



# **Accountability Report**

FY 2001-2002

## Section I - Executive Summary

Under new leadership and guided by a tightly focused mission, the DMH in 2001 -2002 delivered quality mental health care services to South Carolinians, in spite of unprecedented losses of financial and human resources. By the end of FY01-02, the Department had lost more than 800 full time employees, more than \$40 million in state and federal funds, had closed clinics and programs, and saw problems building around the state in emergency rooms and jails. Not lost, however, was the Department=s commitment to help people with mental illnesses recover.

### Mission, Priorities, Values

*Recovery* has become the driving force for DMH and is at the heart of the Department=s new mission: To support the recovery of people with mental illnesses. Simply put, *recovery* is a journey that involves consumers and their families, employees of the Department, citizens in South Carolina=s communities, and other state agencies B all working together to help people with mental illnesses regain hope and lead independent, productive lives. A recovery approach to care embraces consumers= and families= social and educational needs, their spiritual and cultural needs; and helps them to find affordable, decent homes and meaningful employment.

The Department=s new mission is the result of a community planning process that began in November 2001, and culminated in a 2002 roadmap called AMaking Recovery Real.@ This document defines the Department=s mission, its priorities, its values. Specifically: our service priorities are to adults, children, and their families affected by serious mental illnesses and significant emotional disorders. We are committed to eliminating stigma and promoting the philosophy of recovery, to achieving our goals in collaboration with all stakeholders, and to assuring the highest quality of culturally competent services possible. Our values are respect for the individual, support for local care, commitment to quality, and dedication to improved public awareness and knowledge.

### Key Goals

In this new fiscal year, we will begin to implement the community plan and the Recovery Model of care. Nine mental health centers and one inpatient facility have been selected to serve as pilot sites to begin the recovery initiative. Other priorities identified in our community planning roadmap include: improving access to services for all consumers; enhancing services for adults and children; improving the Department=s information system so that the leadership has better management tools; improving the Department=s quality improvement processes; strengthening public education and advocacy; determining a better way to fund our centers and hospitals and providing financial incentives to serve more people in the community; and providing cost effective training in those clinical practices that are evidence-based.

Implementing evidence-based, Abest practices@ will help us achieve greater accountability in services delivery and will help us measure our program outcomes against those already known to work. Such Abest practices@ include: supported employment for adults; assertive community treatment (ACT) teams; family support programs; programs for people with both a mental illness and a substance abuse disorder; medication treatment algorithm (standardized prescribing patterns based on the best available science); school-based services; and Multi-Systemic Therapy (MST), which includes in-home services for children with severe behavioral disturbance and involves multiple social agencies.

In addition, we will improve the collaboration between our mental health centers and hospitals, private community hospitals, and other stakeholders to develop more crisis stabilization and crisis diversion programs in the community. The benefits of these programs include an improvement in the pre-screening of patients and avoidance of unnecessary hospitalizations; a reduction in the number of admissions to our own psychiatric hospitals; a reduction in the numbers of patients waiting in local emergency rooms; and support for psychiatric beds in the community.

The Department realizes that one key to achieving its goals will be to continue to build strong alliances with other state agencies. We already have several initiatives underway, including partnerships with the Department of Education to increase the number of mental health counselors in public schools, the Department of Vocational Rehabilitation to build supported employment programs for people with mental illnesses, the Department of Alcohol and Other Drug Abuse Services (DAODAS) to share resources to serve people with a mental illness and substance abuse problems, and the Department of Corrections to make certain that inmates receive the best evaluations when they are admitted, treatment while incarcerated, and after-care plans when they are paroled.

Realizing goals and striving for excellent results are synonymous with the Malcolm Baldrige Program for Excellence, a program the Department has identified in the community plan as one whose tenets will form the basis of all our activities. The leadership of the agency is committed to Baldrige principles, has received training, and is mandating that all employees participate in this program of assessment, self evaluation, and improvement.

#### Challenges

One of the greatest challenges facing the agency is maintaining our ability to deliver safe, quality care in a cost effective manner with the resources that have been provided. This accountability report has already alluded to the impact of budget reductions. Last year the Department served over 98,000 citizens, but many South Carolinians went unserved or had to drive further for services, wait longer, or get in line with 250 other consumers to be treated by one clinician. People were (and are) waiting in jails around the state to receive treatment in DMH facilities. Emergency rooms are backed up with people with a mental illness waiting for a state psychiatric bed to become available. Further, the Department has had to take funds from traditional mental health programs to maintain the underfunded Sexually Violent Predator (SVP) program at a safe level, a program that is growing at 1.5 new admissions per month.

Another challenge the Department faces is adhering to the federal Olmstead ruling, which requires that states serve patients in the least restrictive settings possible. We want to move our consumers from costly inpatient facilities to less restrictive community alternatives. Our model for this is the Department's nationally recognized Toward Local Care (TLC) program, but this, too, will require more resources. Today, there are slightly over 125 consumers in the South Carolina State Hospital. When the program began there were two long-term care psychiatric facilities with the capacity to treat 1,100 consumers.

Re-integrating consumers into the community is part of their recovery journey, but one of the biggest challenges the Department faces is the community's attitude toward mental illness. The prevailing attitude is one of discrimination and stigma. Published in 1999, *Mental Health: A Report of the Surgeon General* identifies stigma as one of the leading barriers that keep people with mental illness from seeking treatment.

### Major Achievements

In the last fiscal year, the Department of Mental Health achieved excellent results, in spite of the fiscal constraints placed upon the agency. First, with fewer staff we were able to treat a significant number of adults and children with mental illnesses in our hospitals and our mental health centers: over 66,000 adults and 32,000 children and adolescents. About 90 percent of our consumers were seen in the community, nearer to their families and friends. The Department is close to the point where it is spending as much on outpatient operations as it is on inpatient (47 percent vs. 53 percent), which mirrors our commitment to growing our community system of care.

Another major accomplishment was the consolidation of our hospitals in the Columbia, SC, area. The Department streamlined the management and administrative operations of four inpatient facilities. This move enabled us to deliver hospital level of care to our consumers and their families in a more efficient manner. We are realizing our objective to close as many wards of the old State Hospital as possible, transferring consumers to more modern facilities or into the community where possible.

We continued our emphasis on serving children and their families. Our data show that in South Carolina there are about 40 thousand children with serious emotional disorders. Last fiscal year the Department served 20,000 of these children. Of that number, about 10 percent were served through our Family Preservation program, an area we hope to expand this year. Furthermore, our school-based counselors successfully served 12,000 children.

There is a commitment in the agency to doing the right things, and doing them well. Evidence-based practices that respond to consumer needs are the basis for key processes. Quality, customer satisfaction, and the Baldrige principles are our standard. In clinical programs, in management decision making, and as stewards of the public trust, the Department has a vision of where it is going and a plan to get there.

In summary, the Department of Mental Health continued to serve the citizens of South Carolina last fiscal year to the best of its ability, through the commitment of its governing boards, the dedication of its employees, and the strength of its alliances with other stakeholders. Certain themes emerged during the year Bchange, accountability, results, prioritization, quality, care B themes that are reflected in this report and ingrained in the Department=s mission to support the recovery of people with mental illnesses.

## **Section II -- Business Overview**

The SC Department of Mental Health (DMH) is a large, complex state agency, serving individuals with mental illnesses. The agency also provides services to persons with alcohol and/or substance abuse problems, sexually violent predators, and persons requiring nursing home care. South Carolina was the second state in the nation to pass legislation (in 1821) establishing and financing a state hospital for citizens with mental illness.

DMH, through legislative mandate, is the governing authority over the state's mental hospitals, community mental health centers, and facilities for nursing care and inpatient alcohol and drug addiction. Its chief executive officer is hired by the Mental Health Commission, a seven-member governing body that is appointed to five-year terms by the governor, with the consent of the state Senate.

Today, the department operates five inpatient facilities in Columbia and two more near Anderson, along with a statewide network of seventeen (17) comprehensive community mental health centers (CMHC=s) serving clients in every county of the State. Unlike mental health centers in many other states, CMHC's are part of the state mental health system, and each community mental health center has its own governing board appointed by the Governor upon the majority recommendation of the county legislative delegation. The local boards set policy for their respective catchment areas. The 17 CMHC's provide services within their respective counties and operate within the policies and guidelines set by DMH. The catchment areas covered by each of the 17 CMHC's range from part of a county to seven counties.

State appropriations comprise approximately 52% of the agency=s budget. About one-third of the state funds are used to match federal Medicaid dollars, generated primarily in the community and state nursing homes (Medicaid for psychiatric inpatient services is only available for children under 21).

The agency served approximately 98,000 clients in FY 02 in hospitals and community programs. DMH experienced a \$40 million budget reduction in state and federal funds during FY 02. As a result, the agency lost approximately 800 permanent personnel during the year.

### **KEY MEASURES OF ORGANIZATIONAL EFFECTIVENESS**

	<b>Measure:</b>
Penetration Rates	Per Capita Served Children with Major Mental Illness Per Capita Served Adults with Major Mental Illness
CMHC Local Capacity	Admission Rates to Inpatient Facilities Inpatient Bed Day Utilization
CMHC Local Capability	Time Between Inpatient Discharge & Receipt of CMH Service 30 Day Readmission Rate
Inpatient	Restraint and Seclusion Use Length of Stay

**KEY MEASURES OF ORGANIZATIONAL EFFICIENCY**

Program Cost	Comparison by Facility Comparison by Program Medicaid Revenue
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**KEY CUSTOMER PERFORMANCE MEASURES**

Customer	Key Requirements	Key Measures	Key Processes
Adults with Serious Mental Illnesses	Satisfaction	Consumer Perception of Care. Consumer-to-Consumer Evaluation.	<b>Best Practice Programs:</b> Crisis Stabilization, Case Management (ACT/PACT), Dually Diagnosed Program, Criminal Justice System Interventions, TLC, and Trauma Initiative.
	Functional Improvement	BASIS 32	
	Symptom Reduction	BASIS 32	
	Employment	No. Employed	
	Housing	No. Supported Housing Units	
	Recovery	Survey	
Children with Severe Emotional Disturbances	Functional Improvement	CAFAS	<b>Best Practice Programs:</b> School-Based Programs, Multi-Systemic Therapy, Wrap Services, Juvenile Justice Diversion, & Trauma Services.
	Symptom Reduction	CAFAS	
	Parental Satisfaction	Survey	

