,008	$4,374,046
Psychiatrist	4	$926,213	$332,868	$1,259,081
Psychologist	4	$358,819	$168,117	$526,935
Physician (Medical)	1	$206,874	$81,052	$287,926
Recreational Therapist	8	$444,164	$187,978	$632,142
Medical Records	4	$146,060	$97,192	$243,252
Social Worker	4	$292,453	$132,223	$424,676
Transportation Staff	2	$118,647	$50,784	$169,431
Specialist - Neuropsychologist	2	$230,564	$92,226	$322,790
Specialist - Psychologist with an Expertise in the Treatment of Personality Disorders	3	$345,846	$138,338	$484,184
Specialist - Psychologist with an Expertise in Development / Intellectual Disabilities and Applied Behavior Analysis	3	$345,846	$138,338	$484,184
Specialist - Substance Addiction	4	$461,128	$184,451	$645,579
Nurse Anesthetist	1	$194,800	$77,920	$272,720
ECT Nurse	1	$113,573	$42,643	$156,216
Misc. Unit Support Staff	12	$788,631	$412,750	$1,201,381
Total	**185**	**$14,323,322**	**$5,971,656**	**$20,294,978**

Figure 41

Option C - Civil Capacity Expansion and Clinical Program Enhancement Development and Ongoing Operational Expenses (Non-Labor)		
Service	**Estimated One-Time Expense**	**Estimated Annual Expense**
Unit Renovations	$5,604,500	-
Housekeeping / EVS	-	$412,610
Food and Nutrition Service	-	$715,934
Medications and Pharmacy	-	$989,491
Facility Maintenance	-	$459,013
Utilities	-	$325,227
All	**$5,604,500**	**$2,902,275**

Option C Total Cost (Est.) -
Initial: $5,604,500
Ongoing Annual: $23,197,253 / yr

Option D - Create a Civil Reintegration Unit

Figure 42

Option D - Civil Reintegration Unit FTE Additions and Labor Expenses				
Position	**Required Adjustment**	**Total Salary**	**Total ERE**	**Estimated Annual Cost Increase**
Behavioral Health Technician	12	$711,885	$304,704	$1,016,588
Registered Nurse	4	$454,291	$170,573	$624,864
Psychologist Supervisor	1	$110,457	$50,261	$160,718
Psych. Nurse Practitioner	1	$181,037	$59,694	$240,731
Psychologist	1	$95,482	$41,704	$137,187
Occupational Therapist	1	$74,189	$40,009	$114,197
Recreational Therapist	4	$222,082	$93,989	$316,071
Medical Records	1	$36,515	$24,298	$60,813
Social Worker	1	$73,113	$33,056	$106,169
Nurse Shift Supervisor	4	$572,830	$177,446	$750,276
Total	**30**	**$2,531,881**	**$995,734**	**$3,527,614**

Figure 43

Option D - Civil Reintegration Unit Development and Ongoing Operational Expenses (Non-Labor)		
Service	**Estimated One-Time Expense**	**Estimated Annual Expense**
Facility Development	$8,064,000	-
Housekeeping / EVS	-	$88,023
Food and Nutrition Service	-	$152,733
Medications and Pharmacy	-	$216,292
Facility Maintenance	-	$97,923
Utilities	-	$69,382
All	**$8,064,000**	**$624,353**

Option D Total Cost (Est.) -
Initial: $8,064,000
Ongoing Annual: $4,151,967 / yr

[This Page Left Intentionally Blank]

Option E - Develop a Special Needs Unit for ACPTC

Figure 44

Option E - Develop a Special Needs Unit for ACPTC FTE Additions and Labor Expenses				
Position	**Required Adjustment**	**Total Salary**	**Total ERE**	**Estimated Annual Cost Increase**
Psychologist	1	$89,705	$42,029	$131,734
Rehabilitation Therapist	1	$55,050	$30,408	$85,458
Registered Nurse	6	$681,437	$255,859	$937,296
Residential Program Specialist	15	$922,718	$484,179	$1,406,897
Residential Unit Manager	1	$61,235	$32,132	$93,367
Total	**24**	**$1,810,144**	**$844,607**	**$2,654,751**

Figure 45

Option E - Develop a Special Needs Unit for ACPTC Development and Ongoing Operational Expenses (Non-Labor)		
Service	**Estimated One-Time Expense**	**Estimated Annual Expense**
Facility Development	$2,500,000	-
Housekeeping / EVS	-	$82,522
Food and Nutrition Service	-	-
Medications and Pharmacy	-	-
Facility Maintenance	-	-
Utilities	-	-
All	**$2,500,000**	**$82,522**

Option E Total Cost (Est.) -
Initial: $2,500,000
Ongoing Annual: $2,737,273 / yr

[This Page Left Intentionally Blank]

