Accountability Report

FY 2004

Submitted September 13, 2004

Section I - Executive Summary

1. Mission and Values

The South Carolina Department of Mental Health's mission is to support the recovery of people with mental illnesses, giving priority to adults, children, and their families affected by serious mental illnesses and significant emotional disorders. We are committed to eliminating stigma and promoting recovery; achieving our goals in collaboration with all stakeholders; building a system of care using evidence-based best practices; and 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.

2. Major Achievements

When the Department presented its budget request to Governor Mark Sanford in July 2003, its management team outlined several broad goals. Included was the development of a comprehensive, community-based system of care.

Overall, the DMH community system of care continues to grow and produce good outcomes. All community mental health centers and all SCDMH inpatient facilities are fully accredited by national organizations. More significantly, 62% of the children receiving services showed improvement in functioning; 87 percent of clients surveyed showed satisfaction with services; 15.9 percent of the priority adults were employed; 216 new units of housing were added; and the nationally acclaimed school-based services program expanded to 47 percent (527) of the state's schools. Moreover, to stay on course, the Department began the development of a new community plan.

In March 2004, the Department closed the last remaining ward of the historic State Hospital. The closing of this institution has enabled its patients to find new life in their communities, experiencing recovery closer to family and friends. Many of these clients are part of the 750 now served by the Department's Toward Local Care (TLC) program, which has saved the state about $34 million in annual costs by providing higher quality, community-based care.

Another goal was to develop more crisis stabilization and diversion services to help keep people with mental illnesses out of emergency rooms and local jails and placed in more appropriate treatment settings. To help achieve this goal, Department leadership committed to reducing the numbers of people waiting in local emergency rooms by at least fifty percent. The number has steadily declined with some spikes, from a high of 86 in March 2004, to a low of 36 in June 2004.

Further, all community mental health centers are now developing programs to provide emergency services around the clock, every day of the week. During the fiscal year, the Department awarded ten centers $1.7 million for crisis programs. In addition, in Charleston and Columbia, people with mental illnesses are being diverted from jail and into treatment through mental health courts. Courts in Anderson and Marlboro County are slated to open later this year, thus providing another solution to serving people in crisis.

Closely related is the goal to increase services to people with co-occurring disorders – mental illness and an addictions disorder. Though struggling through repeated budget cuts, the Department's leadership recognized the growing crisis and made funds available to its centers, state agency partners like DAODAS, and to local hospitals willing to confront the

challenge. Today, these partnerships are beginning to bear fruit in Charleston, Georgetown, Florence, Spartanburg, and other areas where teams are working together to develop integrated models of care.

Because of a firm commitment to getting a return on its investments and to providing quality care, the Department set as another goal the continued implementation of evidence-based best practices -- clinical programs with data supporting their efficacy. Initiatives such as Medication Algorithm, Multi-systemic Therapy (MST) sites, supported employment for clients, and urban and rural Assertive Community Treatment (ACT) teams are enabling the Department to fulfill its mission in a fiscally responsible manner.

3. Key Goals

A major goal of the Department is to continue to develop crisis services in the community. Critical to this end are the relationships with key business partners such as the South Carolina Primary Healthcare Association, local law enforcement, the South Carolina Hospital Association, local hospitals, advocacy organizations, and other state agencies such as DAODAS and Health and Human Services.

Equally important forthcoming goals include:

- continuing to roll out evidence-based best practices;
- improving accessibility to services;
- delivering services in both inpatient and outpatient settings that are quality driven, culturally competent, and cost effective;
- recruiting and retaining qualified healthcare professionals;
- building interagency collaborations;
- work closely with HHS on new Chapter 200 improvements;
- stressing organizational efficiencies; and
- promoting the Recovery Model of Care.

The Department's blueprint for the future can be found in its new community plan, *Recovery and Resilience: A Life in the Community for Everyone.* A key goal for the year will be the gradual implementation of the plan with its emphasis on improving services for children and adults. The six goals recommended in President Bush's New Freedom Commission on Mental Health report are integral to the Department's strategic plan.

4. Opportunities and Barriers

Over the next twelve months, the Department will face many opportunities. Included among these are the following:

- leaving the State Hospital campus, while finding suitable locations for children and adolescent programs currently in the Hall Psychiatric Institute;
- maintaining an aging physical plant with facilities that pose life safety issues;
- managing the financial burden caused by such non-core programs as veterans' nursing care and the sexual predator program;
- work toward a ten-year goal to end chronic homelessness for the South Carolina's homeless mentally ill;
- determining the appropriate number of psychiatric hospital beds both public and private;
- integrating mental health care with primary health care;
- streamlining the evaluation process for people waiting in jails;

- gaining greater understanding of the impact of trauma on adults and children;
- developing a workplace culture that understands Return on Investment (ROI);
- strengthening strategic alliances with all stakeholders;
- improving communications between leadership, staff, and governing boards;
- providing continual training and professional development for staff;
- implementing an Electronic Medical Record to improve continuity of patient care; and
- educating the public, thus eliminating the stigma surrounding mental illnesses.

The Department has ample opportunities to meet the mental health needs of a growing and aging state population, but there are significant barriers to overcome. Among these is inadequate funding. Widely known are the budget cuts the Department has seen in the last three years. These cuts have eliminated programs and services and led to more than 900 jobs lost to the Department.

The current budget includes over $10 million in non-recurring funds, and while the Department has identified $5.19 million for crisis programs and services, less than half is in recurring funds. Further, the Department will have to ask for state appropriations to operate the new veteran's nursing home in Colleton County when it opens in 2006. The Sexually Violent Predator program continues to be under funded, drains resources from traditional mental health services, and needs to be relocated.

Another significant barrier is public attitudes about mental illness. According to the 1999 U. S. Surgeon General's report on mental health and the 2003 final report of the President's New Freedom Commission on Mental Health, public education about mental illness must be a priority. Both of these important works stress the prevalence of stigmatizing attitudes about mental illness in the general population. These attitudes are reflected in negative media portrayals of mentally ill people, in employment and housing discrimination, in the lack of funding for mental health programs, and in the lack of insurance parity for treating mental health problems. One of the core values of the Department is a commitment to improving public awareness and education as one step toward eliminating a significant barrier to success.

5. How the accountability report is used to improve organizational performance

Realizing goals and striving for excellence are inherent in the DMH culture. The leadership of the agency has turned this philosophy into practice. Management encourages all employees to embrace a work ethic that calls for self-evaluation, continuous improvement, and return on investment.

Four of the Department's management staff, two on Governing Council, have become Examiners for the Governor's Quality Award, and several others on the senior leadership council have completed training in how to use the Accountability Report for agency assessment and improvement. For the past three consecutive years DMH has conducted a self-assessment using its Accountability Report as the primary source document, and from these assessments senior leadership continues to identify key areas for improvement.

Section II – Business Overview

Number of employees

5,105 permanent full-time equivalencies (FTE's) and 57 temporary employees

Location of operations

The Department of Mental Health (DMH) operates in locations across South Carolina. The main administrative offices of DMH -- as well as William S. Hall Psychiatric Institute, G. Werber Bryan Psychiatric Hospital, and the Earle E. Morris, Jr. Alcohol & Drug Addiction Treatment Center -- are located in Columbia. Patrick B. Harris Psychiatric Hospital is located in Anderson. DMH also operates seventeen community health centers (MHCs) around the state which serve all forty-six counties. The centers consist of: the Aiken-Barnwell MHC, the Anderson-Oconee-Pickens MHC, Beckman MHC (located in Greenwood), Berkeley MHC, Catawba MHC (located in Rock Hill), Charleston/ Dorchester MHC, Coastal Empire MHC (located in Beaufort), Columbia Area MHC, Greenville MHC, Lexington MHC, Orangeburg MHC, Pee Dee MHC (located in Florence), Piedmont MHC (located in Simpsonville), Santee-Wateree MHC (located in Sumter), Spartanburg Area MHC, Tri-County MHC (located in Bennettsville), and Waccamaw MHC (located in Conway).

Key customers segments linked to key products/services

DMH's key customers are adults, children, and their families who are affected by serious and persistent mental illnesses and/or significant emotional disorders. Their key requirements, and how DMH measures its success in meeting their requirements, are presented in Table 1. The key processes are the best practice programs designed to meet the key requirements of our customers.

Key stakeholders

Groups that have a stake in the success of the Department of Mental Health include other state agencies, in particular the Department of Alcohol and Other Drug Abuse Services, the Department of Disabilities and Special Needs, the Department of Health and Human Services, the Vocational Rehabilitation Department, the Department of Social Services, the Department of Corrections, the Department of Juvenile Justice, and local school districts. The legislative, executive, and judicial branches of government are also special stakeholders as they make decisions that impact individuals with persistent and serious mental illness. Other key stakeholders are public health systems, especially hospital emergency staff, and jails, as they work together with DMH to identify and support key customers in crisis. Nonprofit entities which advocate for clients such as the National Alliance for the Mentally Ill, the Mental Health Association, Protection & Advocacy for People with Disabilities, and SHARE (Self-Help Association Regarding Emotions) are key stakeholders. SAMHSA (Substance Abuse and Mental Health Services Administration), the Veterans' Administration and other federal funding sources are also stakeholders.