### Base Budget Expenditures and Appropriations

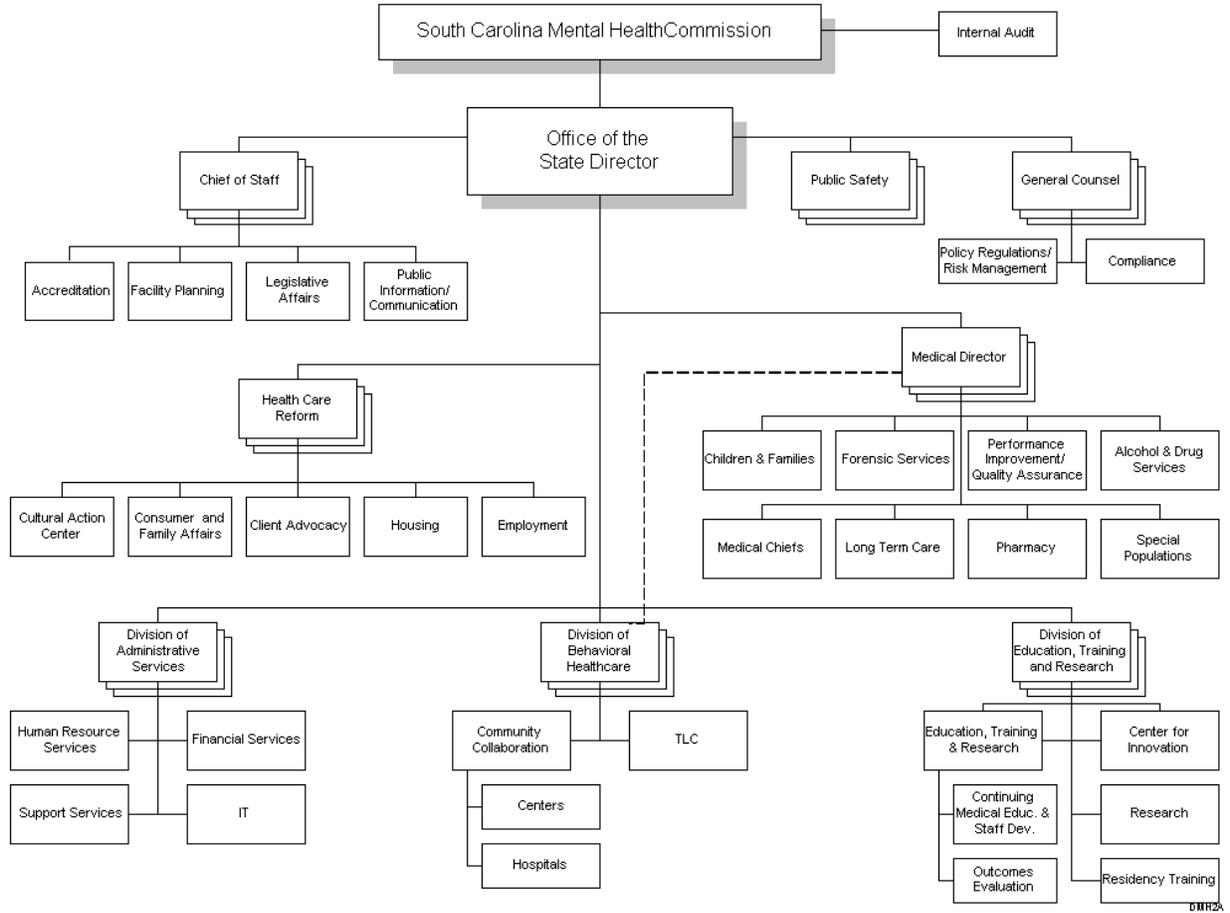
Major Budget Categories	00-01 Actual Expenditures		01-02 Actual Expenditures		02-03 Appropriations	
	Total Funds	General Funds	Total Funds	General Funds	Total Funds	General Funds
Personal	196,883,917	122,759,044	184,770,266	114,414,155	183,073,071	110,019,398
Other Operating	81,505,860	26,314,963	81,349,180	17,521,015	87,233,537	21,925,772
Special Items	12,985,504	3,236,732	1,174,064	200,200	592,192	192,192
Permanent Improvements	18,356,198	3,500,000	15,679,499			
Debt Service	265,768					
Case Services	18,866,322	10,958,863	19,022,235	11,517,712	21,545,742	13,372,395
Distributions to Subdivisions						
Fringe Benefits	55,516,399	34,469,756	54,946,984	34,284,167	51,918,023	13,372,395
Non-recurring						
<b>Total</b>	<b>384,379,96</b>	<b>201,239,358</b>	<b>356,939,228</b>	<b>177,937,249</b>	<b>344,362,565</b>	<b>178,412,977</b>

### Other Expenditures

Sources of Funds	00-01 Actual Expenditures	01-02 Actual Expenditures
Supplemental Bills	3,500,000	
Capital Reserve Funds		
Bonds	4,250,000	

Note: These include \$3.5 million for a new veterans hospital, \$3 million for Columbia Area Mental Health Center and \$1,250,000 for a satellite mental health center in Greer.

## S. C. Department of Mental Health Organizational Chart



## **Section III BB**

### **Category 1 -- Leadership**

*1.1 How do senior leaders set, deploy and communicate: a) Short and long term direction; b) Performance expectations; c) Organizational values; d) Empowerment and innovation; e) Organizational and employee learning; and f) Ethical behavior?*

Leadership of the Department of Mental Health is value-driven with a clear mission: **A**To assist individuals with mental illness in their recovery, to use data in decision making, and to include the customer as a partner for both long term and short term planning. **@** These are the operating principles that were strongly supported by mental health stakeholders who met this past November to draft our new strategic plan.

To fulfill these principles the Department is creating a learning organization that promotes a science-to-practice approach by embracing evidence-based practices to support our mission of recovery. Senior leaders communicate direction, values, and expectations throughout the department in a number of ways: including key stakeholders in our centralized committee structure; publishing the minutes of governance meetings; conducting quarterly all-staff and stakeholder meetings; meeting regularly with CMHC Boards; hosting Kitchen Cabinet Sessions with advocacy groups; publishing newsletters, monthly internal publications, and intranet articles; meetings with newspaper editorial boards and legislators; and holding ETV closed circuit interactive discussions with employees.

The agency=s top management positions have been reorganized to better fit organizational priorities, and a new committee structure has been put into place to provide a channel for information to be communicated up, as well as across, the chain of command. In the coming year the Department will expand recognition of performance improvement teams whose efforts have made major contributions to the department by conducting an annual quality day to celebrate these activities and recognize the employees and stakeholders who made a positive difference in the department.

The bottom line is that the department sets direction by promoting knowledge, setting priorities and core measures, and designing a system that not only does the right thing, but does it well.

*1.2 How do senior leaders establish and promote a focus on customers?*

With the establishment of consumer outcome and satisfaction measures, with consumers as our designated partners and included on all DMH policy and planning committees, with consumers being hired as employees of the department, with consumers serving on all CMHC management teams, and with consumers hired to conduct independent consumer-to-consumer satisfaction evaluations of DMH programs, senior leadership provides a clear message that the customer is the focus of all DMH work.

*1.3 What key performance measures are regularly reviewed by your senior leaders?*

The department has focused considerable time and energy to create a set of dashboard indicators and more in-depth drill-down measures to produce a management-by-fact governance. The key performance measures identified in Section II include Customer Measures, Organizational Effectiveness Measures, and Organizational Efficiency Measures.

*1.4 How do senior leaders use organizational performance review findings and employee feedback to improve their own leadership effectiveness and the effectiveness of management throughout the organization?*

The department is in the early stages of its effort to use performance improvement methodology to produce systems change. While there have been quality improvement teams in operation for years, the department has only recently begun to look for organizational learnings from the team=s findings and create a systems approach to quality improvement as a result of key performance data analysis. The Department is reorganizing the structure of its performance improvement system to better promote the tracking of performance improvements, to encourage the creation of more teams, and to transfer knowledge through the system.

*1.5. How does the organization address the current and potential impact on the public of its products, programs, services, facilities and operations, including associated risks?*

The Department of Mental Health is very sensitive and aware of its responsibilities regarding treatment and care of the citizens we serve. They are a vulnerable population, some seeking help voluntarily and some under court order. There are issues of stigma, public acceptance, legal rights, and moral imperatives. The Department=s commitment to the state of South Carolina is to provide the best possible care and treatment in a safe and therapeutic environment which ensures staff, patient, and public safety.

A SWOT analysis (strengths, weaknesses, opportunities, and threats), part of our recent strategic planning process, reaffirmed the Department=s focus on public safety and the provision of treatment in a safe, therapeutic environment, e.g.,

- S Individuals are rigorously assessed prior to their discharge from inpatient care;
- S Clients found Not Competent to Stand Trial or Not Guilty by Reason of Insanity are treated in secure settings. Their gradual reintegration into the community is closely monitored by trained staff who are very knowledgeable of each client=s treatment needs;
- S Forensic evaluations are provided at the request of local communities within the mandates of state law and the judicial system; and
- S An integrated system of community-based treatment with inpatient support is strived for to ensure the safety and well being of the citizens we serve.

We provide support services including housing, employment, wrap-around services and case management to consumers, depending on individual needs, to ensure the quality of their community life and to engender public support for our work. DMH collaborates with other state agencies, including Department of Alcohol and Other Drug Abuse Services, Department of Juvenile Justice, Vocational Rehabilitation, Department of Education, and Department of Social Services, to provide a full range of services to the consumers we serve.

Mental Health Center Boards, made up of local citizens, provide feedback to the mental health center and DMH management on issues or concerns in their communities. They assess local and centralized programs and the impact these programs have on the public. Advocacy groups, represented by consumers, families of consumers, professionals and other interested people also provide feedback to DMH management. DMH has developed a working relationship with the Hospital Association and the Medical Association. We hold periodic meetings with probate judges across the state to address issues and concerns. The State Director has met with members of the legislature, news media, editorial boards of newspapers across the state, and community leaders in an effort to provide information about the Department of Mental Health and the people we serve.

In 1994 the Governor=s Office required all cabinet agencies providing health care in out-patient settings to become accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF). DMH felt strongly that our system of care should be independently accredited by the same organization. CARF accreditation ensures the public that an independent review of clinical work,

finances, public input, and, most importantly, the respect and dignity of the people is done against national standards.

There is a commitment to the Baldrige concept of continuous improvement by monitoring, measuring, setting baseline outcomes, and taking what we learn and improving services. Our goal is to reduce stigma and raise the quality of life for all people in South Carolina by enhancing the lives of the mentally ill.

#### *1.6 How does senior leadership set and communicate key organizational priorities for improvement?*

Organizational priorities for improvement are identified through the strategic planning process and by senior management review of performance measures and are communicated through the avenues identified in Category 1.1. The system for overseeing the agency's performance improvement process is currently being revised to improve organizational learning and more effectively assist senior management in acting on its review of key performance measures.

#### *1.7 How does senior leadership and the agency actively support and strengthen the community? Include how you identify and determine areas of emphasis.*

The Department of Mental Health is a community-based public mental health system and, as such, its primary role is to serve persons who suffer from mental illnesses. Where possible, however, the Department extends itself to be a system of support for the non-mentally ill. Responding to community requests and local CMHC Boards, the Department provides education, counseling, and public information for persons dealing with life stressors, those in temporary crisis, and those whose life has been affected by a loved one with mental illness. The Department is also a prime force in assisting the citizens of our state to understand those with a mental illness and reducing the stigma that is too often associated with the mental illness recovery journey.

As specified in Category 5.6, the Department has developed a *Teen Matters* website which provides fact-based information to teenagers on mental health issues, and it has an Education Specialist in every Community Mental Health Center to speak to community organizations on issues of interest. Our employee participation in the annual United Way campaign resulted in a \$112,408 donation, and the Good Health Appeal produced \$25,981 in contributions.

## **Category 2 -- Strategic Planning**

#### *2.1 What is your Strategic Planning process?*

The new director has brought a vision of consumer empowerment and consumer involvement to the agency. Central to this vision are a Recovery philosophy, *Best practice* models as cornerstones of service delivery, and the Baldrige criteria as management's tool to produce a fact-driven agency. To move this vision forward, the agency undertook a state-wide, stakeholder driven, strategic planning initiative in November, 2001 that would chart system change for the next three years.

More than 600 stakeholders took part in this statewide planning process. Input was collected, aggregated, analyzed, and prioritized around specific targeted activities, including consumer need, human resource, financial, data management, and support strategies. The process was designed to be interactive and included feedback and action loops to keep the planning relevant to a changing environment.

Within the context of evidence-based practices, five programmatic services were identified as priorities for children, adolescents, and their families. These include: School-Based; Multi-Systemic

Therapy; Wrap Services; Juvenile Justice Diversion; and Trauma Services. For adult consumers, nine priorities were identified: Employment; Housing; Crisis Services; ACT/PACT Services; Dual Disorder Programs; Criminal Justice System Interventions; TLC; Trauma Services; and Recovery. Administrative supports priorities include: Improved Data Systems; Public Education and Advocacy; Improved Outcomes for the Inpatient System; Training and Support for Best Practices; Cultural Competence; and Budget Reallocation to Strengthen a Community-Based System of Care.

These priorities are the basis for our Community Development Plan, known as AMaking Recovery Real. Strategic planning in the Department is not a static event, however; it is an on-going process that responds to a changing environment. Plan refinement and goal setting is also a function of our Commission, Governing Council, Transition Council, State Planning Council, major committees, and other representative bodies who give form and substance to the agency=s goals. These groups address the details of agency planning, such as:

- S financial, per capita funding formula overhaul to ensure equity of service and allocation across Centers;
- S budget reduction strategies to deal with diminished appropriations;
- S monitoring of the strategic plan;
- S right-sizing and consolidation of facilities and transferring of funds to community programming; and
- S human resources development, succession planning, recruitment and training.