Option F - Expand Service Model Beyond Primary Psychiatric Care

Figure 46

Option F - Expand Service Model Beyond Primary Psychiatric Care FTE Additions and Labor Expenses				
Position	**Required Adjustment**	**Total Salary**	**Total ERE**	**Estimated Annual Cost Increase**
Psychiatrist - Geriatric	1	$ 231,553	$ 83,217	$ 314,770
Psychiatrist - Autism Disorders	1	$ 231,553	$ 83,217	$ 314,770
Psychiatrist - Psychodynamic	1	$ 231,553	$ 83,217	$ 314,770
Psychiatrist - Addictions	1	$ 231,553	$ 83,217	$ 314,770
Psychiatrist - Dual Diagnosis	1	$ 231,553	$ 83,217	$ 314,770
Psychologist - Neuropsychologist	1	$ 231,553	$ 83,217	$ 314,770
Psychologist - Neurodevelopmental	1	$ 231,553	$ 83,217	$ 314,770
Psychologist - Personality Disorders	1	$ 115,282	$ 46,113	$ 161,395
Psychologist - Substance Addictions	2	$ 230,564	$ 92,226	$ 322,790
Social Worker - LMSW on Unit	5	$ 337,843	$ 153,800	$ 491,643
Social Worker - Discharge Specialist	2	$ 135,137	$ 61,520	$ 196,657
Behavioral Analyst	1	$ 63,420	$ 37,089	$ 100,509
Therapist	1	$ 63,420	$ 37,089	$ 100,509
Physical Therapist	1	$ 55,520	$ 23,497	$ 79,018
Occupational Therapist	2	$ 148,377	$ 80,017	$ 228,395
Substance Abuse Specialist	1	$ 115,282	$ 46,113	$ 161,395
Vocational Specialist	2	$ 113,995	$ 48,245	$ 162,240
Therapy Technician	5	$ 216,827	$ 108,570	$ 325,397
Medical - MD/DO (Neurologist)	1	$ 250,151	$ 98,859	$ 349,010
Medical - MD/DO (Generalist)	1	$ 206,874	$ 81,052	$ 287,926
Nurse Unit Manager	5	$ 560,701	$ 248,950	$ 809,651
Nurse Shift Supervisor	20	$ 2,864,149	$ 887,232	$ 3,751,381
Registered Nurse	48	$ 5,648,602	$ 1,967,166	$ 7,615,768
Behavioral Health Technician	142	$ 8,423,968	$ 3,605,662	$ 12,029,630
Medical Assistant	2	$ 89,302	$ 50,268	$ 139,571
Unit Coordinator	2	$ 105,418	$ 71,707	$ 177,125
Unit Clerk	5	$ 208,367	$ 108,675	$ 317,042
Appointment Scheduler	1	$ 41,674	$ 21,735	$ 63,408
Transportation	2	$ 118,647	$ 50,784	$ 169,431
Total	**259**	**$ 21,734,394**	**$ 8,508,889**	**$ 30,243,283**

Figure 47

Option F - Expand Service Model Beyond Primary Psychiatric Care Development and Ongoing Operational Expenses (Non-Labor)		
Service	**Estimated One-Time Expense**	**Estimated Annual Expense**
Facility Development	$61,635,000	-
Housekeeping / EVS	-	$620,730
Food and Nutrition Service	-	$1,161,632
Medications and Pharmacy	-	$1,458,052
Facility Maintenance	-	$637,778
Medical	-	$356,400
Indirect Costs (Legal, Insurance, etc...)	-	$2,445,076
Utilities	-	$452,202
All	**$61,635,000**	**$7,131,870**

Option F Total Cost (Est.) -
Initial: $61,635,000
Ongoing Annual: $37,375,153 / yr

Appendix B - Community Stakeholder Survey Results

On March 6, 2023, the Hospital published an online survey to solicit feedback from the general public regarding the various requirements of this Plan. As part of that exercise, a posting was added to the Hospital's public website with the survey's link, and approximately fifty (50) individuals with extensive lived experience and an in-depth knowledge of Arizona's psychiatric system of care were contacted via email and asked to participate in this process. Additionally, a link to this survey was added to the signature line to Social Work employees' outgoing emails to solicit input from patient guardians, representatives and/or family members, and a notice of the survey's availability was posted to the Department's various social media accounts.