Table 1	**KEY CUSTOMER PERFORMANCE MEASURES**		
Customer	**Key Requirements**	**Key Measures**	**Key Processes**
Adults with Serious Mental Illnesses	Satisfaction	Consumer Perception of Care (MHSIP). Consumer-to-Consumer Evaluation.	**Evidence-Based or Best Practice Programs:** Crisis Stabilization, Case Management (ACT/PACT), Dually Diagnosed Program, Criminal Justice System Interventions, TLC, Trauma Services, Employment Program, & Housing Program
	Functional Improvement	Clinical Assessment (GAF)	
	Symptom Reduction		
	Employment	Number/Percent Employed	
	Housing	No. of Units	
Children with Severe Emotional Disturbances	Functional Improvement	Clinical Assessment (CAFAS)	**Evidence-Based or Best Practice Programs:** School-Based Programs, Multi-Systemic Therapy (MST), Juvenile Justice Diversion, & Trauma Services.
	Symptom Reduction		
	Parental Satisfaction	Parent's Survey (MHSIP)	
	Youth Satisfaction	Youth Survey (MHSIP)	

KEY MEASURES OF ORGANIZATIONAL EFFECTIVENESS AND EFFICIENCY	
Domain	**Measures**
CMHC	Hospital Admissions Bed Day utilization Avg. Days Between Hospital Discharge and Date seen by CMHC Emergency Room waits
Inpatient	ORYX Measures: Restraint/Seclusion Use; 30 Day Readmission Rate; and Length of Stay Admission Rate Discharges with CMHC Appointment
Administrative and Financial	Comparison by Facility and/or Program Medicaid Revenue Billable hours of service Regulatory compliance and audits

Key suppliers
DMH contracts with several major vendors to provide services to our clients. The Campbell Veteran's Nursing Home in Anderson, SC, a 220-bed nursing home, is operated through a contract with Health Management Resources, Inc. DMH also contracts with Just Care, Inc. for the general operations of the agency's inpatient forensic services. Located on DMH property leased to this provider, DMH provides some of the professional treatment staff, while the vendor provides general nursing care, room and board, etc. Our community mental health centers contract with a number of local providers such as general hospitals, private practioners, and other organizations for a variety of professional services including local inpatient care, residential treatment and other general medical care for agency clients.

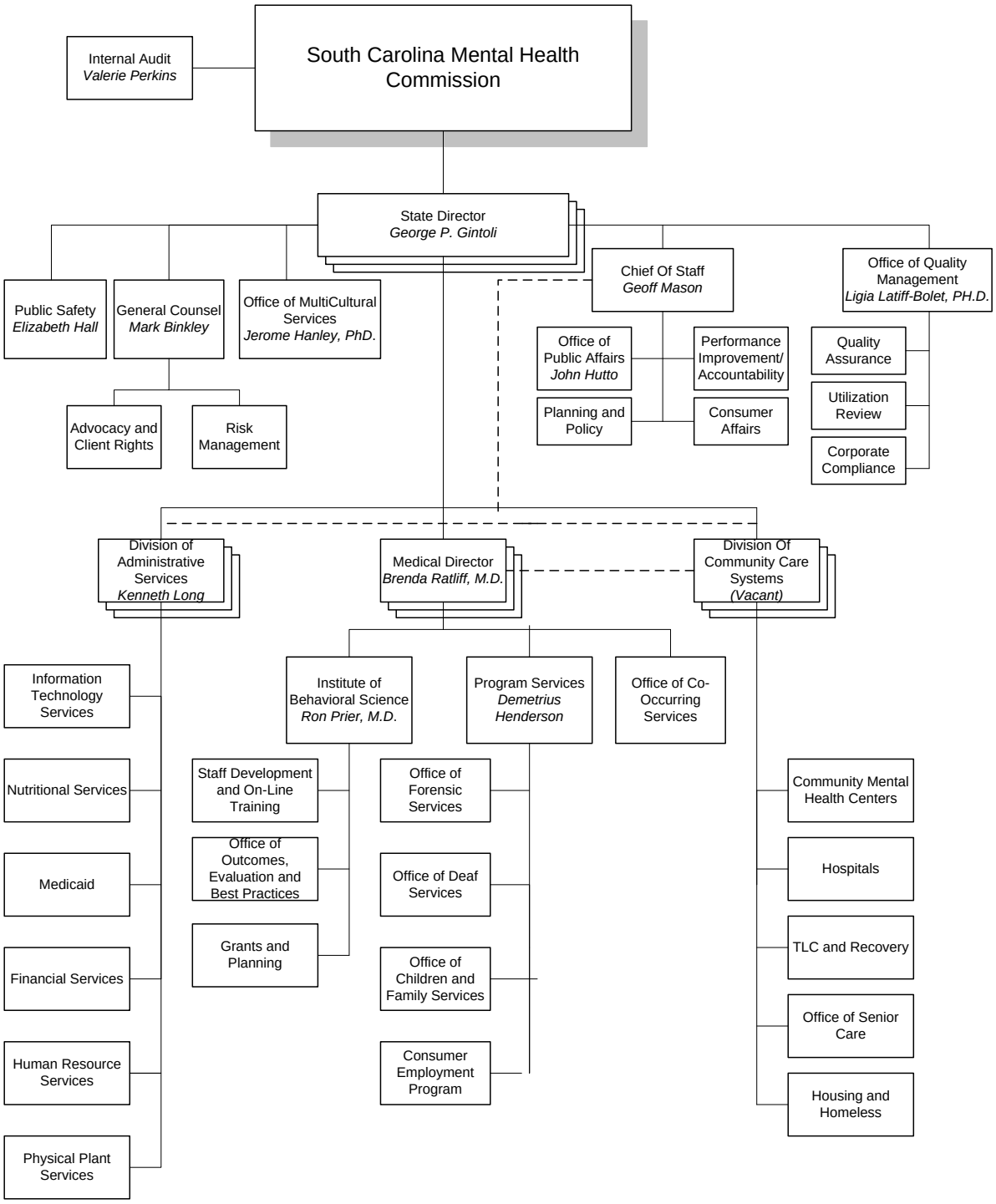
Table 2 **Expenditures/Appropriations Chart**

	FY 02-03 Actual Expenditures		**FY 03-04 Actual Expenditures**		**FY 04-05 Appropriations Act**	
Major Budget Categories	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**
Personal Service	178,089,941	108,260,084	175,038,759	104,779,990	175,829,250	97,550,645
Other Operating	84,953,287	14,523,999	86,421,479	18,934,403	84,453,293	17,664,106
Special Items	592,192	192,192	4,695,499	4,295,499	592,192	192,192
Permanent Improvements	7,753,328	0	10,811,969	0	0	0
Case Services	11,576,135	2,058,518	16,695,964	10,919,878	16,688,401	8,444,691
Fringe Benefits	52,694,431	33,394,587	54,752,132	33,561,668	52,850,143	31,468,205
Total	**335,521,510**	**158,429,380**	**348,415,804**	**172,491,440**	**332,003.875**	**158,899,719**

Interim Budget Reductions

Total 02-03 Interim Budget Reduction	**Total 03-04 Interim Budget Reduction**
$ 15,307,618	$ 1,694,383

8. **Organizational structure** (Table 3)



Section III –
Category 1 – Leadership

1. **How do senior leaders set, deploy, and ensure two-way communication for: 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?**

From stakeholder and field input, and in accord with legislative mandates, DMH has developed a clear mission/values/ priorities statement, a responsive set of strategic priorities, and an ambitious, coherent strategic plan. From these documents and guiding principles, the Mental Health Commission and senior leadership set the short- and long-term direction of the agency.

Department managers are required to have clear performance goals, aligned with agency priorities, and are formally evaluated annually based upon these goals. Individual managers are similarly rated on their contribution to division expectations.

Senior leadership communicates the Department's values and priorities in a variety of ways, such as:

- publishing the minutes from all governance meetings;
- conducting quarterly meetings with staff;
- meeting regularly with CMHC boards;
- holding "Kitchen Cabinet" meetings with advocates;
- publishing newsletters and other internal reports;
- posting information on the Intranet site;
- meeting with editorial boards, key legislators, and other influencers; and
- using the interactive capabilities of SC ETV to reach the field.

The consumer, or customer, plays a vital role in the Department's realization of its values and priorities. Consumers and other stake holders participate in the major committees, serve on mental health center leadership teams and boards, and conduct consumer satisfaction surveys.

The Department places a high value on research-based outcomes and expansion of evidence-based services for clinical programs. All new programming must be of this genre, and existing programs must be brought into line with best practice outcomes. The development of an evidence-based system of care is central to the DMH program development philosophy.

To encourage innovation, organizational components are encouraged to submit outcome data on locally developed programs that meet, or exceed, the outcomes of established practices. Conferences and stake holder meetings feature educational reports on state-of-the-art treatment approaches, and the Department's quarterly publication, Images, routinely features model DMH programs.

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

At DMH, consumers, or customers, are the agency's reason for existing. Through consumer advisory boards, consumer employees, consumer conducted surveys, advocacy groups, and other stakeholders the agency is able to maintain its focus on providing excellence in customer satisfaction. Further, as described in Table 1, senior management is able to review key measures to determine how well the agency, and each of its components, is doing with customer satisfaction.

3. **How do senior leaders maintain fiscal, legal, and regulatory accountability?**

Data and written evaluations on fiscal, legal, and regulatory compliance are reviewed regularly by the director, senior leadership, and the Commission. Formal litigation reports and the findings of the Internal Audit Division are reviewed every six months. The

Management Dashboard, a data driven, scorecard presented in Table 1 is reviewed on a schedule dictated by the measure.

4. What key performance measures are regularly reviewed by your senior leaders?

Customer satisfaction, symptom reduction, functional improvement, housing and employment are part of the data reviewed regularly by leadership. In addition, every month the Commission and senior leaders review "dashboard indicators," which provide comparative data on organizational efficiency and effectiveness. Copies of the "dashboard indicators" are provided to all DMH management, CMHC and inpatient facility directors, and CMHC board chairs. Table 1 provides a more detail listing of the performance measures regularly reviewed by senior leadership.

5. 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 agency is in the early stages of using performance improvement methods to produce systems change. While there have been quality improvement teams for years, the Department has just begun to learn from the teams' findings and create a systems approach to improvement. The Department is reorganizing the structure of its performance improvement system to track performance improvements, to encourage the creation of more teams, and to transfer knowledge throughout the system. Many members of the leadership team are graduates of the South Carolina Executive Institute, and the exchange of learnings between leadership members strengthens the individual and the full team.

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

DMH is aware of its obligation to provide the best possible care and treatment in an environment that ensures patient, staff, and public safety. As part of its strategic planning process, the Department's own SWOT analysis (Strengths, Weaknesses, Opportunities, and Threats) reaffirmed its focus on public safety.

Regular reviews are conducted to ensure that standards are met for programs and procedures. All inpatient facilities are licensed by DHEC, and all are fully accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). All CMHCs are also CARF accredited.