## *2.2 How do you develop and track action plans that address your key strategic objectives?*

The Department=s Governing Council members assumed individual responsibility for statewide implementation, oversight, and deployment of specific objectives. To guide their process a work-plan using an adaptation of the Plan/Do/Check/Act (PDCA) model was developed. Governing Council and the DMH Commission receive quarterly reports on progress.

While there is justifiable concern that the agency=s budget cuts will endanger these initiatives and some objectives will clearly depend on external funding, Governing Council has committed itself to implementing the plan. In support of these objectives Governing Council tentatively set aside six million dollars of its funding allocation as follows.

- \$500 thousand - Employee education and training
- \$500 thousand - Community diversion programs
- \$1.5 million - Crisis Stabilization programs in the community
- \$500 thousand - Evidence-based, new best practices
- \$1.0 million - Dictation/transcription systems replacement
- \$2.0 million - Computer hardware/software upgrades

## *2.3 How do you communicate and deploy your strategic objectives, action plans and performance measures?*

To deploy the objectives at the local level, each Division, Community Mental Health Center and inpatient facility submitted their own PDCA to Governing Council, specifying how they would contribute to the agency goals. Quarterly reports from each organizational components are reviewed by Governing Council and the DMH Commission.

To communicate the AMaking Recovery Real plan to staff and stakeholders, the agency undertook a broad-based educational effort. Articles in the agency newsletter AImages,@ discussions at Center/facility Directors= meetings, presentations at All-Hands Staff Meetings and Quarterly Stakeholder Meetings, internet and intranet web postings, and ETV closed-circuit broadcasts to

employees are a few of the avenues that DMH leadership used to meet the Director's mandate that All employees and stakeholders should be aware of where we are going, and how we are going to get there.

For continuity in planning, the agency has been diligent in ensuring that there is an integration and coordination of all planning documents, e.g., the strategic plan, the annual State Plan, the budget request. Having continuity between planning documents is critical to an organization Asinging from the same hymnal. Staff and management are able to focus their work on the priorities of the agency as identified by the stakeholders. Performance measures are tied to outcomes, which are based on program priorities, which are defined by stakeholder feedback, which define budget allocation and program development.

### **Category 3 -- Customer Focus**

#### *3.1 Identify key customers and stakeholders.*

Historically, the Department of Mental Health has viewed a vast array of individuals and groups as its customers: severely mentally ill adults and children, their families, individuals with alcohol and other drug addictions, nursing home residents, other less-ill individuals seeking services, state agencies, legislative, executive and judicial branches of government, public health systems, suppliers and vendors, federal regulators and accreditation bodies, SAMHSA and other funding sources, advocacy organizations, the media, taxpayers, and the communities in which we operate. This view of being all things to all people has not been productive, diffusing our focus, spreading our limited resources too thin, and creating a plethora of priorities.

With concerted effort and great debate, the Department's mission statement now clearly defines our key customer groups: adults, children, and their families affected by serious mental illnesses and significant emotional disorders. It is toward these individuals that the department is focusing its resources, developing service programs, and weighing its effectiveness. Leadership has determined that stakeholders are the organizations, individuals, and agencies that impact our key customers. The groups listed above fit the definition of stakeholders rather than customers.

#### *3.2 How do you determine who your customers are and what are their key requirements?*

Customers are determined by diagnostic categories and functioning levels. The key customer requirements for adult severely mentally ill persons are defined by them and are consistent with what is reported in the literature: regaining a sense of self worth and dignity; having a hopeful outlook on life; actively pursuing goals and aspirations in the areas of affordable housing, education, employment and social supports; and/or living a quality life. These requirements are operationalized in Section II of this report as: symptom reduction and functional improvement (Fig. 7.2.7); meaningful employment (Fig. 7.2.8); housing which is safe, affordable, and decent (Fig. 7.2.10); and satisfaction (Figs. 7.1.1-8). Although recovery can begin or continue in inpatient care, the context of recovery is community based and the Department is committed to a community-based system of care.

Recovery for children means increasing self-esteem and dignity, school performance, remaining in the community and reducing out-of-home placements, and working with the families to resolve issues and preserve the integrity of the family unit. These requirements are operationalized in Section II of this report as: symptom reduction and functional improvement (Figs. 7.2.17-20); and parental satisfaction. To promote recovery in the child population requires working closely with the family and system collaborations with other agencies that are involved with the child and family.

### *3.3 How do you keep your listening and learning methods current with changing customers/business needs?*

To promote recovery for people with mental illnesses it is essential to have customers - people with mental illnesses and their families - involved in the planning, evaluating, and delivery of care.

Toward this end, each CMHC has a Consumer Affairs Coordinator, a self-identified mental health consumer, who participates in management meetings and decision-making. Each CMH and inpatient facility also has an advisory board composed of consumers of mental health services.

Similarly, all major planning committees of the Department have consumers, family members, and advocacy organizations as representatives. As a standard practice in the Department, advocacy organizations review key plans, policies, and procedures prior to their completion. Once a month, the State Director holds a kitchen cabinet meeting with the primary advocacy groups to discuss improving our system of care, and advocacy groups are among those who attend monthly Assembly meetings and Commission meetings.

The Department has established a presence on the Internet and receives questions, concerns, and comments about the Department=s services. The webmaster brings each of these to the attention of the Director of Behavioral Health Services, as well as the state Director. ETV interactive broadcasts are used by the Director as a means of communicating policy and direction and receiving feedback from consumers, advocacy groups and employees statewide.

### *3.4 How do you use the information from customers/stakeholders to improve services or programs?*

The Department collects data on a number of key indicators that reflect the customer perspective. It participates in the mental Health Statistical Improvement Project (MHSIP) 16 State Data Collection Project to develop benchmark customer perceptions of access to services, appropriateness of services, outcomes, treatment planning involvement, and health care needs (Figs. 7.1.7-8). This data, reviewed annually by the Department=s Governing Council and CMHC Directors and Board members, is used to plan service system improvements.

The Department has initiated Consumer-to-Consumer Evaluation Teams (CCET) to evaluate and spur improvement in our system. These teams, composed of primary consumers, interview other consumers on their perception of care, level of satisfaction, and ways to improve services. A written report is sent to the facility/center director, and directors have 90 days to develop a plan of correction to improve areas that have been identified by consumers as being deficient.

### *3.5 How do you measure customer/stakeholder satisfaction?*

Each CMHC conducts an annual consumer satisfaction survey which contains two standardized questions. The data is analyzed on a statewide level and submitted to the State Director and Commission members (Figs. 7.1.1-2).

The CCET has begun using all MHSIP questions to measure consumer satisfaction. These outcomes will be collected from the centers and benchmarked nationally. A family survey has been developed to measure family satisfaction. All centers and facilities will have family members complete the survey process and report the results to the State Director and the Commission.

### *3.6 How do you build positive relationships with customers and stakeholders? Indicate any key distinctions between different customer groups.*

Advocacy organizations, involving families with mentally ill members, consumer groups, and protection and advocacy groups, are involved in the planning of services. Members from these groups are represented in the Clinical Care/Coordination Committee, which advises and approves

clinical polices and programs. These same groups meet with the State Director once a month to discuss issues and resolutions on improving the department=s performance. The Department is committed to a customer and stakeholder driven strategic planning process. Customers are involved with committees and contact Department leaders to discuss issues. The Department actively encourages employees to participate in advocacy groups and stakeholder organizations at the state and local level.

The culture of the Department is one of AInclusion.@ Advocates, consumers, family members, and all stakeholders are actively encouraged to take their place at the DMH table. A phrase used by Consumer Affairs Coordinators is indicative of the inclusive philosophy: ANothing about us, without us.@

## **Category 4 -- Information and Analysis**

### *4.1 How do you decide which operations, processes and systems to measure?*

At the Department level, decisions about which operations and/or processes to measure are made by the Governing Council and affirmed by the SC Mental Health Commission. At the Division, Center and Facility level, decisions are made by the manager. Candidate indicators are proposed because of their impact on the system and the relative ease of collection. Key processes and key measures in the public mental health system, however, are an evolving science, and there is never an assumption that the measures used to assess a process are sacrosanct. Two criteria have governed our decision to select the process or operation for measurement: high resource use (cost) and/or clinical impact (high levels of restrictiveness or risk). Consumer requirements provide the underpinnings for these criteria.

Clearly, the Department chooses to measure program performance in areas identified as priorities in the Community Development Plan Figs. 7.1.1-8, 7.2.2,8-12,17-20). These are the services and programs most important to the stakeholders. The four elements of efficiency, effectiveness, consumer perception of care, and clinical outcomes (identified in Section II) are beginning to provide management with highly relevant information about system functioning, and we are just reaching the point of being able to turn data into useful information to drive the system. Initiatives such as the Recovery Model, Trauma Intervention, and Treatment for the Dually Diagnosed Client emerged in the recent strategic planning effort and are currently being put into place.

### *4.2 How do you ensure data quality, reliability, completeness and availability for decision making?*

A new client information system was implemented in the Fall, 2001 and is the backbone of all client information for the agency. Individual data sets provide historical and current consumer information, allow managers to monitor program performance, and provide administrators with decision-making tools to manage by fact. Data and reports are requested on a regular basis by Governing Council and used in priority setting and decision-making. Centralized data is compiled on a weekly, monthly, quarterly, and yearly basis and is disseminated on the Department=s Intranet website and through various publications. The objective is to provide the right information to the right people to improve consumer care and organizational performance.

To ensure that data is accurate and reliable, computer programs assess the completeness of data elements and an audit process is in place which checks the integrity and accuracy of specific hospital data submitted for accreditation purposes on a monthly basis.

A new financial management system contract was awarded in October, 2001 to replace the current system that has been in use for over 25 years. Scheduled to go live November 1, 2002, the new system will provide real time data and eliminate duplication of work processes by allowing the end-

user to input procurement and financial documents directly.

DMH continued to work towards compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) during FY 02. A contract programmer was hired in March 2002 to assist in modifying the outpatient billing system to comply with HIPAA requirements. Coding is scheduled for completion by January, 2003, and testing will begin shortly thereafter.

#### *4.3 How do you use data/information analysis to provide effective support for decision making?*

The department's management information system includes an integrated database consisting of data for all consumers served by its hospitals and mental health centers. In its effort to develop benchmarks, the department has adopted national data standards and collects a range of data including organizational, client/patient, event, human resource, financial, and performance.

The Department is shifting from measurements of traditional programs (Day Treatment, Club House, Continuing Treatment and Support, etc.) to measures of the best practice programs, as delineated in the Community Plan. Best practice programming is research driven and, as such, has tested key performance measures. The results in Section 7 reflect our transition between best practice programming and traditional programming, as both are evident.

The outcomes built into the Community Development Plan should enable us to improve benchmarking, an area in which we are severely lacking. While many of the measures may remain the same (e.g., CAFAS, Consumer Satisfaction), measures for others are new and currently under construction (MST, Trauma, etc.).

#### *4.4 How do you select and use comparative data and information?*

Some specific data-sets are mandated by accrediting bodies, like the ORYX measures required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which compare SCDMH with other inpatient facilities in South Carolina and nationally (Figs. 7.2.23-25). We also participate in a sixteen-state study, attempting to set standards for the community system of care, and collect several data-sets, e.g., readmission rates (Fig. 7.2.12-13), per capita hospital utilization (Fig 7.2.1), hospital discharges seen in CMHCs within seven days (Figs. 7.2.14-16). The goal is to develop core measures of mental health performance that will be used by all states. It has been difficult to find utility in these measures, however, since each state has different definitions for populations served and state vs. private facility inclusion (Figs. 7.2.5-6). We continue our participation because the development of national norms and benchmarks is a priority for DMH leadership, and working through multi-state cooperatives appears to be our most productive avenue for developing these data-sets.