The following tables include the responses submitted to the survey and, where applicable, a categorical analysis of the information collected. The survey was publicly available from March 6, 2023 through April 28, 2023, and 39 unique responses were received. Some participants opted not to provide feedback for each question presented.[50]

Which of the following *best describes* your role in the state's behavioral health system and/or your interaction with the Arizona State Hospital?		
Response Selection	*Number of Respondents*	*Percent of Respondents*
Independent Oversight Committee (IOC) Member	4	10.26%
Parent, Family Member, Guardian or Representative of a Current or Former ASH Patient/Resident	0	0%
Parent, Family Member, Guardian or Representative of an Individual Treated at a Facility Other Than ASH	1	2.56%
Patient/Resident Advocate (Non-Family Member, Guardian or Representative)	1	2.56%
Former ASH Patient/Resident	0	0%
Health Plan Employee	7	17.95%
Employee of a Private or Public Behavioral Health Services Provider	14	35.9%
Employee of Other State Agency (Non-ADHS/ASH)	4	10.26%
Other:[51]	8	20.51%
Total	**39**	**100%**

[50] All responses are included in their initial format as submitted. The Hospital has ***[Redacted]*** any patient-identifiable information in adherence to applicable privacy and confidentiality standards pursuant to HIPAA.

[51] 'Other' respondent categories include: 'The Arizona Center for Disability Law'; 'ASH Employee'; 'Civilian / Community Member'; 'Security'; 'Physician', and; 'None of the Above'.

Please Identify Your County of Residence		
Response Selection	*Number of Respondents*	*Percent of Respondents*
Apache County	0	0%
Cochise County	1	2.56%
Coconino County	0	0%
Gila County	0	0%
Graham County	0	0%
Greenlee County	0	0%
La Paz County	0	0%
Maricopa County	34	87.18%
Mohave County	0	0%
Navajo County	0	0%
Pima County	4	10.26%
Pinal County	0	0%
Santa Cruz County	0	0%
Yavapai County	0	0%
Yuma County	0	0%
Total	**39**	**100%**

Do you represent, or are you a member of, a Federally Recognized Native Nation in Arizona?		
Response Selection	*Number of Respondents*	*Percent of Respondents*
Yes	0	0%
No	39	100%
Total	**39**	**100%**

Admissions: **In your opinion, what changes are necessary to reduce the number of individuals requiring involuntary admission at the Arizona State Hospital (ASH)? (35 Total Responses)**	
Respondent	*Comment Received*
1	change classification policies. more penalties for the patients.
2	• The community-based healthcare system should have a more collaborative approach to support individuals with dual diagnoses. Integrated care should be used to treat an individual holistically. • The network of community-based behavioral health providers is also inadequate and needs to be expanded with more providers contracted with AHCCCS health plans. • There needs to be a broader network of assertive community treatment providers, supported housing, and supported employment. The caseload for case managers is also too large and results in case managers who are not responsive to their clients. Workforce retention strategies need to be employed to increase the number of qualified case managers. • Law-enforcement and the behavioral health systems need to collaborate more to assist individuals in mental health crises to be diverted away from involuntary commitment. The behavioral crisis system needs to be integrated with law-enforcement, so behavioral health providers arrive at a scene of a potential mental health crisis. Nonviolent crisis intervention also needs to be applied more often to help individuals access voluntary treatment.
3	Education in schools regarding drug use.
4	I'm not certain. I believe ASH may benefit from providing additional PR for the facility to the community, provide transparency in clinical workflows so analysis can be conducted to identify barriers and gaps to care, as well as re-evaluating individuals for involuntary admission. What are/is the current criteria to be met when involuntary admission is required? Is the cost of involuntary admission significantly higher in Arizona/Maricopa County in contrast to other states' hospitals? ASH can benefit from receiving community outreach - and collaborating closely with BH Agencies & RBHA. Does ASH have it's own social media pages? Maybe a monthly letter from ASH Director posted on ASH Website (ASH, not ADHS)? Maybe posting information to the public via social media for Improvement Plans or hospital metrics from Joint Commission? We need to understand and develop a baseline report metric to determine if and how a reduction would be required, whether through workflow modifications, or policy change, or legislative action.
5	Earliest intervention possible to help the individual - will take systemic problem solving.
6	[No Response]
7	Strick (sic) adherence to state policy
8	base on need and urgency
9	Actually, there needs to be an increased bed capacity for admission to ASH, or a 2nd state hospital to be opened. Currently there's a backlog of very symptomatic individuals waiting for ASH beds in level 1 hospitals. I work for a psychiatric hospital as a psychiatric nurse practitioner, and we have patients waiting months to be admitted to ASH.
10	nothing to suggest