Further, the DMH Corporate Compliance function develops plans to strengthen our auditing procedures as necessary, and our Office of Internal Audit, answerable directly to the Commission, regularly reviews all DMH activities (administration, inpatient, and community) to ensure fiscal responsibility, accountability, ethical behavior, and legal compliance.

Also helping the Department assess its impact on the public are local CMHC boards, advocacy groups, the South Carolina Hospital Association, and the Medical Association. The Department subscribes to a "press summaries" service and runs a volunteer "media watch," reviewing all newspaper articles and editorials in the state to maintain an awareness of public concerns and opinions. Periodic meetings are held with probate judges and the South Carolina Hospital Association across the state to address issues and concerns. The state

director meets regularly with news media, editorial boards, members of the legislature, advocacy groups, and other community leaders to provide information about the Department and hear concerns and recommendations.

7. How does senior leadership set and communicate key organizational priorities for improvement?

Organizational priorities for improvements are identified through the strategic planning process, through leadership's regular meetings with key stake holders, and by review of performance measures. Data used to assist leaders in establishing priorities for improvement include "dashboard indicators," quality assurance and risk management findings, and performance improvement team results. These priorities for improvement are communicated and/or deployed through the avenues identified in Section 1.1. In addition, we are involved in the Mental Health Statistical Improvement Project (MHSIP), a national effort to produce reliable measures of recovery.

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

The Department supports the communities it serves and is committed to educating the public about mental illness and reducing stigma associated with the disease.

Senior leadership actively encourages employees to educate the public about mental illness and participate in actions that reduce the effects of stigma associated with mental illness. It develops public service announcements about mental illness and maintains educational websites. DMH also supports contributions to strengthen non-profit organizations dedicated to the physical and social well-being of the citizens of South Carolina.

Category 2 – Strategic Planning

1. What is your Strategic Planning process, including KEY participants, and how does it account for:
   a. Customer needs and expectations
   b. Financial, regulatory, societal, and other potential risks
   c. Human resource capabilities and needs
   d. Operational capabilities and needs
   e. Supplier/contractor/partner capabilities and needs

The Department has a three-year planning cycle, with annual updates for major plan refinements and quarterly progress reporting that produces minor adjustments. In late 2001, the agency conducted a statewide, stakeholder-driven, planning initiative that engaged more than 600 stakeholders: consumers; advocates; probate judges; law enforcement; private practitioners; hospital emergency room staff; human service agency staff; local government officials; and DMH employees. Input was collected through focus group exercises and prioritized around targeted activities, including consumer need, human resource, financial, data management, and support strategies. The interactive process included feedback and action loops to keep the planning relevant to consumer identified needs. In 2004, the agency began this process anew.

Strategic planning in the Department is not a static event. It is a systematic, on-going process that allows for a changing environment. Plan refinement is 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 goals, addressing the details of agency planning such as:

- per-capita funding formula overhaul to ensure equity of service and allocation across centers;

- budget reduction strategies to deal with diminished appropriations while maintaining core clinical programming;
- monitoring of the strategic plan;
- right-sizing facilities and transferring funds to community programming; and
- human resource development, training, succession planning, and recruitment.

This process allows senior leadership to re-affirm that all plans and strategies are in accordance with stakeholders' requirements and the goals of the Department.

Central to our challenge is the improvement of services to priority mental health consumers with decreasing resources, to which the Department has responded by absorbing its budget reductions in areas serving non-priority consumer groups, in central administration, and inpatient facilities. These cuts have been in keeping with our strategic plan which gives priority to community program expansion of evidence-based practices for adults, children, and their families who are affected by serious mental illnesses and significant emotional disorders.

2. What are your key strategic objectives?

The Strategic Planning attachment contains the strategic plan goals, key initiatives, and a cross references to Category 7 – Results.

3. How do you develop and track action plans that address key strategic objectives?

The Department's Governing Council members assume individual responsibility for statewide implementation, oversight, and deployment of specific goals and objectives. To guide their process, a work-plan is developed for each objective using an adaptation of the Plan/Do/ Check/Act (PDCA) model. The workplan includes key "deliverables" --measures of progress which are reported to senior leadership and the Commission quarterly.

4. What are your key action plans/ initiatives?

The action plan with key deliverables and a timetable are contained in the PDCA for each goal and presented in abbreviated form in the Strategic Planning attachment.

Budget reductions over the past three years have severely and repeatedly jeopardized the strategic plan timetable due to the personnel costs of program implementation or program expansion. While there are justifiable concerns that the agency's budget cuts will endanger these initiatives and some objectives have clearly depended upon external funding, Governing Council committed itself to implementing the plan.

In support of these objectives, Governing Council tentatively set aside $6.8 million of its FY 04 funding allocation for this purpose. Even with further budget reductions, the current set-aside is as follows:

$1.7 million – Crisis Stabilization programs

$1.5 million – TLC

$2.0 million – Community Residential Care Facilities

$550 thousand – Evidence-Based, new best practices

$500 thousand – Evidence-Based Practices training

$398 thousand – Dually Diagnosed Programming

$200 thousand – Peer Support Programming

5. 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 submits a PDCA to the Governing Council member who "owns" the objective, specifying how it will contribute to the agency goals and the statewide objective. Quarterly progress reports from each organizational component are reviewed by the Oowner and reported to

Governing Council and the DMH Commission.

To communicate the "Making Recovery Real" plan to staff and stakeholders, the agency has a broad-based educational effort. Articles in the agency newsletter Images, 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 uses 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."

6. If the agency's strategic plan is available to the public through the agency's internet homepage, please provide an address for that plan on the website.

The SCDMH homepage includes a wide selection of key publications, including our strategic plan, bimonthly newsletter, and others (http://www.state.sc.us/dmh/). Other homepage links are to consumer resources, clinical information, clinical services, career opportunities, and timely events and news.

Category 3 – Customer Focus

1. How do you determine who your customers are and what their key requirements are?

Our customer base is defined, in part, by legislative mandates and the South Carolina Code of Laws, which give the Department jurisdiction over the state's mental hospitals and community mental health centers. We receive our customers voluntarily and involuntarily, through family members, through the court system and through law enforcement. We also seek out customers through embedded staff working in schools, other agencies, and hospital emergency rooms. To become a customer of the Department of Mental Health, one must have a diagnosable mental illness.

Our key customers are adults, children, and their families who are affected by serious mental illnesses and significant emotional disorders. These priorities were established by stakeholders through the strategic planning process and by the Clinical Care/Coordination Committee, a stakeholder group which assists the Department in program and policy development. DMH management and the Commission affirmed this decision, designating these groups of individuals as "priority populations" in its mission statement, and adopted the federal definitions of specific diagnostic categories for serious mental illness and significant emotional disorder.

The key customer requirements for adults with severe mental illness have been defined by our consumers through focus groups, needs assessments, and satisfaction surveys and are consistent with what is reported in the literature: regaining a sense of self-worth and dignity; having a hopeful outlook on life; functional improvement; actively pursuing goals and aspirations in the areas of affordable housing, education, employment and social supports; and/or living a higher quality life. These requirements are operationalized by SCDMH as: symptom reduction and functional improvement; meaningful employment; housing which is safe, affordable, and decent; and satisfaction.

Although recovery can begin or continue in inpatient care, the heart of recovery is community-based, and the Department is committed to a community-based system of care which meets the requirements of its consumers.

Recovery and resiliency for children means increasing self-esteem, dignity, and school performance; remaining in their home; and working with the families to resolve issues

and preserve the integrity of the family unit. These requirements are operationalized by SCDMH as: symptom reduction and functional improvement and parental/ youth satisfaction.

Promoting recovery and resiliency in the child population requires working closely with the family and system collaborations with other agencies that are involved with the child and family.

2. How do you keep your listening and learning methods current with changing customer/business needs?

The Department believes that 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, evaluation, and delivery of care. All major planning committees of the Department have consumers, family members, and advocacy organizations as representatives. Each CMHC has a Consumer Affairs Coordinator, a self-identified mental health consumer who participates in management meetings and decision-making to provide a voice for the customer. Each CMHC and inpatient facility also has an advisory board composed of consumers of mental health services, and there is a statewide Consumer Advisory Committee operated by the Office of Consumer Affairs.

It is standard practice in the Department that 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.

Consumer focus groups indicated a desire for "Advance Directives," instructions on level and type of care preferred by the consumer, made at a time when they were unclouded by the effects of their illness. The Department assists individuals in the preparation of these documents and actively supports their use.

To stay current on evolving health care service needs and directions, the agency also participates in national forums, has representatives on health care measurement task forces, and has senior leaders who hold offices in national bodies that help set the direction of health care delivery systems. A "Legislative Update" is published monthly during the legislative session to keep stakeholders, internal and external, aware of issues and events and their feedback to the agency offers insight into current perspectives on health care trends. Key staff are surveyors for major accrediting bodies which allow them to bring innovative approaches back to South Carolina and receive training in new approaches to service need assessment.

3. How do you use information from customers/stakeholders to improve services or programs?

The agency director and other senior leaders engage in "Listening and Learning" meetings with stakeholders at each of the 17 community mental health centers and participate in monthly conference calls with CMHC Board chairs to discuss priorities/concerns, community issues, and statewide issues.

In 2002, President Bush commissioned a group of leaders in the mental health field to evaluate the state of the national mental health system. This group created a report called "President's New Freedom Commission Report." The report informed the President of six critical goals to improving the mental health system, and, as a result of this ground breaking report, DMH has organized the structure of it new strategic plan on these goals.

SCDMH is only the third state in the country to have peer-support services as a Medicaid billable service. A peer support person is a self-identified individual with a diagnosed mental illness who delivers mental health services to other adult customers. To date, 18 peer support specialists have been certified and are working in 10 out of 17 community mental health centers.

The Department has established a presence on the Internet and uses this medium to receive questions, concerns, and comments about the Department's services. The webmaster brings each of these to the attention of the director of Community Care Systems, 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.

4. How do you measure customer/stakeholder satisfaction?

The Department collects data on a number of key indicators that reflect the customer perspective. We were initial participants in the Mental Health Statistical Improvement Project (MHSIP) to develop national comparative data on customer perceptions of satisfaction with access to services, appropriateness of services, and outcomes.