### **Category 5 -- Human Resources**

#### *5.1 How do you and your managers/supervisors encourage and motivate employees (formally and/or informally) to develop and utilize their full potential?*

The Department's use of flex-time, especially in our Community Mental Health Centers, has been welcomed by employees and has allowed CMHCs to expand the hours of operation which has improved customer service by providing appointments outside of normal working hours. The Department also has a tuition reimbursement program which allows employees to be reimbursed for classes that are helpful to his/her current job performance or to prepare the employee for other positions within the Department.

Other innovative means that employees report as motivating or encouraging include: Job Sharing to

accommodate employee needs while still accomplishing the mission of the office; Cultural Action Center training of staff to assist them in providing culturally sensitive services to our clients; staff meetings with the State Director to keep employees informed about what is happening in the department and to answer questions that the staff may have; and development of best practice models which allow employees to work in state of the art programs.

In addition to the standard state agency Outstanding Employee Award Program, the Department had 29 other organized recognition events during FY 02, with a total of 881 individuals receiving special recognition.

*5.2 How do you identify and address key developmental and training needs, including job skills training, performance excellence training, diversity training, management/ leadership development, new employee orientation and safety training?*

A formal training needs assessment of all staff was conducted in April 2002 to ensure that clinical and support staff receive training and learning experiences which support the goals, objectives and performance expectations of SCDMH. The assessment was designed using input from: Management Team interviews; focus group interviews; review of active clinical performance data; written surveys/questionnaires; and the strategic plan priorities.

For FY 02, 704 hours of instruction were offered and 5,031 employees attended. Of the 704 training hours offered, there were 76 hours of Continuing Medical Education (CME), 38 hours of Nursing Continuing Education (NCEU) and 41 hours of non-discipline specific Continuing Education (CEU). A reduction in training from FY01 to FY02 was directly related to staff being unable to attend classes due to budget cuts and staff shortages (Figs. 7.3.1-2).

100% of new employees received a general and a job specific orientation upon hire. This included all elements of safety training, patient rights, compliance, documentation, accreditation standards, and documentation. Each employee receives updates annually, specific to their facility/center.

This year the Department implemented its Computerized Learning Modules (CLMs), designed to improve employee training and save taxpayer dollars. The CLMs bring training to the employees workstation, enhance knowledge, reduce travel time and costs, provide consistency of instruction, and provide a more responsive training development and deployment system. Staff report CLMs to be user friendly, offer useful information, and require less time away from work. Of the nine CLMs already developed, seven address mandatory training items as identified by the Governing Council, and it is estimated that the CLMs will reduce training time from 8 hours to less than 4. The estimated cost savings is \$319,000. All CLMs have been developed in-house, thereby realizing an additional cost savings.

*5.3 How does your employee performance management system, including feedback to and from employees, support high performance?*

All of the Department's inpatient facilities and community mental health centers are accredited by various national accreditation organizations. Surveyors review the performance evaluations of employees to ensure that the evaluations measure the actual work of the employee. The evaluation system provides an opportunity for each employee and his/her supervisor to meet at least twice a year to discuss job performance. During these meetings, employees are encouraged to share information with their supervisor and clarify job expectations.

*5.4 What formal and/ or informal assessment methods and measures do you use to determine employee well being,*

*satisfaction, and motivation?*

The Division of Education, Training and Research provides consultation and assistance to managers in regard to employee satisfaction and well being. In the past year ETR has developed two separate satisfaction instruments for CMHCs. Employees were made aware of the survey results, management is currently implementing changes, and specialized training was designed and delivered to address employee needs.

Employee satisfaction surveys were conducted in four (4) of our community mental health centers. The results of the surveys were summarized and provided to DMH management as well as the individual center boards.

The Department's Communication Office maintains a Hotline which allows employees to ask questions about policies and procedures or rumors. This Hotline allows the department to get accurate information to its employees. During the consolidation of four inpatient facilities a web site was created to answer questions from concerned employees.

The Employee Separation Program analyzes employee turnover. This information is used in conjunction with our Exit Interview Program to better understand why employees leave the department and to develop strategies for retaining these employees in the future.

*5.5 How do you maintain a safe and healthy work environment?*

In addition to our own inspections, the department takes full advantage of the health and safety inspections provided by the numerous accrediting bodies who survey each of our community mental health centers and our inpatient facilities. Examples of our own initiatives in this area include: safety training for departmental staff; a Fire and Safety Officer conducts safety inspections of all Department facilities; annual employee health screenings; annual Employee Health Clinic free flu shots; annual wellness related activities; a pilot program to treat injured employees with the goal of providing them with immediate quality care and returning the employee to work as quickly as possible; inspections by quality assurance teams, internal audit, and public safety; and ongoing monitoring of community residential care facilities that provide residences for consumers in local communities.

*5.6 What is the extent of your involvement in the community?*

In May 2000, DMH launched an Anti-Stigma Campaign to raise public awareness about mental illness and reduce the stigma associated with the disease. During the past year:

- \$ Radio public service announcements were sent to 18 stations statewide;
- \$ Included in the department's by-monthly newsletter is a Recovery Spotlight section that features a consumer who tells his/her recovery story;
- \$ The Art of Recovery project, showcasing the artistic skills of people who receive care from DMH, has featured over 200 works from more than 200 artists;
- \$ A Palmetto Media Watch Program was organized which gives feedback to the media on coverage of mental health issues and how people with mental illnesses are portrayed. Currently, there are 40 members involved in the program;
- \$ A Teen Matters website for teenagers was initiated which focuses on mental health issues. To date, more than 15,000 hits have been received;
- \$ A Million Mile Walk, initiated last year, was sponsored. 2,000 people walked 1,000,000 miles to show their support of people who have a mental illness;

- § Presentations were made to 13 classes (about 300 students) by representatives from SCDMH, consumers, and family members to educate senior Journalism students about mental illnesses;
- § DMH=s Speaker=s Bureau made over 100 presentations to civic and community groups this past year on topics of interest to the organizations; and
- § DMH staff made 469 presentations to schools, 78 presentations to civic groups, 92 presentations to churches, 312 media contacts and 200 other public information contacts in the community. Each community mental health center has a staff member who serves as the consultation, education and prevention coordinator.

### **Category 6 -- Process Management**

*6.1 What are your key design and delivery processes for products/ services, and how do you incorporate new technology, changing customer and mission-related requirements, into these design and delivery processes and systems?*

Four driving forces dictate program development: consumer needs identified by stakeholders, within the confines of the agency=s mission; economic realities; performance improvement findings; and science-to-practice technology.

The actual design and delivery of services is based upon ABest Practice@ or APromising Practice@ technology. Quite literally, the department constructs program and service delivery systems based upon the reported results from research studies in the mental health field, making the agency=s design process a AScience-to-Practice@ methodology. These Best Practice programs are the priorities identified in our strategic plan and the agency=s budget request.

By basing our design and delivery processes on research findings, the department ensures that limited dollars directed into high priority areas will produce the highest return on investment and produce the best outcomes for the persons we serve. By including stakeholders in the annual goal setting process by including stakeholders in all Departmental policy and program activities, and by continually monitoring customer satisfaction and program outcomes, we are able to stay responsive to changing customer requirements

*6.2 How does your day-to-day operation of key production/ delivery processes ensure meeting key performance requirements?*

The overall quality system operates under the Performance Improvement Committee, one of the three major committees of the Department through which information and action flows up and down the organizational structure. The PIC is designed to receive action items from Governing Council, initiate quality improvement teams, report findings back to Governing Council, and ensure that learnings from one part of the system are transferred to other parts of the system.

All of our service processes are defined, measured and managed through our Quality Assurance/Performance Improvement and Outcome Measurement Program. Our QAPIOM program, underpinned by the accreditation standards of JCAHO and CARF, constantly monitors our service delivery processes to ensure we provide the highest quality of services. The elements of accreditation standards are made operational through policy documents, the Continuity of Care Standards Manual, Case Record Reviews, QAPIOM local and state office level audits, Corporate Compliance audits, risk management system, and utilization review (Figs. 7.5.1-2). Our standards are frequently higher than those set by accrediting bodies, and never lower. All facilities of the Department, community and inpatient, are fully accredited by these reviewing bodies.

Even our external vendor contracts for clinical services are subject to our strict QAPIOM quality of

care standards, including customer input and active participation requirements at each step of the therapeutic service process. Compliance with our QAPIOM standards is required on all employee performance reviews.

While this is the formal system to ensure that processes meet our key requirements, the heart of the system is the relationship between the clinical staff and the consumer. There is an active partnership between the treating team of professionals and the persons we serve. From the assessment which identifies the needs, requirements, and personal preferences and desires of the customer, to the explanation of consumer rights and recourses, to the creation of a Service Plan which identifies goals, objectives, strategies, and time frames for treatment, the process is a customer-driven contract between the department and the consumer.

*6.3 What are your key support processes, and how do you improve and update these processes to achieve better performance?*

In FY 02, the Department began implementation of a three year IT improvement plan focusing on emerging technology, needs of clinicians and management, and integrated system components. In an effort to update its information technology, DMH implemented a comprehensive, client information system during FY 02 that provides admission, discharge, and transfer data, as well as inpatient billing (See 4.2). This provides a seamless system and enhances continuity of care. Additionally, efforts moved forward in FY 02 to implement a new financial management system, replacing a system based on early 1970=s technology.

The Department has developed a computer-assisted learning program that is designed to improve employee training and save taxpayer dollars (see 5.2). During FY 02, a Funding Reallocation Committee was established to develop an equitable formula for the distribution of funds to the agency=s seventeen community mental health centers.

*6.4 How do you manage and support your key supplier/contractor/partner interactions and processes to improve performance?*

All contracts are coordinated by the Contracts Office. Key performance requirements involve timely review and approval of contracts, conformity with state law and DMH policies, and compliance with contract terms. The DMH Contracts Office maintains a contract database (DCON) available to mainframe users providing information on all professional service contracts. Approximately 1,250 contracts and memorandum of agreements are tracked and monitored to ensure that all provisions of the agreements are met.

DMH successfully renegotiated its food service management contract in FY 02 with Morrison=s to lower the fees paid to the vendor while at the same time sharing in increased revenue from the sale of food to other entities using DMH facilities (Figs. 7.4.1-2). In the Fall, 2001, DMH entered into a contractual agreement with Just Care, Inc. to transfer 178 DMH forensic patients to a facility operated by this private entity. The result was that the agency was able to vacate two buildings on the state hospital campus that were deemed unrepairable.