11	You tell me
12	Return patient back to DOC if they do not comply with treatment, taken medication, disobedience on the unit ,and not going to therapy.
13	[No Response]
14	[No Response]
15	Unsure
16	Improved patient compliance in the community with combination of increased resources in the community.
17	I'm not sure
18	expansion of current facility and more staff
19	More mental health services for the public
20	[No Response]
21	Increased community services but reducing involuntary admissions may not be an appropriate goal given the lack of current behavioral health services.
22	Better access to mental health clinics, medicine, and practitioners.
23	There needs to be more outpatient services available for treatment and resources. Our state lacks the behavioral health resources needed.
24	Evidence based, clinically driven, experience informed contemporary pharmacotherapy and psychosocial integrated care.
25	Better outpatient services, including medication monitoring and supportive housing
26	Better outreach policies originating in the AZ state Legislature to inform the public of available resources for at risk individuals, and to fund those programs.
27	DDD needs to have behavior health group homes for members who are dual diagnosed that have high level of behaviors.
28	Unknown. Too many people need ASH services because they can't be safely maintained in an outpatient setting or lower level of care. There's people now that I see on my caseload that could benefit but it's too difficult to get IN
29	Better services for mental health patients
30	Triage lockdown secured behavioral health centers multiple beds. Better oversight tracking monitoring of SMI members. Better coordination and less emphasis of memember (sic) rights
31	Better community services during first episode, and stable housing with wrap-around services, though there will always be a need for long-term hospital stays to provide people insight to maintain their recovery. Most community hospitals are very short stays 3-14 days.

32	Have longer term treatment available locally. This was done before in Pima County with the former Extended Care Unit but the payment became an issue since the state pays for anyone at the AzSH but the health plan or RBHA -plan has to pay for anyone at the local level.
33	Better statewide communications about what help is available to people and other professionals to prevent the need for involuntary admission to ASH.
34	1) Having available secured residential treatment program beds for involuntary patients whose symptoms and behaviors can be safely treated in a lower level of care but who frequently leave when placed in settings which have the supports they need 2) Having more availability of specialized behavioral beds at SNFs, for patients with dementia and severe behavioral disturbances or comorbid psychiatric conditions who now have dementia or serious chronic medical conditions requiring a SNF level of care. 3.Having a specialized inpatient setting for adults with intellectual disability, including autism, and behavioral disturbance requiring an inpatient level of care; ideally such a setting would be paired with a step-down residential treatment center. 4) Having DD group homes specifically intended for patients with ID and comorbid psychiatric conditions, at which the typical DD staff have additional training and supports to address the psychiatric symptoms. 5) Having a way to coordinate transfer to a pyschiatric (sic) hospital in Mexico for Mexican nationals who do not have legal residency status in the U.S. or family ties here and require a high level of psychaitric (sic) care. 5) Having specialized hospital and residential treatment units for AHCCCS patients with some of the chronic psychiatric conditions which may require prolonged hospital or residential care, such as: severe BPD, severe anorexia nervosa, severe PTSD. 6) Having RBHAs contract with a "master psychopharmacologist" to provide consultation for highly treatment resistant patients who have failed to improve after over 3 months at a local psychiatric hospital.
35	More wrap around outpatient services.
36	Remove county cap on admissions and facilitate admission for those with the greatest need.
37	Funding for and implementation of secure residential treatment facilities in the community.
38	Increase the number of ASH beds.
39	More community based levels of care

Discharges: **In your opinion, what community-based (non-ASH) resources or services would best assist ASH patients to transition from the State Hospital to a less-restrictive, clinically-appropriate, setting? (34 Total Responses)**	
Respondent	*Comment Received*
1	prisons
2	• Assertive community treatment needs to be expanded to provide services to all former ASH patients. This team approach to behavioral health care will ensure that former ASH patients receive all of the wraparound services they need to successfully reside in the

	community. Assertive community treatment should also identify and provide for all of an individual's needs, including physical health care and social determinants of health; such as housing, education, employment, and social supports. • Although some of these wraparound services may not be covered by Medicaid, State policymakers have the authority to provide the services using State funding. • Patients are often committed to ASH for a longer time than necessary. Reviews of court orders for treatment typically occur only once per year to determine whether commitment should continue or the individual should be discharged. This review should occur more frequently to ensure that patients who are ready for discharge are not unnecessarily remaining committed at ASH. • Many patients are not involved in their treatment planning and are unaware what type of progress the patient needs to make for discharge to be available. ASH should provide more transparency with patients by involving them in treatment planning and informing patients what the expectations are before discharge will be considered.
3	Group homes.
4	It depends on the severity of the patient's condition, their prognosis and what challenges and barriers the patient would face upon discharge. A discharge plan or program cannot be a "one-size-fits-all" approach. How is the patient going to receive value from the inpatient setting to reduce the possibility of future readmission? What plan can be developed to improve patient outcome and what does the vision of success look like in terms of successful community transition?
5	opportunities for skill building, education, opportunity to work at ASH in some capacity - bring in partners to train
6	[No Response]
7	housing assistance, food and a continues counselling (sic) and access to mental health service after discharge from ASH
8	A monitored but less restrictive environment
9	Need for more aggressive monitoring when discharged, maybe even have members directly monitored by ACT teams
10	not sure
11	Medication, therapeutic care, and spiritual care.
12	group home
13	[No Response]
14	[No Response]
15	Unsure
16	Patient's consistent compliance with treatment and improved motivation to improve.
17	Guardians and family
18	Government run facility with same level or discharges (sic) ready patient.