The Department uses Consumer-to-Consumer Evaluation Teams (CCET) to evaluate and spur improvement in our system. These teams, composed of primary mental health 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. The Department's consumer-driven evaluation system is a model program that has received national recognition.

DMH also determines customer satisfaction through annual satisfaction surveys conducted by each CMHC. CARF standards require consumer satisfaction measures, and all CMHC programs have been active with consumer evaluations since becoming accredited.

Because of the extent to which stakeholders are included in the fabric of the Department, stakeholder satisfaction levels are assessed more informally but more diligently than could be obtained through periodic surveys or questionnaires. In addition to participation in all policy and program development committees and task forces, advocacy stakeholders are singled out for private meetings and discussions to address concerns and strategies for problem resolution. During the past year, the state director's calendar showed 98 meetings, over and above committee and task force meetings, with these key stakeholders

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

The culture of the Department is one of *inclusion*. Advocates, consumers, family members, and all stakeholders have an active place at the DMH table. The Department is definitive in its commitment that all stakeholders are an integral part of the state mental health service system, and a phrase used by Consumer Affairs Coordinators is indicative of the inclusive philosophy: "Nothing about us, without us."

Families of mentally ill consumers, consumer groups, protection and advocacy groups, and other agencies are involved in the planning of services. Members from these groups are represented in the Clinical Care/ Coordination Committee, one of the two primary DMH committees answerable to

senior leadership, which advises and approves clinical policies and programs

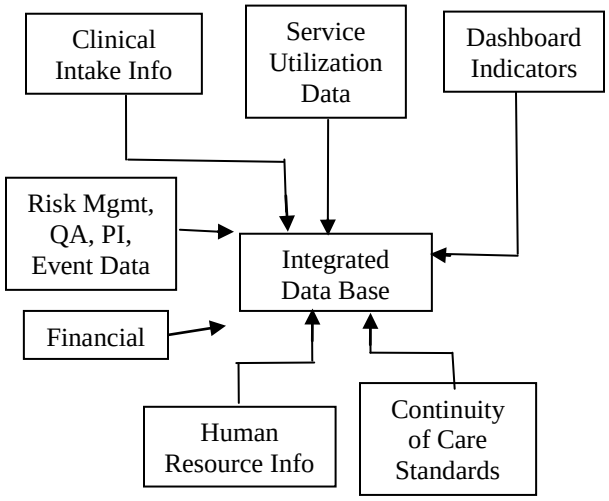
We also have more routine avenues to receive consumer or family complaints, like letters, e-mail, suggestion boxes, and web access. One of the richest sources of useful information has been the Consumer-to-Consumer Evaluation Teams. The data that has been gathered by consumers having an informal, yet structured, discussion with a fellow consumer has been an eye-opening, rewarding experience.

Category 4 – Measurement, Analysis, and Knowledge Management

1. How do you decide which operations, processes and systems to measure?

The Department's management information system (MIS) includes an integrated database consisting of data on all consumers served by its hospitals and mental health centers. This includes demographic and clinical data on consumers, service utilization, expenditures, event data, human resource data, and operational costs (Figure 4.1-1)

Figure 4.1-1



At the Departmental level, decisions about which operations and/or processes to measure are made by the senior leadership and affirmed by the DMH Commission. At the division, center, and facility levels, the manager may make decisions on additional data elements to collect and aggregate to help track daily operations.

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 and consumer outcomes in areas identified as priorities in its strategic plan. These are the services and programs most important to the stakeholders.

For our inpatient system, many of our performance measures are mandated by accrediting bodies. A measurement system called ORYX, from JCAHO, gives us the ability to compare DMH inpatient facilities with other public mental health facilities nationally on key performance measures such as readmission rates and the use of seclusion and restraints. DMH leadership reviews this comparative data monthly, and South Carolina has volunteered to be a pilot site for the development of national normative outcome data sets for an ORYX community mental health system.

2. What are your key measures?

Key measures are identified in Table 1 as they relate to the key requirements of the customers served. Key measures include direct feedback from customers and families, clinician assessment of customer improvement, and tangible measures of employment and housing.

3. How do you ensure data quality, reliability, completeness and availability for decision making?

A client information system provides individual data sets on consumers. It allows managers to monitor program performance and provides administrators with decision-making tools to manage by fact. A Master Patient Index (MPI) ties the inpatient and outpatient billing and registration systems together, resulting in a major reduction in duplicate client identifiers and facilitating the tracking of consumers across all service programs.

In partnership with our Division of Financial Services, the Information Technology Division (IT) implemented Phase I of SAP Financials on 2002. The new system, with DMH as the pilot SAP site for state agencies, decentralized purchasing and accounts payable to CMHCs and hospitals. All organizational component sites have T-1 communication circuits, providing improved performance support for SAP and web-based applications such as SAP Imaging, Report2Web, pharmacology on-line, and telepsychiatry.

Data and reports are requested on a regular basis by management 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 internal (Intranet) website and through various publications. The objective is to provide the right information to the right people at the right time to improve consumer care and organizational performance.

A report-generating software package is available to clinicians and managers system-wide with canned or customized reports generated from the integrated database. Reports can be obtained on any variable, or combination of variables, as delineated in Figure 4.1-1.

Access to the Department's data base is strictly monitored and controlled. Authorizations must be provided through supervisory channels, and all programs are password protected.

Patient confidentiality has always been a priority for the Department. New employees receive extensive training in this area and must sign a "Confidentiality of Medical Information" form prior to patient contact.

Computer programs assess the completeness of data elements to ensure that data is accurate and reliable, and all computers have anti-virus software. IT backs up all critical files on prescribed schedules and has disaster recovery capabilities per to industry standards.

The entire DMH data communication network sits behind a Check-point firewall. DMH also uses 128 bit encryption to protect DMH e-mail access. IT monitors all network devices (routers, switches, servers) for reliable and continuous connectivity.

The IT Division maintains a hotline for reporting problems with hardware and software, and each organizational component has a Systems Administrator with designated responsibilities for installing new software, trouble-shooting the system, and securing appropriate training for division staff.

4. How do you use data/information analysis to provide effective support for decision making?

The Management Dashboard contained in Table 1 (Measures of Organizational Effectiveness and Efficiency) contains an analysis of both trend and comparative data across time and against standards. These, combined with the Key Customer Performance Measures of Table 1 and the risk management analysis described in Category 6, provide managers with measures on key customer requirements for customer groups, program effectiveness, and program efficiency.

The dashboard indicators are distributed to key staff and stakeholders and are published on the Department's Intranet, and the monthly ORYX inpatient outcomes are distributed to facility directors. Management staff at CMHCs, facilities, and the administration produce reports of their choosing from a large selection of "canned" programs on financial, human resource, and clinical performance of the agency.

Best Practice Programs are measured for fidelity to the model, since research indicates that key factors such as staffing patterns, service configuration, and treatment regimen equate to treatment outcomes.

Strategic Plan accomplishments are monitored and reported quarterly. Each goal contains due dates for program development milestones. Strategic Plan program development also contains key requirements for program success. Quarterly updates on strategic plan activities and accomplishments are given at stakeholder Assembly meetings and Commission meetings.

5. How do you select and use comparative data and information?

The Department has participated for many years in efforts to develop and implement core performance measures for public mental health systems across the country. Our criteria include areas such as consumer perception of care, penetration rates, populations served, and service utilization. In 2002, states began reporting this performance data to the Federal Uniform Reporting System (URS) and receiving comparative data for the measures to use for improving planning and accountability.

The Departmental continues to examine outcome and satisfaction instruments. An ongoing committee performs a comprehensive review of professional literature to assess the strengths and weaknesses of different approaches.

6. How do you manage organizational knowledge to accomplish the collection and transfer and maintenance of accumulated employee knowledge, and identification and sharing of best practices?

The Department continues to focus on best practices for ongoing improvement in the quality of service provided. Organizational information regarding best practices is routed to general or specific audiences utilizing various methods.

- A "Data Board" has been displayed at the Central Office to disseminate information about Best Practice Programs, their locations, and plans for expansion.
- The Dashboard Indicator Report is sent to Governing Council, board chairs, the Commission, center and facility directors, and other Departmental management. It is discussed at various meetings including Governing Council, the Commission meeting, center board meetings, etc.
- In FY 04, the DMH Governing Council implemented an in-house Mentoring/ Succession Program. This eleven-month program includes monthly classroom instruction lead by DMH senior leaders and homework supervised by mentors at their home facility.
- Reports are available on the Intranet for key indicators, hospital data, service data, center data, etc.
- The risk manager distributes the results of Quality Care Review Boards to all mental health centers for implementation as appropriate.
- The director of the Office of Best Practices has arranged statewide Individual Placement and Support training with external consultants and training of trainers for sustainability; held monthly conference calls for Rural ACT teams, and consultation for Multi-Systemic Therapy expansion.

- A statewide Best Practice Advisory Group has been formed to coordinate needs assessments and dissemination of Best Practices.
- The risk manager has made presentations to the center directors and the Commission.

Category 5 – Human Resources

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

Job classifications and assignments are designed to support service delivery and the needs of the agency's consumers. While the concept of Treatment Teams has always been the norm in mental health service delivery, Best Practices Programs like ACT/PACT teams have made treatment teams a science. In addition to the benefits received by the consumers, the team concept carries a strong motivating force for job enrichment.

The Department's use of flex-time has created a win-win situation for the Department and our employees. The ability for employees to flex their hours has allowed our community mental health centers to increase their hours of operation, and consumers and families now can access mental health services outside of the normal business day.

The Department also has a tuition assistance program which allows employees to be reimbursed for classes that are beneficial to the employee's current job or to prepare the employee for other positions in the Department.

Other initiatives that employees report as motivating or encouraging to utilize their full potential include: job-sharing, which allows employees to meet their needs while still accomplishing the mission of the office; 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 which recognized 20 employees for their outstanding performance, the Department had 27 other organization events during FY 04, including a Performance Improvement Team Recognition Program.

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?**

Agency priorities and training beyond the expertise of individual units are conducted by the Institute of Behavioral Science (IBS). While the agency's training plan is driven by the strategic plan and accrediting body standards, IBS also has a Training Council for policy/priority setting. At the individual level, training and development needs are an integral part of annual employee evaluations and planning stages for the next year.