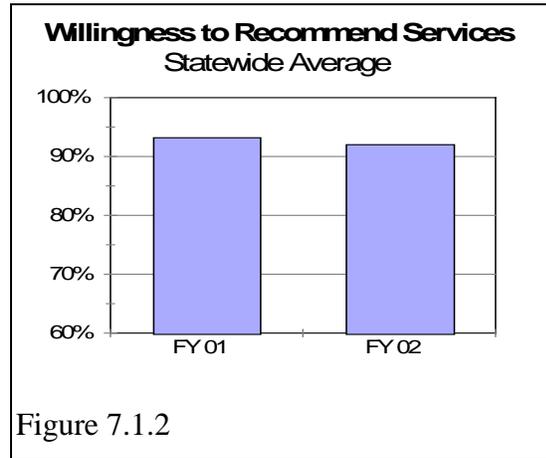
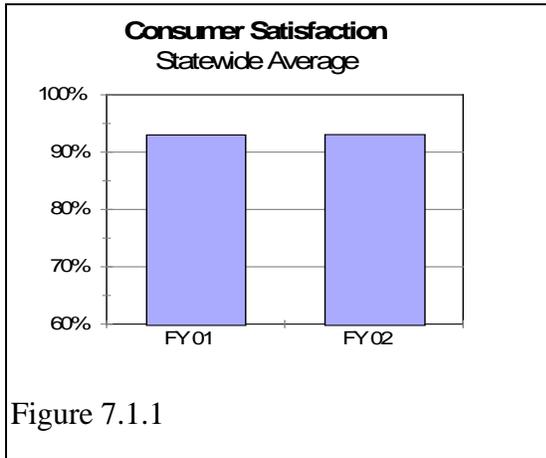
## Category 7 -- Results

### 7.1 What are your performance levels and trends for the key measures of customer satisfaction?

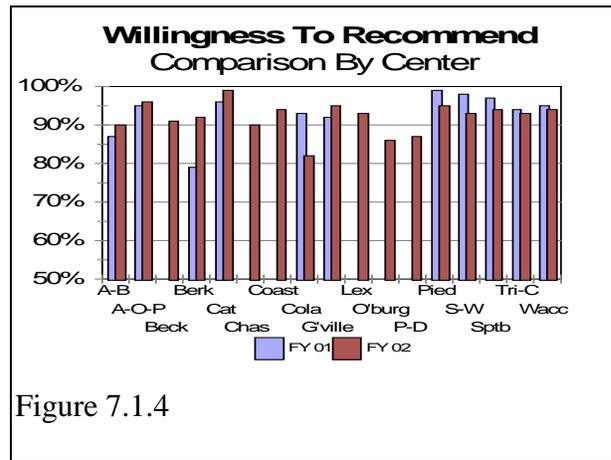
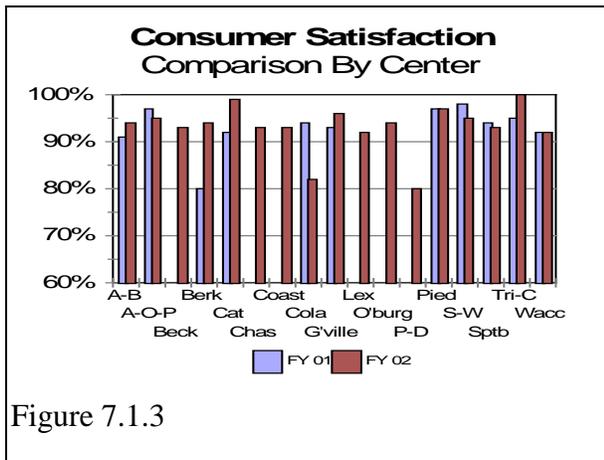
CMHCs develop and conduct annual surveys to assess the level of consumer satisfaction. All centers are required to include two standard questions in their surveys: AOverall, are you satisfied with services received at your mental health center?@ and AWould you recommend this place to a friend of yours with a similar problem?@

Figures 7.1.1 and 7.1.2 show the consumer responses to these two questions as statewide averages for the past two years.

#### CMHC Satisfaction Data



Satisfaction measures, compared across CMHCs, show variation between centers and variation over years. In general, the larger the sample size used by the center, the more stable the rating appears to be.



Consumers in the TLC program evaluate a wide range of services. Since these are persons who have been long-term residents of inpatient facilities, it is critical that their community living arrangements be appropriate and that they receive intensive case management services.

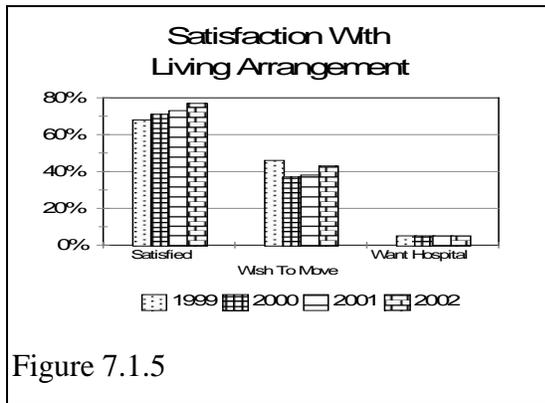


Figure 7.1.5

The majority of TLC clients report that the living situation is what and where they want to live. Under half report that they would like to live somewhere else and a consistent percentage want to return to the hospital setting.

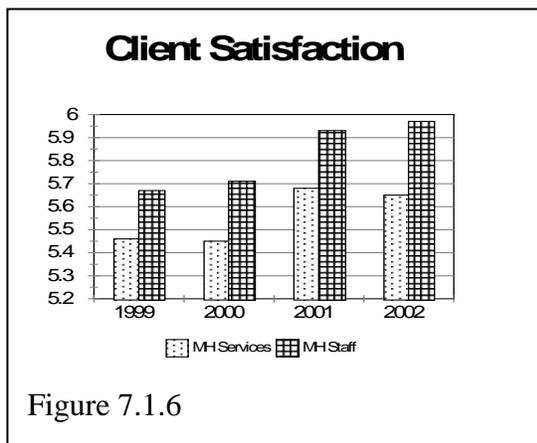


Figure 7.1.6

TLC clients were asked how they feel about mental health services and mental health staff. On a range from 1-7 with 1 being Terrible to 7 being Delighted, TLC clients report that they are Mostly satisfied and Pleased with mental health services and with the staff providing those services.

**Access, Quality Appropriateness, and Outcome:** For several years, the department has collected data on the consumer's perception of the care received. This has emerged as a critical measure at the national level and within South Carolina. The data sets are still emerging as the utility of each is established.

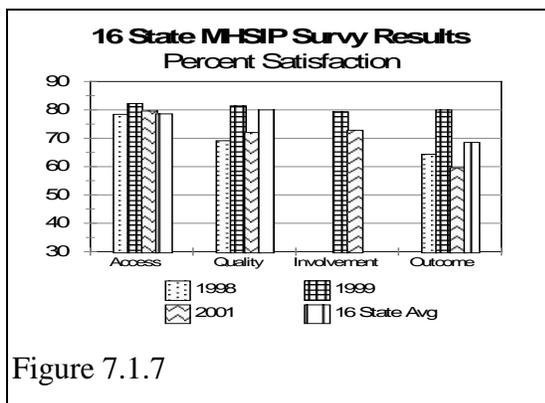


Figure 7.1.7

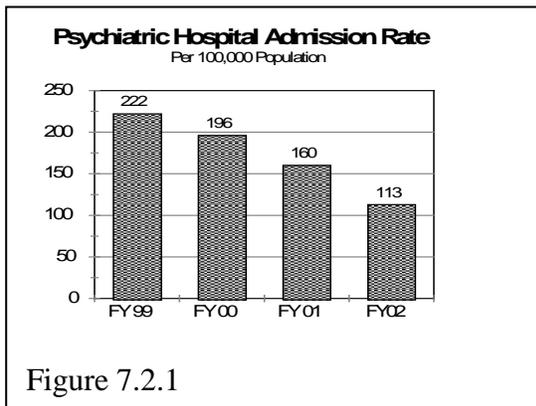
**MISHIP Satisfaction Data:** Access to Services, Outcome, and Perception of Quality have been reported since 1998 by the sixteen participating states. Other measures, like Treatment Involvement and Level of Satisfaction, have not been consistently used measures. The results are presented as the percent of respondents that agree or strongly agree to the items in each of the domains.

**Rural Behavioral Health Services:** The MHSIP 16 State Survey Results are useful to SCDMH as it evaluates its programs for meeting best practice standards. Figure 7.1.8 indicates that the results achieved by the RBHS Program are equal to, to better than, the optimal levels achieved by other programs in other states.

	Range of Scores Reported by Other States*	RBHS Results
Access	68.2% to 92.2% (10 States Reporting)	94%
Appropriateness	73.5% to 90.1% (10 States Reporting)	91.7%
Outcome	57.5% to 83.9% (9 States Reporting)	83.8%
Treatment Planning	65.5% to 75.8% (5 States Reporting)	90.5%

Figure 7.1.8

7.2 What are your performance levels and trends for the key measures of mission accomplishment?



**Hospital Admission Rates and Hospital Census:**

The Department continues to make progress in reducing inpatient utilization by increasing community mental health capabilities.

During FY 02 acute admissions to DMH inpatient psychiatric facilities totaled 4,679, a 28% decrease from the 6,516 admissions in FY 01. This follows a 15% decrease in FY 01 and a 10% decrease in FY 2000.

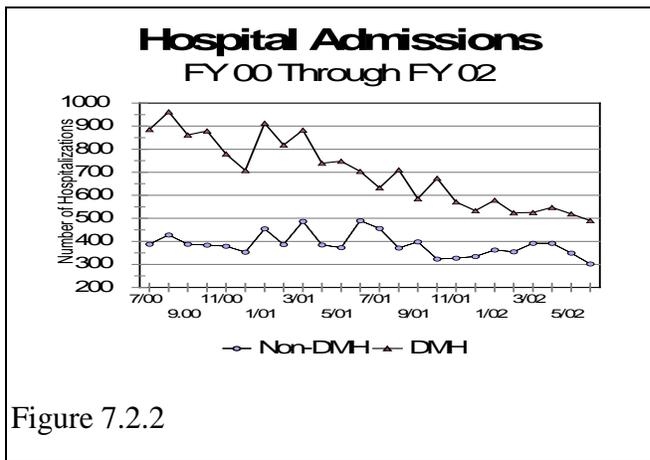
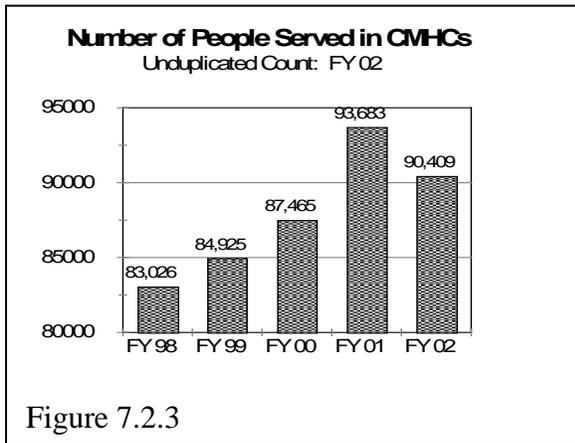
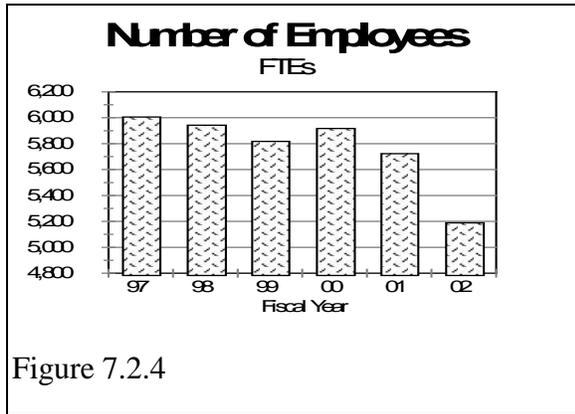


Figure 7.2.2 shows the steady progress being made in decreasing the total number of hospitalizations to DMH facilities (BPH, HPH, WSHPI, and MV). Through crisis stabilization and case management, hospitalizations are being decreased to DMH inpatient facilities without increasing the burden to non-DMH hospitals.

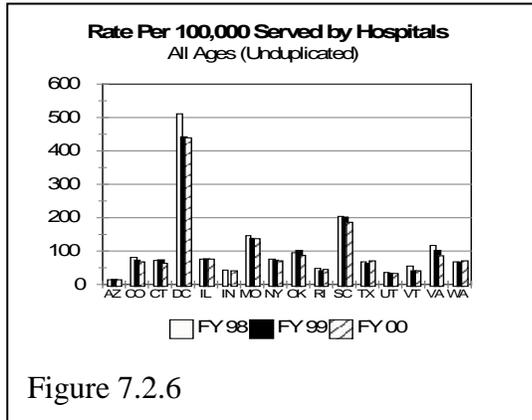
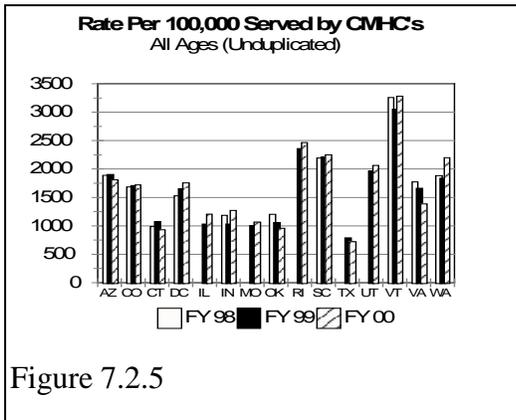


**CMHC Service Expansion** The CMH system has shown a clear rise the number of persons served from FY 98 through FY 02 and is consistent with the Department=s effort to develop a community-based system of care.