19	Working with the patient more after they are discharged
20	[No Response]
21	Need stable housing with supportive care services
22	Better access to mental health clinics, medicine, and practitioners.
23	More high needs case managers, more providers to treat these individuals. They need more support to be successful in the community.
24	Structured residential treatment options
25	Supportive housing, job placement assistance, day programming
26	Publicly funded agencies able to implement & provide such services.
27	DDD needs behavior health group homes for members who are dual diagnosed. more community behavior health supports for people with mental illness as a step down program to provide supports.
28	Intensive wraparound services where one can ensure meds are taken correctly and there's a level of freedom that's appropriate.
29	healthy housing options with oversight
30	Day treatment programs release step down process to ensure no premature discharge. Police monitoring and requirement SMI agency monitor. Group home, probation home, secure staffed
31	more 24 hr bhrfs, even some secure bhfr
32	Supported housing, residential treatment designed for transitioning patients, Transitional Housing, and post-AzSH teams to bring care to the persons where they are and as part of the transitioning, assess their ability to get to appointments, take the bus or other transportation, assess ability to live on their own, truly...
33	Depending on their background some are tribal,U.S. military groups,ddd options,or religious institutions that they might be affiliated with.
34	See answer to #4 above. Also: 1) Having a better and longer transition time for ASH patients - eg, able to go on pass to proposed placements and having outpatient team much more involved prior to ASH discharge. 2) Having many more community placements with 24 hour staff presence and house model. This type of setting is often more appropriate for patients with very severe symptoms even with optimal treatment and who will end up getting kicked out of a BHRF due to non-participation and then be homeless and then deteriorate. BHRFs discharge a patient if they are gone for 48 hours ,even if it is because they required urgent care treatment.
35	More step down -private in home care. Residential treatment centers.
36	Continued investment in a network of facilities that are able to accommodate patients meeting these requirements. We lack available placements in the community today.
37	Secure residential treatment facilities with realistic treatment expectations.

38	Residential treatment programs that provide more comprehensive behavioral health care including for persons with DD, dementia-neurocognitive DOs, personality disorders, etc.
39	[No Response]

Successful Community Reintegration: **In your opinion, what community-based (non-ASH) resources would ensure a recently-discharged patient does not require readmission to the State Hospital or another inpatient psychiatric facility?**	
Respondent	*Comment Received*
1	leg monitor, and 10 year probation period.
2	• Assertive community treatment is also very important to prevent re-admission because it will provide the kind of wraparound services necessary to prevent a mental health crisis and allow the individual to successfully remain in the committee. • Social determinants of health also need to be continually tracked and addressed as necessary. It is important to ensure that housing, education, employment, social supports are available with stability to assist in an individual's recovery. • There should also be more of a focus on trauma informed care both within the community based behavioral health system and ASH. Upon admission, ASH should assess trauma history and include addressing trauma in its treatment plans. ASH should also continually assess patients for trauma throughout their stay, and address issues of trauma as they arise. Addressing this can avoid future mental health crises and re-admission. • ACDL's monitoring work has revealed that a number of ASH patients also have a history of substance use disorder, however ASH does not have programming or treatment to address substance use issues. Providing this type of treatment would assist patients after discharge by giving them the tools to prevent a relapse of their substance use, leading to a mental health crisis and readmission to ASH. • It is also important that patients be taught some non-medical coping skills that can be utilized in the community, such as meditation, yoga or other mindfulness techniques. •Treatment at ASH is focused primarily on a medical model, but there is growing evidence that medicating a mental illness is not enough. Individuals need to be treated in a more holistic and integrated fashion to address social determinants of health. ASH should assist patients in acquiring some of these non-medical tools.
3	Day cares.
4	I think a variety of agencies are required. At the least, a Discharge Planner to work with a facility (e.g. Quail Run or Palo Verde or Valley Hosp. or Aurora Behavioral, etc.) Involve a case manager and a social worker, and develop a detailed transition plan for the patient along with the support system, though also track and manage progress. Also include additional community resources to ensure patient social needs/support are met - e.g. does the patient have a home? supportive family? Regular case manager and social worker visits/evaluations? Is the patients location safe? What degree of stimuli does the patients environment provide - is it a risk for patient relapse? What educational resources are supplied to the patient? What about ongoing education for the patient to better understand their condition (if possible)? Food/Clothing/possible employment? And where can this documentation be centralized for ongoing community support for patient care? Unfortunately there is a not a sole solution to this question - the solution will contain a variety of solutions and resources.