A formal training needs assessment of all staff was conducted in July 2003. Based on feedback from the 2002 needs assessment and priorities of SCDMH, the 2003 need assessment focused on clinical needs of staff. All training is prioritized using the results of the needs assessment. Opportunities for training are advertised through course catalogs published twice a year and daily e-mail announcements. Staff, in consultation with their supervisor, registers for training

through the Department's Intranet training management system (Pathlore), which tracks all classes to be held, enrollment, and completed training.

One hundred percent of new employees received a general and a job specific orientation upon hire. All clinical employees receive updates annually, specific to their facility/center. The Department has a 100% compliance with these requirements.

The Department continues to use Computerized Learning Modules (CLMs) which are 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. To date, there are 19 CLMs on-line; 15 are mandatory on an annual basis to meet CARF, JCAHO, DHEC, OSHA or requirements of other regulatory agencies. The estimated cost savings for the 15 mandatory CLMs is $1,203,345.

The Department also utilizes traditional approaches to staff education and training – classroom instruction and the state educational television system. In addition, the agency offers specific training for employees to prepare them for professional license exams and license renewal.

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

All staff receive performance evaluations at least annually based on a set of performance criteria jointly agreed to at the start of the year by both the employee and the supervisor. The criteria are specific to job descriptions which are written to conform to programmatic needs and customer requirements.

The employee and the supervisor are encouraged to meet at least once during the rating period to discuss the employee's performance and to identify problems that are preventing the employee from meeting his/her success criteria and actions to promote improvement and success.

4. What formal and/or informal assessment methods and measures do you use to determine employee well being, satisfaction, and motivation?

The state director continues to take a personal interest in communicating the agency's priorities and reaffirming the Department's commitment to its employees during these difficult times. He has visited each of the state's seventeen (17) mental health centers and the inpatient facilities during the past fiscal year to speak with staff, learn their concerns, and keep them updated on what's happening within the Department. He maintains an "open-door" policy, e-mail accessibility, and conducts quarterly "all-hands" meetings to discuss the state of the Department.

The Department's Public Affairs Office maintains a "Hotline" that allows employees to ask questions about policies and procedures or rumors. This Hotline allows the Department to get accurate information to its employees.

The Department also uses an Exit Interview process which allows individuals who have left the agency to provide written feedback to the Office of Human Resources which is then shared with the appropriate Center/Facility Directors or Division Deputy Directors. This year the Department also conducted an Employee Satisfaction Survey to determine how our employees felt about certain aspects of their work life.

5. How do you maintain a safe, secure, and healthy work environment?

(Include your workplace preparedness for emergencies and disasters.)

In addition to the employee benefits package of health, life, long-term disability, and dental insurance, 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. The Department has received no safety violations in any recent surveys.

Additional initiatives in this area include:

- The development of a "Violence in the Workplace" Directive,
- Mandatory fire and safety training for all staff,
- Safety inspections of all facilities,
- Fire/Safety Committees composed of employees and fire/safety officers,
- Pre-employment tuberculosis testing of employees, annual employee health screenings and annual Employee Health Clinic free flu shots,
- Annual wellness related activities,
- Air quality and hazardous chemical inspections of buildings,
- Inspections by quality assurance teams, Internal Audit, and Public Safety,
- Safety training conducted by safety experts from the State Accident Fund,
- BEST training to assist employees in dealing with aggressive clients
- Preferred provider agreements with healthcare practitioners to assist employees with job related injuries
- Employee clinic that, in addition to caring for and tracking work related injuries, provides immunizations, vaccines, and blood pressure readings.

6. What activities are employees involved with that make a positive contribution to the community?

- Over 40 staff and others are involved in the Palmetto Media Watch Program, which gives feedback to the media on coverage of mental health issues and how people with mental illnesses are portrayed;
- DMH's Speakers Bureau made 13 presentations to civic and community groups this past year on mental illness and stigma;
- DMH staff made 581 presentations to schools, 286 presentations to civic groups, 207 presentations to churches and other business and professional groups, and had 163 media contacts.
- The Art of recovery project, showcasing the artistic skills of people who receive care from DMH, featured 114 works from more than 20 artists. Thirty-one pieces of artwork were displayed at the Wachovia Gallery, Richland County Public Library for May is Mental Health Month. The Art of Recovery traveled to the Trauma Conference at Seabrook Island, the Cross-Cultural Conference at Myrtle Beach, the DMH Assembly at Pee Dee Mental Health Center, the SCDMH May Commission meeting at Tucker Center, and the Mental Health Association's Annual Conference.
- DMH's Teen Matters website has had over 470,000 hits since it went online in 2000.
- The Office of Public Affairs authored 16 positive news releases and received positive coverage on 11 in 25 media outlets.
- DMH's 10,691 volunteers served 340,275 hours and generated a total investment of over $10.6 million in time, money, and goods.

- DMH employees contributed $83,341.60 to the United Way, making it the largest contributor in state government.

- DMH management, senior leadership, and facility/center leadership serve their communities by participating on boards of service organizations and community initiative committees. DMH senior leaders serve on over 80 such boards, and CMHC/facility directors serve an additional 84.

Category 6 – Process Management

1. **What are your key processes that produce, create, or add value for your customers and your organization, and how do they contribute to success?**

Central to the design and implementation of services are the community and clients' needs, which are identified periodically through focus groups, surveys, suggestions boxes, etc..

Evidence-based best practices and promising practices such as Recovery, Medication Algorithms, Employment, Assertive Community Treatment, and others continue to be the basis of program development as these have demonstrated their effectiveness through their design, which is supported by fidelity scales. Standards of care from accrediting bodies guide the operational processes supporting the delivery of services and assure quality of care.

At the treatment level, the client's individualized needs, expectations, and preferences drive the treatment process and serve as the basis for an Individualized Treatment/Recovery Plan.

2. **How do you incorporate organizational knowledge, new technology, changing customer and mission-related requirements, cost controls, and other efficiency and effectiveness factors into process design and delivery?**

Customer requirements, identified through focus groups, surveys, customer feedback, and the strategic plan, are the basis for what programs are chosen for development. The design of the programs is based upon "best practice" or "evidence-based" technology that is proven to show improvement in the quality of life of our customers as well as reducing their symptoms in a shorter period of time than more traditional services.

Quite literally, the Department constructs programs based upon the reported results from research studies in the mental health field, making the agency's design process a "Science-to-Practice" methodology.

Training is provided to staff on these evidence-based best practices primarily through our Pathlore system (automated training system) and by advocacy groups such as SC SHARE and SC NAMI through workshops. Program Managers maintain close communication with agencies such as SAMHSA to keep abreast with changes in the field that will best meet the requirements of our customers.

We also look at ways to reduce barriers to the accessibility of services by developing agreements with Primary Health Care associations, expanding service hours or locations, and by co-developing programs with sister agencies.

3. **How does your day-to-day operation of these processes ensure meeting key performance requirements?**

An array of standards regulate day-to-day operations of all inpatient facilities, community mental health centers, and administration services and are made explicit in directives and policies which conform to, or exceed, state regulations as well as standards from accreditation bodies. The

standards are monitored through Quality Assurance, DMH/ DHHS Contract, Risk Management, Utilization Review, Corporate Compliance, and Continuity of Care.

The Department monitors daily inpatient admissions, discharges, and referrals to the community mental health centers to assure continuity of care. Follow-up activity post-discharge includes the timeliness and confirmation of the follow-up and timeliness of the electronic transmittal of client information from the inpatient facility to the community mental health centers. These activities are monitored regularly and reported on a monthly basis to the Centers and the Senior Management.

The Quality Assurance (QA) process includes monitors that retrospectively assess the appropriateness of care, conformance to accreditation, Corporate Compliance, and Utilization Review standards, and conformance to the DMH/DHHS contract stipulations. The result of the QA reviews identifies strengths in the clinical operations and delivery of services at the inpatient and community mental health center levels, as well as opportunities for improvements.

Risk Management monitors adverse incidents to identify trends, conduct in-depth analysis of high-risk incidents and implement recommendations. The state director receives information of any adverse incidents occurring at the inpatient facilities or any high-risk adverse incident occurring at the community mental health center within 24 hours of their occurrence. A daily report of these adverse incidents is also forwarded to the director of Quality Management, the medical director and the Legal Office.

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

Key support processes include:

- Accounting
- Procurement
- Contracts
- Information Technology
- Nutritional Services
- Physical Plan
- Vehicle Management

The key requirements for each of these processes and the performance levels for each are presented in Figure 7.5-2.

Support processes are managed by the deputy director of Administrative Services, a member of Governing Council and chair of the Business/ Operations Committee. All process improvements for this area are coordinated through monthly meetings of this committee.

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

All contracts and Memorandum of Agreements are coordinated by the Department's Contracts Office and monitored at the local level (facility or internal division or office) by a contract monitor who ensures that all provisions of the contracts and agreements are met.

The Department has approximately 1,300 contracts that serve to facilitate and/or enhance services and/or expand service capability and access. Some of these contracts include leases of real estate for clinical service provision, private providers for community housing, direct service providers as physicians, non-physician medical providers such as x-ray, lab companies and non-residential care, and local hospitals for crisis stabilization services. Information about all contracts is available to users through the agency's financial electronic system.

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

DMH measures consumer satisfaction through:

a) Adult and youth "perception of care" assessments;
b) TLC client satisfaction with living arrangements, services, staff, and quality of life; and
c) Morris Village resident satisfaction with alcohol and drug services

a) Adult and Youth Consumer Perception of Care:

For the past four years the Department has participated in a national project to develop comparative measures of consumer satisfaction. One instrument has emerged and gained national usage: the MHSIP Consumer Survey. DMH now has three years of MHSIP data assessing customer satisfaction (Figure 7.1-1).