**Loss of Employees** The drop in CMHC service expansion for FY 02 (Figure 7.2.3) parallels the decrease in manpower as a result of budget reductions shown in Figure 7.2.4.

**Penetration Data:** A community-based system of care is core to the Department=s philosophy, and data from the MHSIP 16 State Study shows the department=s efforts to provide services to consumers in their home communities. Penetration rates for SCDMH community services in FY 98, 99 and 00, were the third highest of the reporting states. They also show that the penetration rate for state psychiatric hospitals for SC as very high. These data may reflect our centralized system or may reflect a past reliance on this level of care.



## Measures of Consumer Improvement

The Department measures functional improvement and symptom improvement with an instrument called the BASIS 32. In FY 02, 22,369 BASIS 32s were administered (11,779 Admission, 10,216 Mid-treatment, 374 Discharge).

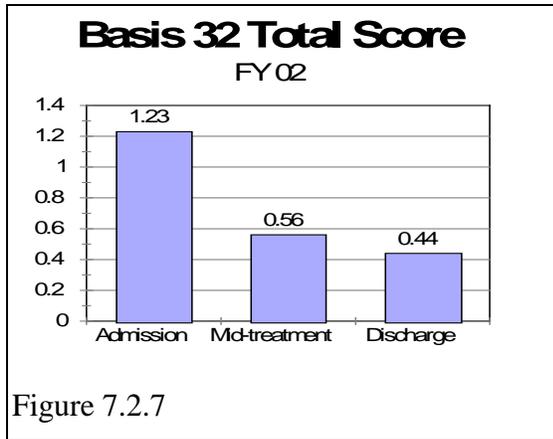


Figure 7.2.7 indicates how consumers achieve a significant amount of improvement following treatment, and how these gains are maintained through discharge.

Figure 7.2.7

**Employment:** SCDMH has hovered at the national average for the past four years in its efforts to improve the employment rate for severely and persistently mentally ill consumers. After showing steady progress for five consecutive years, the effects of budget and staff reductions on employment for the severely and persistently mentally ill

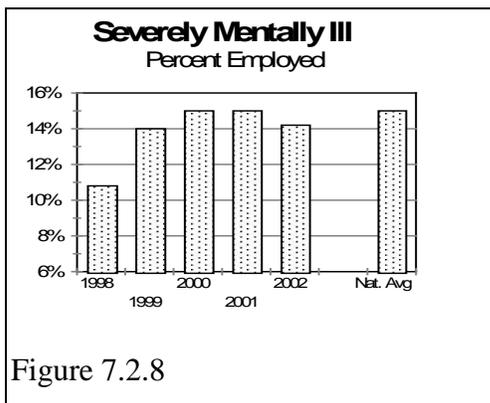


Figure 7.2.8

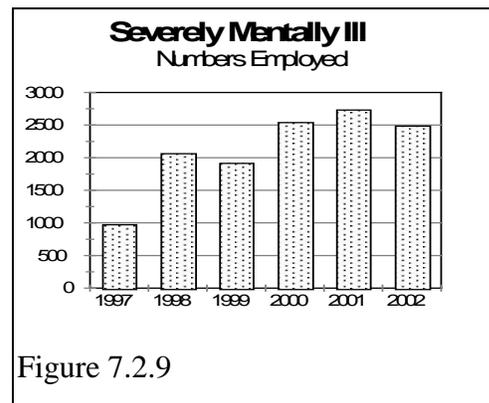


Figure 7.2.9

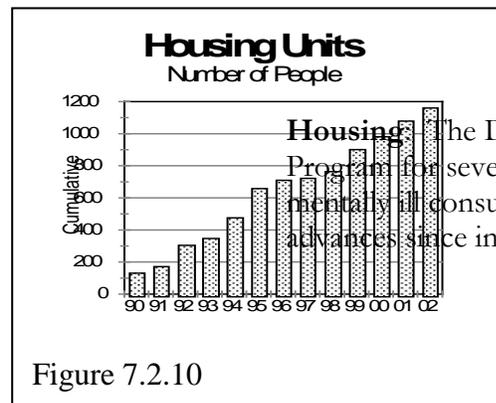
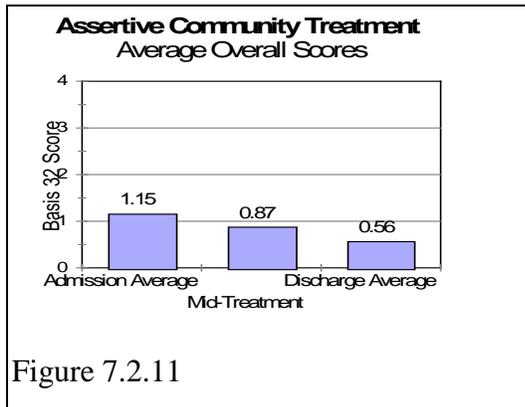


Figure 7.2.10

The Department's Housing Program for severely and persistently mentally ill consumers has shown major advances since inception.

are apparent in 2002.

**ACT Programs:** Admission and discharge measures of consumer symptoms and level of functioning reflect individual treatment progress.



The mean BASIS-32 admission, mid-treatment and discharge scores for consumers in ACT/PACT Programs is presented in Figure 7.2.11.

Figure 7.2.11

### EXPANDING TLC CAPACITY AND DECREASING LONG TERM PSYCHIATRIC FACILITY USE

TLC is building capacity in the community so that people with serious mental illness can receive needed services as close to home as possible through South Carolina's Community Mental Health Centers.

Data reveals that clients in TLC programs are consistently decreasing consumer usage of psychiatric hospitalizations. There is a 90% reduction in the total number of hospitalization days per year for these individuals, and a 92% reduction in the number of hospitalization days per admission

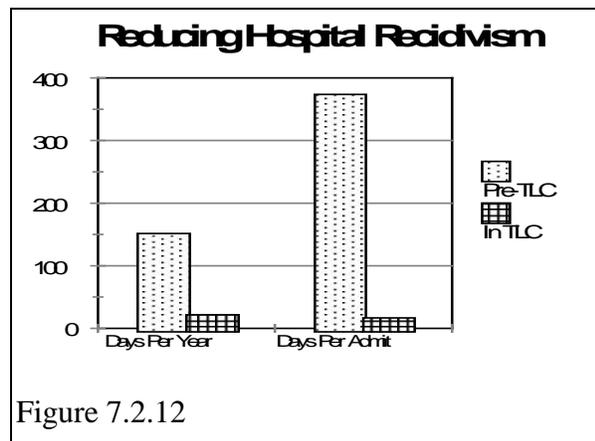


Figure 7.2.12

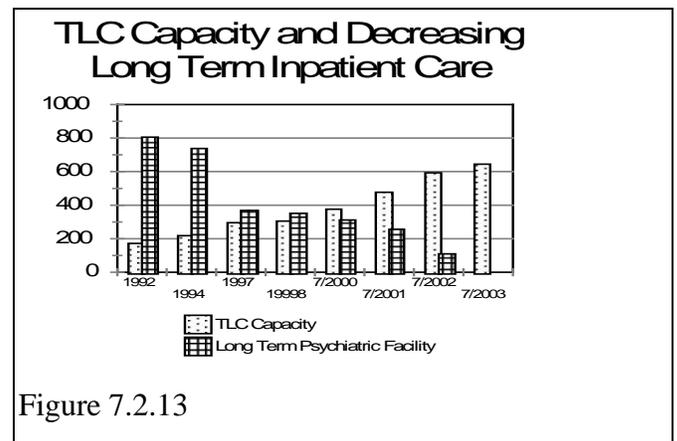


Figure 7.2.13

**Continuity of Care:** Research indicates that the sooner a consumer is seen by a CMHC following inpatient discharge, the less likely they are to be readmitted for subsequent inpatient care.

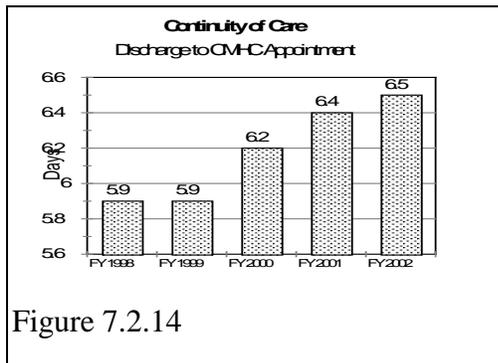


Figure 7.2.14

The steady rise during FY 99 through FY 02 in the number of days from discharge to CMHC appointment is an undesirable trend, causing the Department to initiate improvement activities..

**Follow-up Appointment Improvements:** Figures 7.2.15 and 16 show the reduction in the number of days between inpatient discharge and follow-up appointment at a local CMHC. The FY 02 average is 6.5 days, the April-June average is 5.5 days, and the August average is 4.6 days. Data is presented for statewide averages and by CMHC.

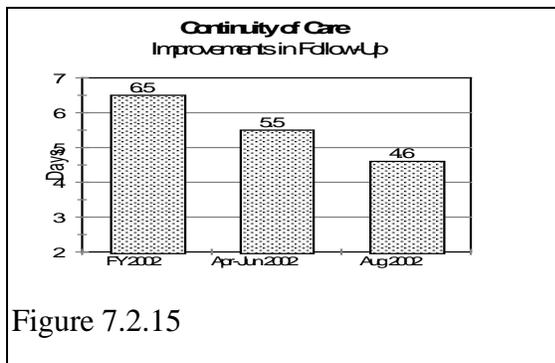


Figure 7.2.15

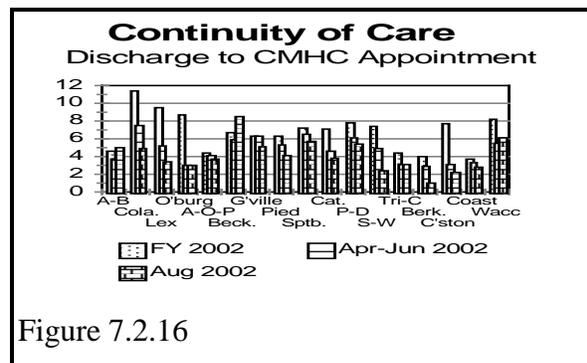


Figure 7.2.16

**DJJ Diversion Programs:** Twenty-two percent (22%) of children entering the DJJ Status Offender Diversion Program scored in the minimal/mild level of impairment. At discharge, 48% of the same children were scored as having only minimal/mild impairment overall.

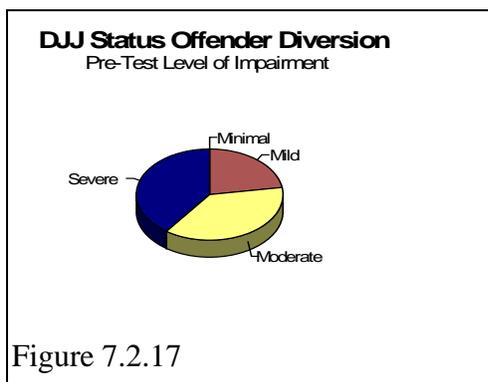


Figure 7.2.17

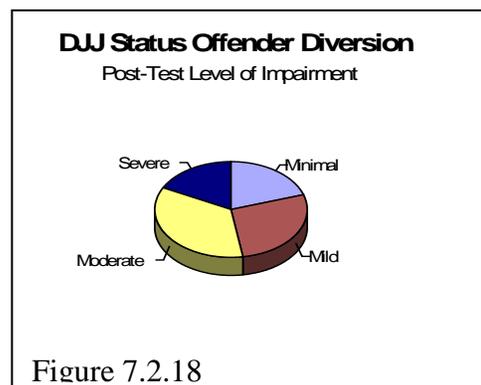


Figure 7.2.18

**School-Based Programs:** School Based Services positively impact students who participate in the program, as measured by their level of functioning and their degree of symptomology. The percentage of children in the minimal category of behavioral impairment at discharge rose from 31% to 91%.