5	More housing options, more community-based treatment programs, more continuum of care, workforce, education - and in the communities where people live.
6	[No Response]
7	home Health services, and access to mental and food and shelter
8	The monitored but less restrictive environments will engage patient therapeutically and checks for triggers factors
9	Wish I knew the answer, but sadly lots of discharged clients become noncompliant with medications and eventually return to state hospital.
10	unsure
11	Medication compliant, continue therapeutic and spiritual care.
12	a monitor that give them there medication on time.
13	[No Response]
14	[No Response]
15	Ensure the patient has a place to stay, and is monitored. Also, ensure that the patient receives their medication.
16	Compliance in their out-patient psychiatric treatment.
17	Guardians, mentors
18	we need community reintegration facility out of ASH.
19	CRU is a good resource for patients
20	[No Response]
21	Stable housing, easily accessible treatment services, supportive care to allow return to work, school, and community life
22	Try step down units of less restrictions before turning patients out to on their own.
23	Being able to see outpatient psychiatrists and therapists and have a supportive team. Even if they can't be in person, utilizing technology to check in on them once they discharge so they feel supported and if they were declining someone would be able to tell sooner to get them in to see someone. More therapeutic housing options for those that are frequent readouts would help
24	Use of integrated care principles
25	some type of required, comprehensive medication monitoring for the first six months
26	What would be needed is adequately funded & staffed state and/or city agencies able to monitor and offer assistance to those needing help.
27	they need a step down program that will provide supports and education and medication

	taking by professional. maybe a group home type of living to ease the transition back into the community.
28	Such a strange question. Mental illness doesn't go away once they are discharged! So there's a good chance that they could need inpatient psych down the road regardless of what services are in place when they leave. Home health agencies local to the person would be needed to ensure they keep close tabs on the person and keep an eye out for decompensating. It's possible to head off an admission if proper intervention happens but The problem is that many agencies are overwhelmed and underpaid-until this is addressed at the community level, people will always be a danger of readmission. Voc rehab would also be very valuable quite possibly
29	Maintain postive (sic) connections
30	Step down day program intial (sic), planning discharge immediate supervised group home.
31	a good discharge plan and continued wrap-around support, family, support system, and stable housing.
32	Tight medication monitoring and administration. Whenever possible, LAIs should have been started wile (sic) in AzSH and continued in the community. Post-AzSH or Reintegration Teams (I don't know that such a thing exists but maybe it's time to develop them. Similar to ACT teams. Perhaps routine for all discharging persons. Not a voluntary choice as ACT as, however.
33	The court system (restraining orders against someone who was involved in problem),aa,na,or ptsd group help even if court ordered attendance is required are some.
34	First, ASH should recognize that sometimes they discharge a patient prematurely and it would be better if they had a slower transition and used the option of Conditional Release on occasion, for appropriate cases who have a very high symptom burden. Secondly, substance abuse is a major reason for early relapse and having a peer-run support system which engages with patients prior to discharge from ASH and ongoing after discharge, which would help with providing non-substance abusing social contacts (also using evidence-based medications to reduce substance abuse relapse). In addition, many patients who have spent prolonged periods at ASH would do better if discharged to a highly supervised and structured setting (like a group home with 24 hour staff). Also, some patients, particularly those with attachment issues, would benefit from starting with a particular therapist months before discharge from ASH and being able to continue with that therapist after discharge. Also, though difficult to make work operatoinally (sic), some personality disordered patients could benefit from a scheduled monthly 1-2 day admission to ASH.
35	At home delivery of medications. In home visits and check in. Community center activities. Job training. Food - Meals on wheels. Cooking classes
36	structured living environments with frequent assessment and visits to assist with re-integration.
37	Secure residential facilities with realistic treatment expectations e.g. may be long-term
38	See #5 above.

39	[No Response]

Please rank the options below indicating what you believe would add the most long term benefit to Arizona's psychiatric system of care. (1=Most Important; 4=Least Important)

Response Selection (n=39)

Adding Staff to the State Hospital Specializing in Treating Individuals With Needs Beyond that of a Primary Psychiatric Condition (DD/ID, Personality Disorders, Neurocognitive/Dementia, etc…)

Priority 1	*Priority 2*	*Priority 3*	*Priority 4*
38.46%	25.64%	20.51%	15.38%

Building Additional Facilities to Treat Individuals Presently Admitted to ASH, but Better Served in a Specialized Setting (DD/ID, Personality Disorders, Neurocognitive/Dementia, etc…)

Priority 1	***Priority 2***	*Priority 3*	*Priority 4*
20.51%	**33.33%**	17.95%	28.21%

Building a 'Step Down' Facility to Expedite Patient Discharges from the State Hospital's Civil Campus When Clinically-Appropriate

Priority 1	*Priority 2*	***Priority 3***	*Priority 4*
25.64%	26.64%	**35.9%**	12.82%

Increasing Bed Capacity at the State Hospital's Civil Campus Without an Expansion of Services or Diagnoses Treated Beyond Current Capabilities

Priority 1	*Priority 2*	*Priority 3*	***Priority 4***
15.38%	15.38%	25.64%	**43.59%**

Please provide any additional observations or insight not otherwise addressed regarding the Arizona State Hospital and its current role in Arizona's psychiatric system of care.