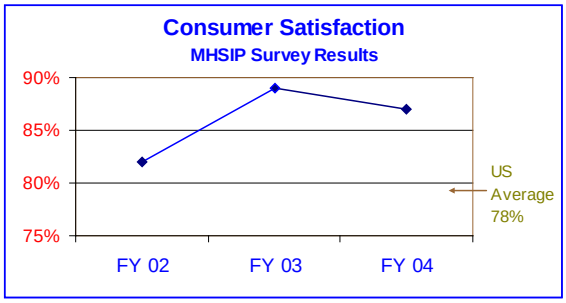


Figure 7.1-1 (Higher is Better)

The consumer ratings of satisfaction are equal to, or better than, the optimal levels achieved by other states in the domains of Access to Care; Perceived Quality of Care; Satisfaction with Treatment Outcomes; and Involvement in Treatment Planning.

The Youth Services Survey and the Family Satisfaction Survey (also a MHSIP product) were introduced by the Department this year to begin capturing data from these two groups of customers.

The Youth Survey satisfaction level was 84.5%, and the Family Satisfaction level was 86.7%. School administrator satisfaction levels were also assessed this year for School-Based Programs. Ninety-six percent (96%) of school administrations rated their satisfaction level as high.

b) TLC Program Consumer Satisfaction: Consumers in the TLC Program have been long-term residents of inpatient facilities and it is critical that their community living arrangements be appropriate and that they receive intensive case management services.

The majority of TLC clients, about 74%, report that they are satisfied with their living arrangement (Figure 7.1-2). Only a very small percentage indicate a desire to return to the hospital.

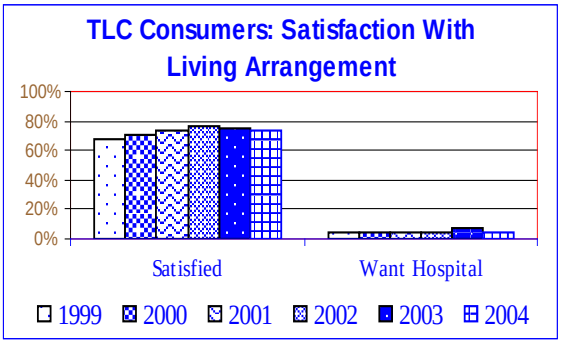


Figure 7.1-2 (Higher is Better for "Satisfied"; Lower is Better for "Want Hospital")

When asked to evaluate their "Quality of Life," TLC consumers consistently reported higher scores after becoming part of the program (Figure 7.1-3). Pre/Post scores are statistically significant at the $p < 0.001$ level.

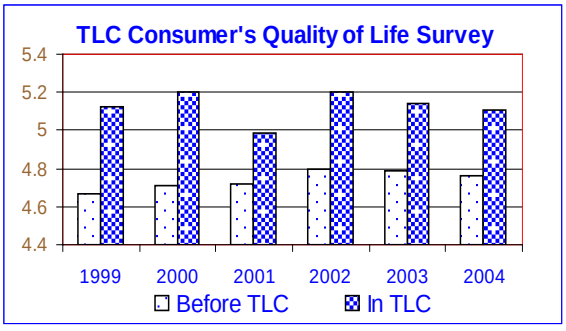


Figure 7.1-3 (Higher is Better)

Clearly, the intense services received by TLC consumers make a dramatic difference in how

they perceive their world. As they feel better about their quality of life, their mental status, self-concept, and well-being improve, which serves to impact positively their recovery.

TLC clients are asked how they feel about the mental health services they receive and the mental health staff (Figure 7.1-4). 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.

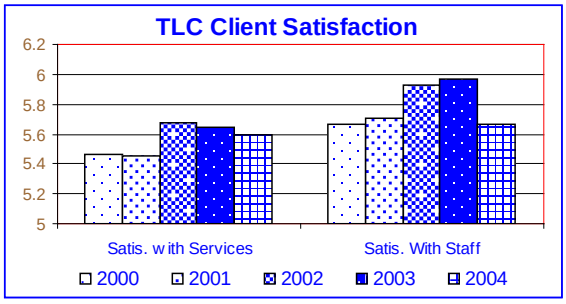


Figure 7.1-4 (Higher is Better)

c) Alcohol and Drug Addiction Inpatient Services:

Morris Village residents report a consistent trend of patient satisfaction, even for services provided to a patient population that is 65% involuntarily committed for treatment (Figure 7.1-5).

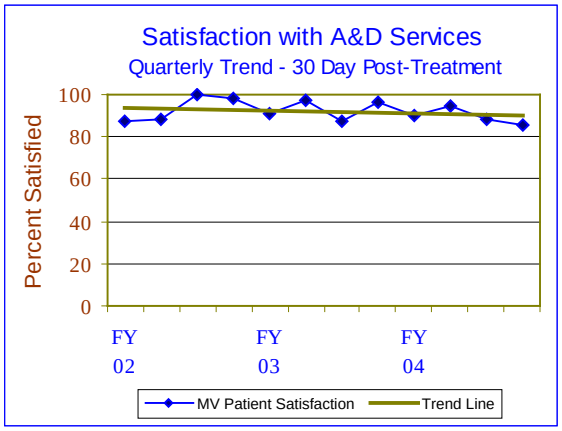


Figure 7.1-5 (Higher is Better)

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

The DMH measures for mission accomplishment and organizational effectiveness are presented in summary form in Table 1. In detail, they may be grouped, as follows:

a) Service Penetration into the Community
b) Child & Adolescent Clinical Outcomes
c) Adult Clinical Outcomes
d) Alcohol and Drug Addiction Services
e) Nursing Home Clinical Outcomes
f) CMH Services Clinical Effectiveness
g) Inpatient Services Clinical Effectiveness
h) Consumer Quality Of Life Outcomes
i) Program Development Outcomes

a) Services in the Community:

Development of a community-based system of care is core to the Department's philosophy and has been a driving force in program development through the past three strategic plans. DMH assesses the extent to which it serves the adults and children who need mental health services (penetration rate), and compares its efforts to other state's "level of penetration."

DMH is currently well above the national average in its efforts to reach into the community to provide services to South Carolina citizens, as reflected in the penetration rates in Figure 7.2-1

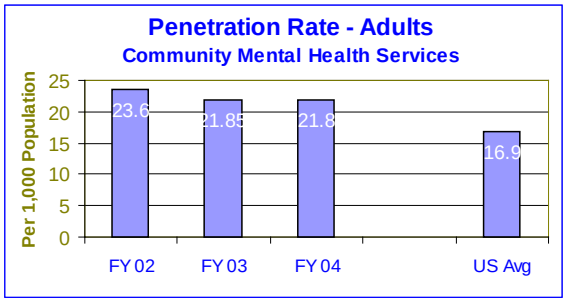


Figure 7.2-1 (Higher is Better)

DMH has continued to increase its focus on providing services to children and adolescents. Penetration data (Figure 7.2-2) shows that we continue to almost double the national average in children served under the age of 17.

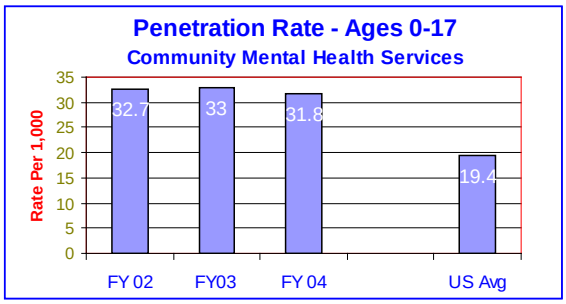


Figure 7.2-2 (Higher is Better)

The actual number of persons, all ages, served through the community centers from FY 98 - FY 04 is shown in Figure 7.2-3.

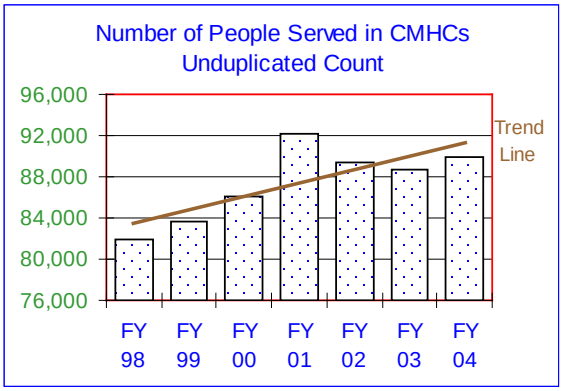


Figure 7.2-3 (Higher is Better)

b) Clinical Outcomes: Child and Adolescent Services.

Children and adolescents are clinically assessed at admission and discharge. Our child clinical instrument is the CAFAS, which assesses psychiatric symptoms as well as functional abilities in school, at home, with peers, and in society.

Of the four CAFAS scoring categories (Minimal, Mild, Moderate and Severe), the Moderate and Severely Impaired individuals meet the DMH definition as a priority population: severely emotionally disturbed.

Figure 7.2-4 shows the degree of improvement for these children following treatment. Over 60% of the children improve their CAFAS scores. About 44% show a significant improvement, moving at least one full category level.

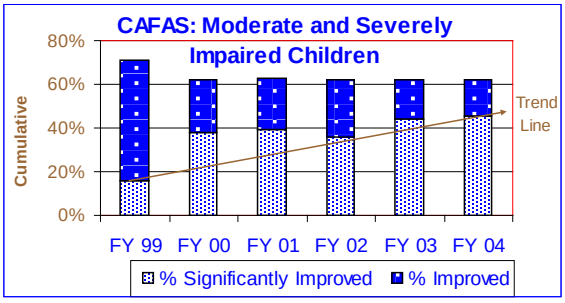


Figure 7.2-4 (Higher is Better)

As indicated by the trend line, treatment effectiveness producing significant positive change for the most emotionally disturbed children continues to increase.

Wrap Services. In its strategic plan the Department set a goal of increasing wrap-around services to children with serious emotional disorders and to their families by 10% each year (Figure 7.2-5). In two years, the expansion of these programs has produced a seven-fold increase in the number of families served.