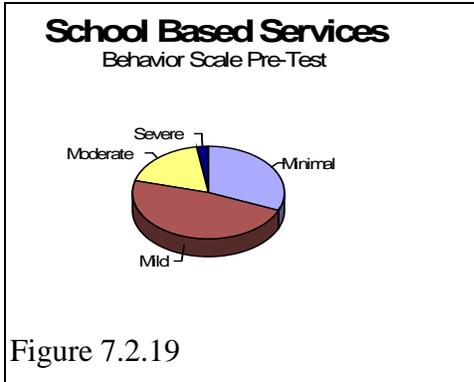


Figure 7.2.19

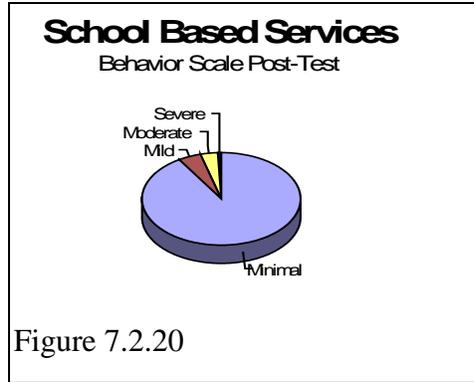


Figure 7.2.20

**Out of Home Placements:** Children are almost always better off in their own homes and several DMH programs have been developed to preserve the family unit (Wrap Services, MST, Family Preservation). Although there are many factors impacting Aout of home placement,@ the Department views the rise in removing children from their homes as a negative trend.

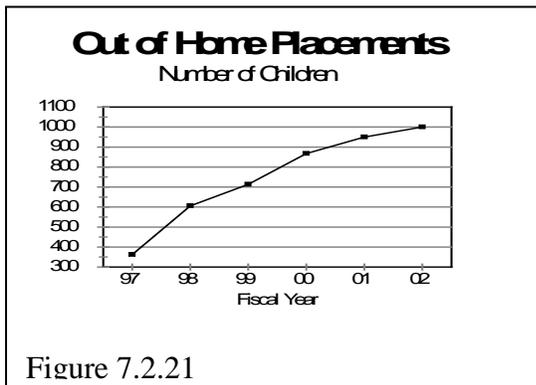


Figure 7.2.21

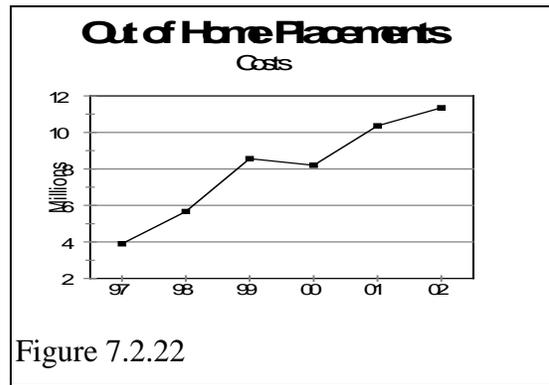
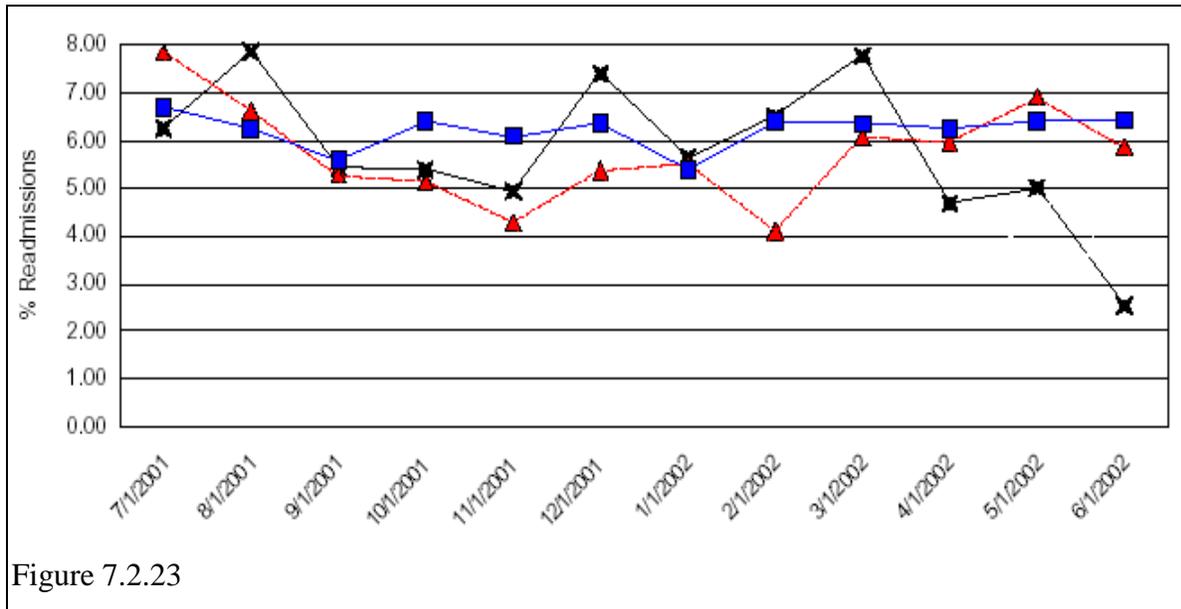


Figure 7.2.22

**Inpatient Performance Measures:** Management reviews key performance data monthly for each inpatient facility. Shown below are sample graphs for one facility.

**30 Day Readmission Rate:** Percent of admissions to the facility that occurred within 30 days of a previous discharge of the same client from the same facility. For example, a rate of 8.0 means that 8% of all admissions were readmissions.



BPH = X                      State = ▲                      National = ■

**Restraint Hours:** The number of hours clients spent in restraint for every 1000 inpatient hours. For example, a rate of 1.6 means that 2 hours were spent in restraint for each 1250 inpatient hours. The graph below compares the hours of restraint used at Bryan Psychiatric Hospital to the state and the national average.

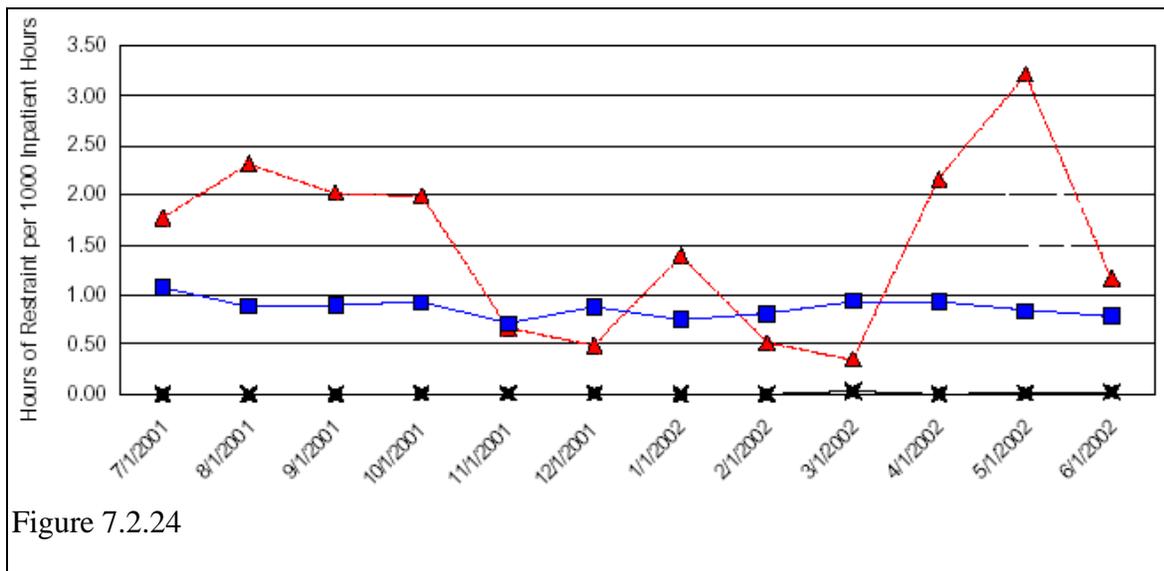
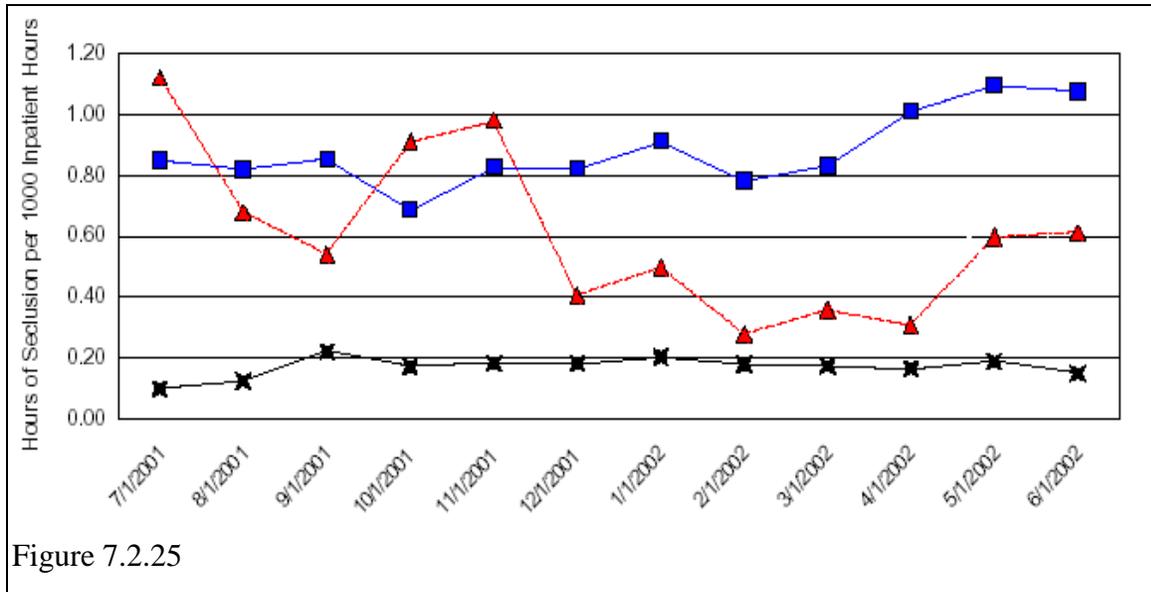


Figure 7.2.24

**Seclusion Hours:** Number of hours spent in seclusion for every 1000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours. The graph below compares the hours of patient seclusion used at Bryan Psychiatric Hospital to the state and the national average.



BPH = X      State = ▲      National = ■

7.3 What are your performance levels and trends for the key measures of employee satisfaction, involvement and development?

7.3.1 Staff Education and Training

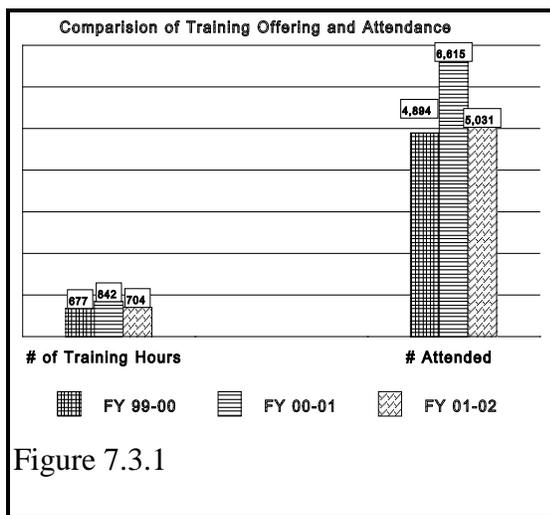


Figure 7.3.1

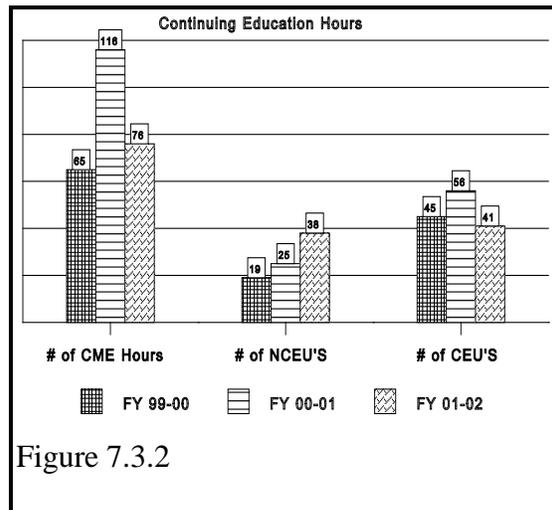


Figure 7.3.2

**Human Resource Services:** Customer Satisfaction Surveys of Inpatient and Community Mental Health Centers are conducted annually. Using a five point scale, with 1= Very Dissatisfied, and 5= Very Satisfied, each office of HRS is rated on three criteria: overall quality, Responsiveness, and Courtesy.