Respondent	*Comment Received*
1	need to treat patient like wards of the state. concentrate on staff safety, better, more punishments for patient actions. better classification policies.
2	ASH should not increase bed capacity or build additional facilities because both of these strategies would encourage the involuntary commitment of people with disabilities without ensuring that the community based healthcare system receive needed reforms. • Through ACDL's monitoring, we have received consistent feedback that the forensic unit is constantly very loud, making it difficult for patients to sleep. Patients report that sound easily echoes in the forensic unit. ACDL has also observed during our

	monitoring visits that sound echoes easily in the forensic unit and that the forensic unit is loud. Patients feel they are constantly bombarded with loud noise because they can hear radios going off, doors banging, other individuals talking, etc. The difficulty sleeping caused by this loud noise exacerbates patients' mental health issues. ASH has put cardboard on some of the walls in the forensic unit, but patients report this is inadequate to dampen all of the loud noises they are exposed to which lead to deprivation of sleep. ASH should consult with noise reduction experts to reduce the loud noise in the forensic unit to ensure patients can sleep, and that sleep deprivation does not inhibit their progress on their mental health treatment goals. • ASH needs to address its consistent inadequate staffing levels. Patients have reported they are unable to go out to the mall/yard as often because there is not enough staff. From ACDL's research, it seems ASH is constantly hiring or putting on hiring fairs, but still has difficulty fully staffing its positions. ASH likely needs to increase the salaries for current and future staff, and provide more support, benefits, and training for staff to ensure retention in positions. This consistent lack of adequate staffing levels has also caused multiple safety issues for both staff and patients, such as the incident in 2022 when a group of patients barricaded themselves with staff in one of the civil campus units. • A major issue is ASH's use of excessive restraint and seclusion that is in violation of State and/or Federal laws or regulations. ACDL has received reports of patients being placed in long-term seclusion as their residence during their stay at ASH. Patients in this situation are required to make a request every time they want to be let out of the room, regardless of whether an emergency safety situation exists. This policy may be referred to as administrative separation or seclusion, but it is in fact solitary confinement, which is known to exacerbate mental health conditions and cause decompensation in patients, rather than support treatment goals. ACDL has also received reports of patients being placed in continuous wrist and ankle restraints, in violation of their court orders and the requirement that restraints only be used in emergency safety situations. ASH should comply with its own restraint and seclusion policies, which require or restraint or seclusion to be used only for emergency safety situations for no longer than the amount of time the emergency safety situation exists. ASH should also comply fully with court orders for treatment regarding restraint and seclusion. ASH administration should also update their policies regarding enforcement of compliance with restraint and seclusion policies. • Another major issue is the processing of ASH patient grievances. ASH and ADHS are responsible for investigating and deciding patient grievances. This has created a conflict of interest in which patient grievances are very rarely substantiated, inadequately investigated, and grievance investigations are not completed in a timely manner with a timely result being provided to the patient. Investigations need to be handled in a more timely and thorough manner. Additionally, a third-party not connected to ASH and not funded by ADHS should be appointed to review all grievances and grievance investigations, and make the final determination.
3	Skill/talent building: Recognize those patients and utilize them in Rehab to teach their peers interested in what they do.
4	I have many thoughts racing through my mind. Staffing is an invaluable resource. Ongoing educational opportunities for them will be helpful. Also maybe re-evaluate the process as how patients identified as DTS/DTO are segregated or separated, maybe develop additional policies or procedures to ensure staff safety? Promote an open-door policy for employees to report incidents? Incentives to employees who demonstrate quality care based on metrics? I still push community outreach because even today in 2023, Mental Health continues to have a stigma associated - indeed an unfair disadvantage at that. Unfortunately ASH was once referred to as the