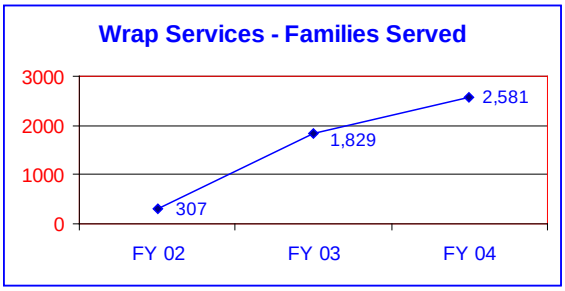


Figure 7.2-5 (Higher is Better)

MultiSystemic Therapy. The MST program is an evidence-based practice providing intensive in-home treatment to children within the family context. Figure 7.2-6 shows statewide results toward keeping the children in school, living at home, and out of trouble with law enforcement.

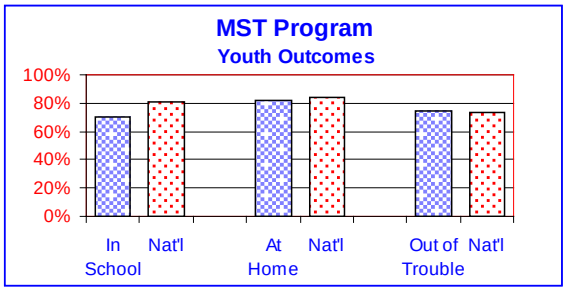


Figure 7.2-6 (Higher is Better)

c) Clinical Outcomes: Adults Services. Adult consumers are clinically assessed at admission and at discharge with a self-administered instrument called the BASIS 32, which rates the individuals' level of symptoms and their ability to apply everyday life skills.

Figure 7.2-7 shows adult admission scores on the BASIS 32 and subsequent scores following treatment. While there are discharge scores for some years, the number is relatively small.

The higher the score on the BASIS 32, the more severe are the symptoms and the poorer the daily living skills. Consumers who continue to receive services for extended periods may receive any number of "mid-treatment" assessments.

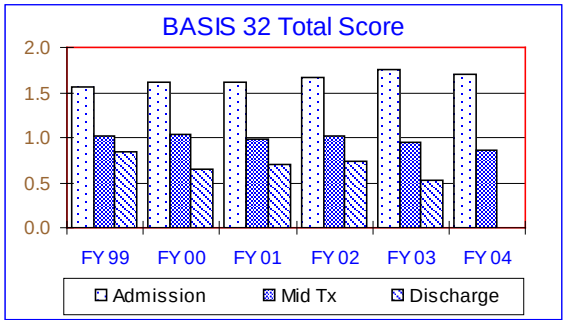


Figure 7.2-7 (Lower is Better)

With seriously mentally ill consumers, there is a leveling-out of improvement after the initial reduction in the severity score (admission to mid-treatment). Even with this leveling-out, there is another 25% drop in scores between mid-treatment and discharge.

Figure 7.2-7 also shows that admission scores have been rising slightly over the years, possibly suggesting the Department's focus on more severely impaired consumers.

Figure 7.2-8 shows the amount of improvement between admission and mid-treatment. Consumers, in general, improve their level of functioning about 40-50% from admission to mid-treatment, and the rate of improvement is increasing each year.

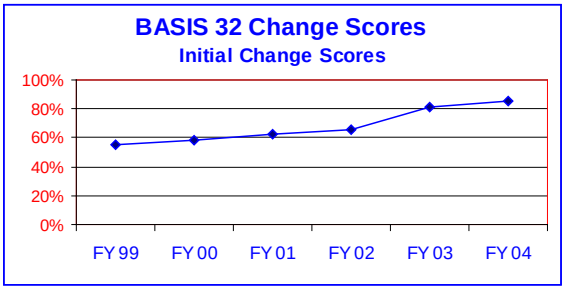


Figure 7.2-8 (Higher is Better)

The Department is transitioning from the BASIS 32 to the GAF, an assessment that will allow us to use national norms for comparative data.

Co-Occurring Disorders. Within the population of mental health consumers, individuals with a dual diagnosis – mentally ill and substance abuse – require clinical interventions even more intensive than other individuals served by DMH. As such, the development of evidence-based programs to treat co-occurring disorders is a high priority.

While preliminary results show a relatively high level of satisfaction with services (Figure 7.2-9), the clinical outcome data for this new programming is not yet available.

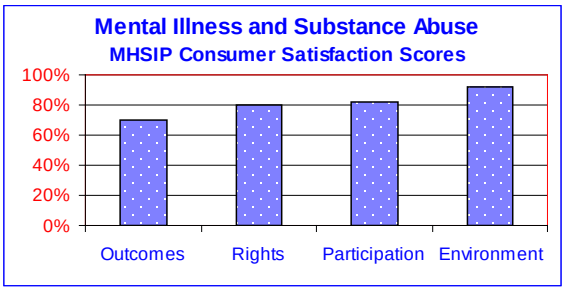


Figure 7.2-9 (Higher is Better)

TLC Consumers. The TLC program has a well established history of transitioning residents from long-term care psychiatric inpatient facilities to living in the community (Figure 7.2-10).

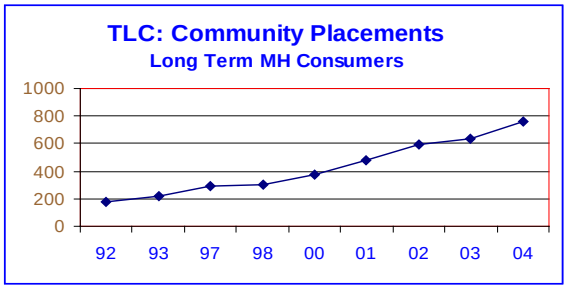


Figure 7.2-10 (Higher is Better)

As TLC funding of community placement has grown over the past nine years, returning long-term, severely mentally ill consumers to the community, the program's growth parallels the shrinking census of the long-term psychiatric hospitals (Figure 7.2-11).

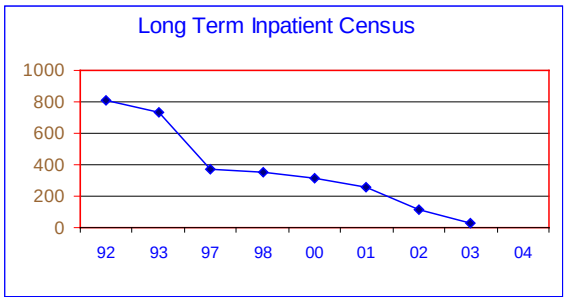


Figure 7.2-11 (Lower is Better)

Participants in the TLC program receive intensive support through the Community Mental Health Centers, helping them adjust to community life and secure daily living skills. Community life for these severely mentally ill individuals does not mean that they will never need hospital care, but with the intensive case management services provided through CMHCs their need for hospitalization is greatly reduced.

There is a 96% reduction in the total number of hospitalization days per year (Figure 7.2-12) for TLC program participants. There is also an 82% reduction in the frequency of hospitalizations.

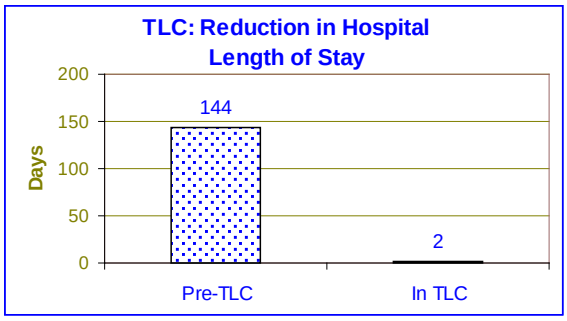


Figure 7.2-12 (Lower is Better)

Adult Criminal Justice Diversion. A best practice designed to keep mentally ill individuals out of the criminal justice system has been initiated in two urban locations, with two rural locations coming on-line this year.

Although preliminary, the results are very promising. Figure 7.2-13 shows a significant reduction in key measures of criminal justice involvement and factors that frequently lead this population to incarceration.

Adult Criminal Justice Diversion			
	Baseline	Year End	Change
Arrests	74	26	-65%
Days is jail	3,019	935	-69%
Psychiatric Symptoms	50	63	-25%
Persons Homeless	15	1	-93%
Days Homeless	1,484	1,056	-29%
Persons Employed	22	27	+24%
Days Employed	2,891	3,215	+11%

Figure 7.2-13

The Rural Behavioral Health Services. The RBHS Program is an evidence-based rural ACT program which serves severely mentally ill persons in their home communities. South Carolina DMH is able to compare MHSIP Consumer Survey results with 16 other states that have rural ACT programs on four measures: satisfaction with access to services; satisfaction with quality of services; satisfaction with treatment outcomes; and satisfaction with involvement in the treatment goal-setting (Figure 7.2-14).

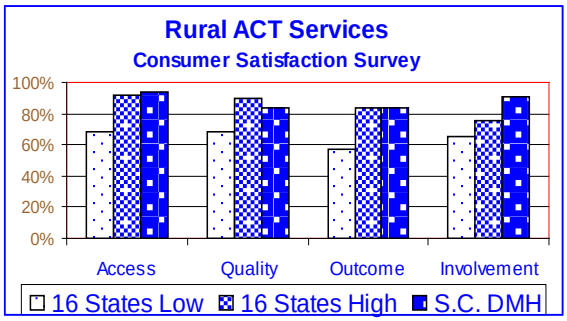


Figure 7.2-14 (Higher is Better)

d) Clinical Outcomes: Alcohol and Drug (A&D) Addiction Services.

The key measure for effectiveness with A&D consumers is abstinence following treatment (Figure 7.2-15). Seventy-nine percent (79%) of Morris Village residents were abstinent at 30-day follow-up in FY 04, and the trend line continues to increase.

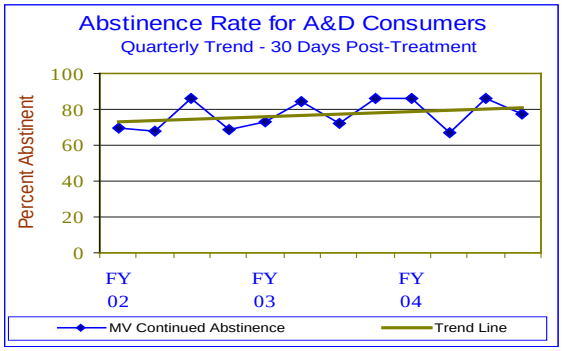


Figure 7.2-15 (Higher is Better)

e) Clinical Outcomes: Nursing Home Residents.