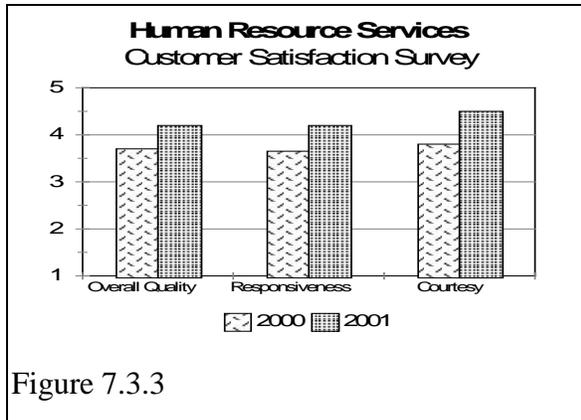


Figure 7.3.3

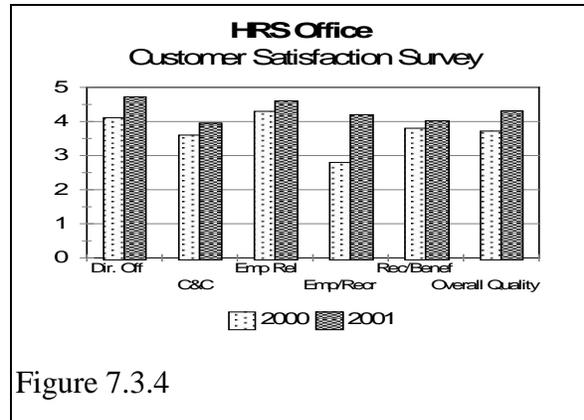


Figure 7.3.4

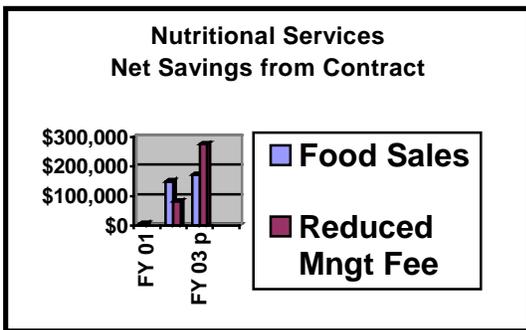
**Network Services:** Figure 7.3.5

**Network Services Customer Satisfaction Survey**  
*Percent of Responses: Satisfied to Very Satisfied*

80%	Timeliness and Effectiveness of Local Administrator in Solving Problems
87%	Staff Helpfulness in Resolving Issue
93%	Printer Availability
76%	Resolution Promptness and Effectiveness in Resolving Issues
81%	Overall Responsiveness and Effectiveness of Service

7.4 What are your performance levels and trends for the key measures of supplier/ contractor/ partner performance?

Figure 7.4.1



**Nutritional Services Contract Management:** The Department has shown significant savings in its management of its Nutritional Services contract management. Food Sales have been increased, while the management fee has been reduced.

**Nutritional Services Customer Satisfaction:** Each inpatient facility is surveyed on a rotating time schedule to assess the level of consumer satisfaction with the meals provided by the contract vendor.

Food Rating				
Hospital	Great	Good	So-So	Awful
SC State Hospital	12%	48%	24%	16%
Tucker Center	8%	57%	18%	7%
Morris Village	15%	46%	31%	7%
Hall Institute	14%	56%	23%	7%
Bryan Hospital	21%	51%	20%	7%

Figure 7.4.2

7.5 What are your performance levels and trends for the key measures of regulatory/legal compliance and citizenship?

**Adverse Event Data:** The department has a well-defined system to actively track and report significant adverse events that occur anywhere in the agency. When an incident indicates a failure in the system, a Quality of Care Review Board (QCRB) is established to determine the root cause(s) of the incident and make recommendations to prevent its reoccurrence. One year after the recommendations are made, the agency conducts an audit to determine the degree to which the recommendations were implemented.

The table below supports the seriousness with which the agency takes QCRB recommendations, with over 94% having been implemented. The gradual reduction in the number of significant events in the years reported is consistent with quality management literature; as the most difficult incidents are corrected through root cause analysis and the system becomes more quality oriented, the overall number adverse incidents decreases.

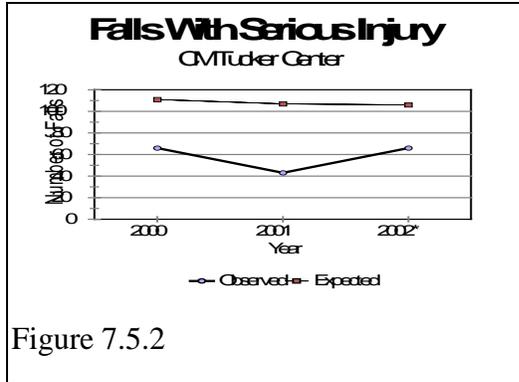
Calendar Year	Number of Significant Incidents	Number of QCRBs	Number of QCRB Recommendations	% of Recommendations Implemented *
94	522	39	113	92%
95	628	32	98	100%
96	626	33	78	100%
97	662	34	78	90%
98	576	26	93	95%
99	523	24	68	100%
01	483	12	36	**
02	381	22	127	85%

Figure 7.5.1

\* Based on audit 12 months after recommendations were accepted

\*\* Audit for 2000 is in progress

**Risk Data Trend Tracking** There are 69 categories of incidents that the Department tracks as they are reported to the Risk Management Office. A daily report is provided to the agency director. Shown below is trend data on one such category with comparative data on the national average for similar facilities.

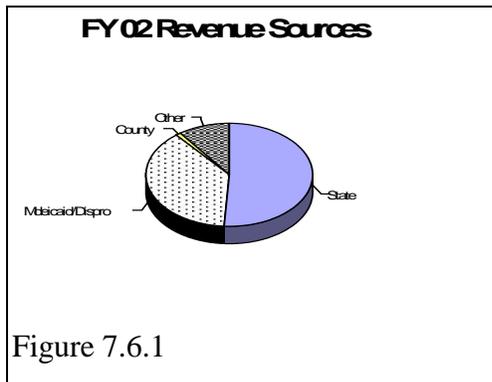


\* Projected Value for 12 Months  
 Observed = actual number  
 Expected = a number of occurrences predicted by national data.

Figure 7.5.2

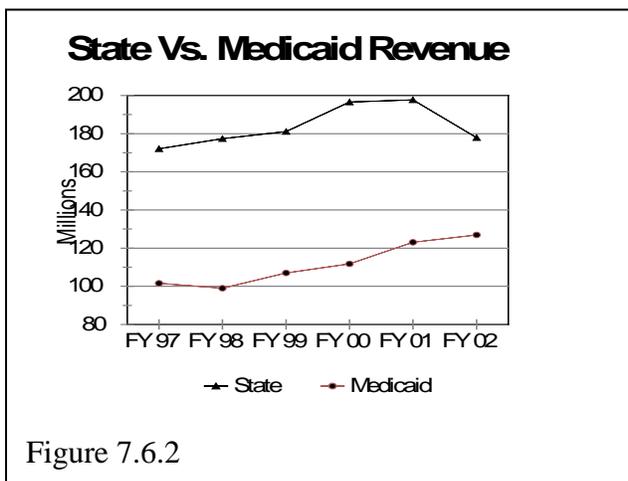
7.6 What are your current levels and trends of financial performance?

**Revenue Source**



Slightly over 2 of DMH funding comes from state appropriations, 36% from Medicaid revenue and Disproportionate share.

Figure 7.6.1



When state appropriations began to level off, then drop, the Department was able to sustain its funding level through efforts to increase Medicaid revenue. The significant drop in state funding and the effects of maximized Medicaid revenue are evident in this graph.

Figure 7.6.2

## Personnel Costs

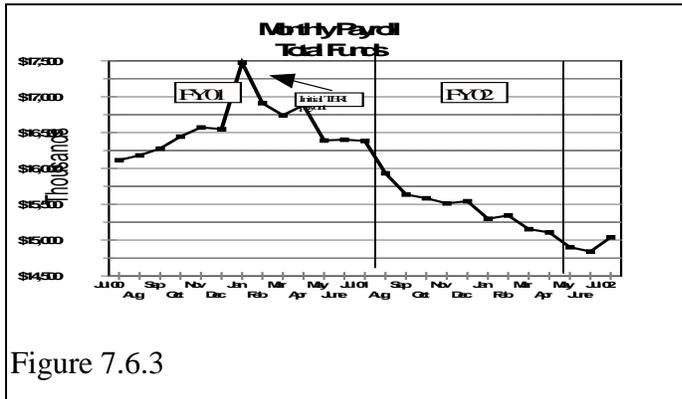


Figure 7.6.3

Tracking personnel costs has been even more critical during this period of repeated budget cuts. The impact of TERI payouts can be clearly seen, along with the loss of positions.

**Program Costs:** All DMH programs are tracked by costs and by the facility providing the program. The graphs below are examples of the costs, per mental health center, for providing one hour of clinical service.

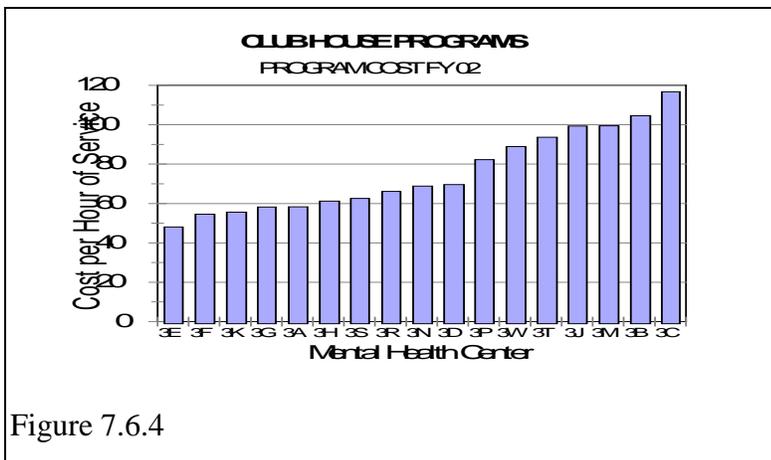


Figure 7.6.4

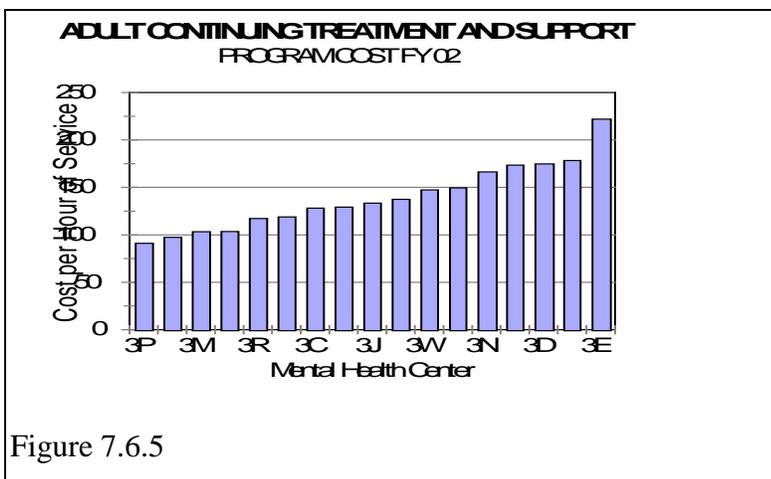


Figure 7.6.5