	Arizona Territory Insane Asylum, so that doesn't help - BUT we cannot change the past. Collaborating with other leaders in the Mental Health Community is a step in that direction so that ASH can benefit from the Community support it needs - AND deserves so that as a community we can help others get past the stigmatization of Mental Health.
5	The civil and forensic facilities are both older. I recommend a design audit of the physical environments: are there simple/less costly modifications that can be made to maximize access to outdoor patios, mall, natural daylight. As we know there were many restrictions during covid - how can the facilities be more resilient and adaptable to support needs of the patients as well as the staff.
6	[No Response]
7	At ASH, the services are great but the hospital definitely need more staff, and staf (sic) retention incentive so that their current will stay.
8	The fact that Arizona state Hospital is not paying BHT based on the numbers of years of experience is not motivating and will lead to higher labor turnovers when there are other job opportunities that pay for the experience else where. For example BHT2 is for staff with experiences but why will those with less experience for example 1- 3 years be paid the same starting salary with those with more experience for example 5 years and above. What opportunities are available for BHTs with degrees in areas like accounting, business, etc?
9	Please simply add bed capacity, there's a significant lack of beds available for ASH.
10	nothing to add
11	Arizona State Hospital plays a important role in Arizona’s psychiatric system of care.
12	I think Arizona State Hospital is the best in the United State
13	[No Response]
14	For administration to assist staff on units for a few hours once or twice a month to understand the needs of the patients.
15	Changes need to be considered in all areas to enhance positive behavioral /therapeutic interventions.
16	[No Response]
17	There needs to be more impactful consequences to patients that assault other patients or staff...
18	To utilized more core staff rather than registry. More incentive to retain staff.
19	[No Response]
20	[No Response]
21	Needs for people with Fetal Alcohol Syndrome must be met
22	DHS should NOT conduct surveys on the State Hospital. This is a direct CONFLICT

	OF INTEREST!
23	[No Response]
24	[No Response]
25	[No Response]
26	The current politically extreme make-up of the majority of our state Legislature ensures adequate funding of mental health services will be ignored or even reduced. Until the extremists are a minority & unable to impede progress, the majority of AZ, citizens will not have access to effective mental health services.
27	there is a state statute to provide active treatment to DDD members which is not being done. something must be done to stop using mechanical restrains for hours on DDD members.
28	I'd love to see more people get help here-there see so many that have fallen in the cracks but it's so difficult to get someone in therr (sic)
29	[No Response]
30	Public safety should be prioritized and independent non conflict interest evaluations. Rigorous probation oversight monitoring. Requirement to avoid drugs or alcohol supervised community and requirement to have stable housing. No release unless long term stable housing occurs
31	We need to build out the 93 acre campus with step down units or other specialized care units.
32	I think the Hospital needs to see it self as an expert for those individuals who have not benefitted (sic) from local treatment/community treatment, regardless of whether the person has been designated as an individual with SMI. That said, the hospital needs the staff with the expertise, pay them accordingly, should be linked to an academic setting as well, and needs to stop seeing itself as only being able or designated to service "typical SMIs" (actually said to me!). Require ongoing collaboration with the treatment team in the community (not just occasional communication) but requires that community agencies, Integrated Health Homes, FQHCs, or usual site of service provision for the person---are at the table all the time, that they can bill and be paid for the time and service of coordination of care while the person is in the AzSH (would require a change in the suspension of AHCCCS during the stay) and be active participants in the member's treatment team during the AzSH stay. This could be the same Reintegration/Transition Team that works with the individual all the way through the process. I understand that there may be low numbers/agency which makes it challenging, so might want to consider designating an integration specialist at each facility or treatment site and make that person responsible although an ACT-like team makes more sense and can serve member across multiple agencies and locations. I'm not sure how many discharges/month or year there are from the AzSH.
33	One problem ASH has is discharging patients as fast as possible to keep numbers looking good without regard for the patients true need. I had a suicidal neighbor admitted to ASH and released within one week,came back to the same situation and attempted suicide 2 more times within 3 weeks never being in ASH for more than 8 days. Reminds me of a teacher that promotes a student so numbers look good and

	they don't have to deal with them. Some kind of checks and balances system needs to be designed.
34	There are some patients who will need a secured treatment setting for many years, but could be safely treated in a secured residential program rather than a hospital, and would have more freedom in such a setting, as well as the opportunity for more community integratoin (sic). If we had secured residential treatment beds to accommodate these patients, we would make better use of the beds at ASH. That being said, there are also some patients with chronic DTS or DTO behaviors which require a hospital setting, sometimes for years at a time. There is no alternative to ASH for these patients, some of whom have non-psychotic disorders. ASH should work on developing some programming appropriate to the needs of such patients. I feel it is very unlikely that the state will be able to find a different provider for these patients, becuase (sic) no hospital is wanting to get "stuck" with a patient who is chronically violent or self-injurious and requires care over a very prolonged period.
35	[No Response]
36	[No Response]
37	Maricopa County needs many more beds than the current 55 bed limit.
38	There is greater demand for ASH services than there are beds available... and, the state lacks sufficient beds and services for persons with mental health and DD, and for those with mental health and neurocognitive disorders.
39	[No Response]