The national life expectancy following admission to a nursing care facility is slightly over one year. At Tucker Nursing Care Center, residents average six and half years, and it is increasing each year (Figure 7.2-16).

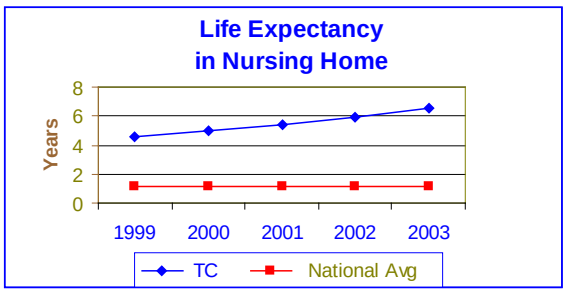


Figure 7.2-16 (Higher is Better)

Two critical factors in the increased longevity of Tucker Center residents are the low incidence of bed sores (Figure 7.2-17) and the low rate of falls (Figure 7.2-18), both common occurrences in homes for the elderly and both life-threatening.

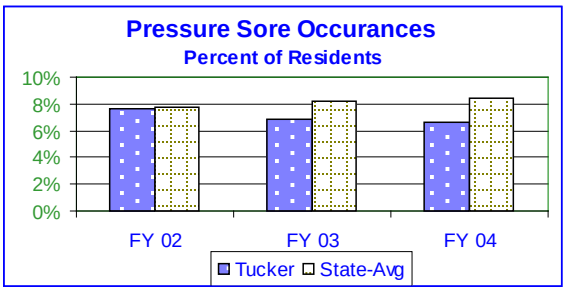


Figure 7.2-17 (Lower is Better)

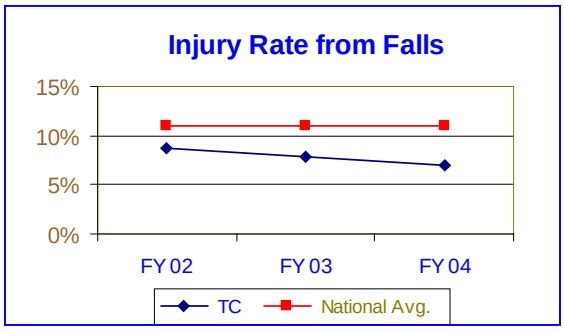


Figure 7.2-18 (Lower is Better)

f) CMHC Services Clinical Effectiveness

In a community-based system of care, mental health centers have an array of services to stabilize individuals in crisis and divert admissions to hospitals when clinically appropriate. Figure 7.2-19 shows the dramatic reduction in psychiatric hospital admissions over the past eight years.

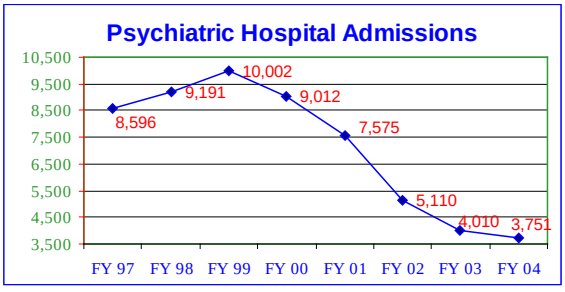


Figure 7.2-19 (Lower is Better)

When persons are hospitalized, research indicates that the sooner a person is seen by

the community mental health center following discharge from an inpatient facility, the less likely the consumer will be readmitted for subsequent inpatient care.

Senior management and the Commission review data monthly on the number of days between inpatient discharge and the date of their first appointment at a local community mental health center (Figure 7.2-20).

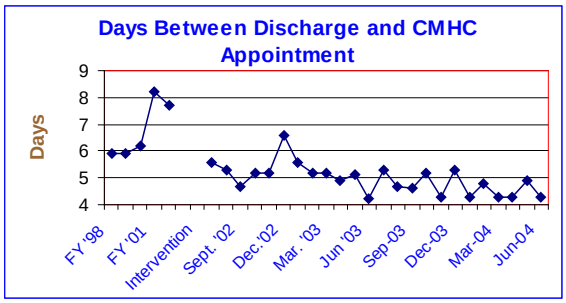


Figure 7.2-20 (Lower is Better)

The steady rise in the number of days from discharge to CMHC appointment in FY 99 and into FY 02 (Figure 7.2-20) is an undesirable trend and caused DMH management to initiate improvement activities. The quality improvement intervention reduced the number of days between inpatient discharge and follow-up appointment at local CMHCs. The FY 04 average is 4.3 days.

In late 2003, emergency rooms around the state began having an increase in the number of persons awaiting admission to inpatient psychiatric hospitals. DMH responded with major initiatives to reduce the burden that was being placed on these hospitals and communities crisis centers.

From a high of 86 persons in March 2004 to 36 in June (Figure 7.2-21), DMH continues to increase the manpower devoted to crisis services. Reports also indicate a decrease in the number of hours individuals wait in emergency rooms for hospital admission (Figure 7.2-22). While the emergency room crisis continues to be a high priority, long term solutions will require a concerted effort of the key partners: DMH, S.C. hospitals, the Department of Alcohol and Other Drug Services, and consumer advocacy groups.

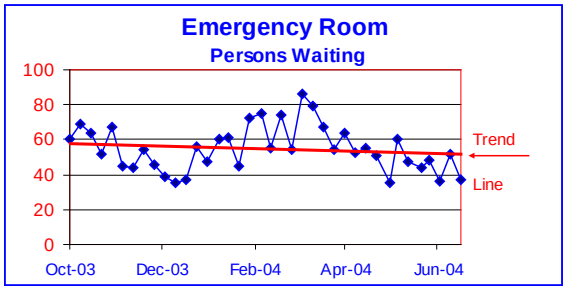


Figure 7.2-21 (Lower is Better)

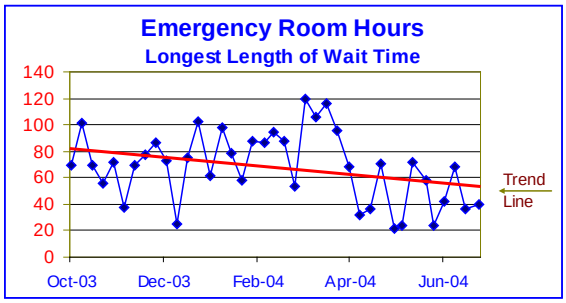


Figure 7.2-22 (Lower is Better)

Similarly, when the number of persons waiting in jail for pre-trial psychiatric evaluation began to rise in July 2002, DMH leadership initiated a quality team to restructure the admission and evaluation process.

Figure 7.2-23 shows the number decreasing from a high of 62 in September 2002 to 2 in June 2004.

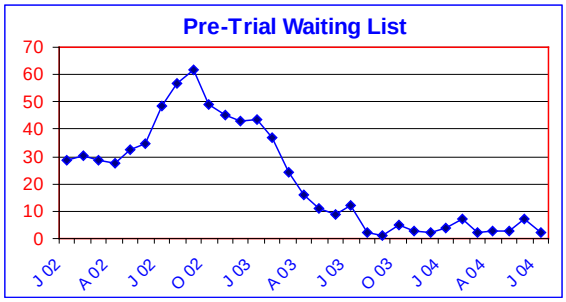


Figure 7.2-23 (Lower is Better)

g) Inpatient Services Clinical Effectiveness

Senior leadership reviews key performance data monthly for each inpatient facility. The

measures include 30-day readmission rates, restraint hours, and seclusion hours.

These measures are broad indicators of the quality of inpatient care. A low readmission rate reflects adequate inpatient treatment as well as solid follow-up and maintenance in the community following discharge.

The use of seclusion rooms and restraints in the care of psychiatrically disabled, while medically necessary at times, is an indicator that DMH management would like to reduce.

30-Day Readmission Rate: Percent of admissions to facilities, occurring within 30 days of a previous discharge of the same client from the same facility.

Figure 7.2-24 shows that DMH remained below the national average in all but 2 of the 32 months shown.

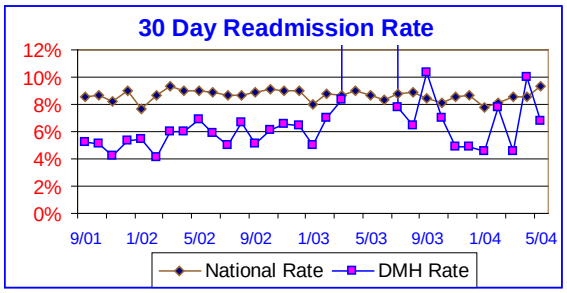


Figure 7.2-24 (Lower is Better)

Restraint Hours: The number of hours that clients spend in a physical restraint for every 1,000 inpatient hours. For example, a rate of 1.6 means 2 hours were spent in restraint for each 1250 inpatient hours. Figure 7.2-25 compares the hours of restraint used at DMH facilities to the national average.

DMH scores vary widely on this measure and occasionally exceed the national rate due to the inclusion of forensic unit patients where ambulatory restraints are used for assaultive clients. Adult psychiatric facility restraint-hours scores are well below the national average.

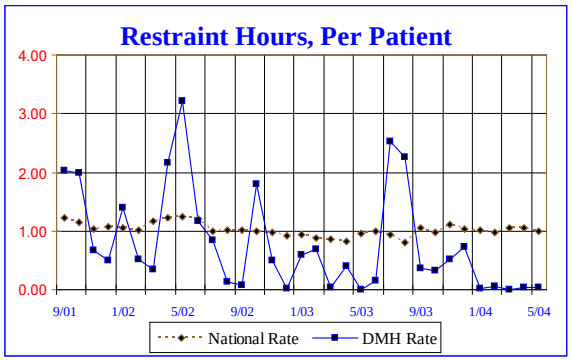


Figure 7.2-25 (Lower is Better)

Seclusion Hours: Number of hours spent in seclusion for every 1,000 inpatient hours. For example, a rate of 0.8 means that 1 hour was spent in seclusion for each 1250 inpatient hours. Figure 7.2-26 compares the hours of patient seclusion used at DMH facilities to the national average.

The national per patient average appears to be dropping as has the DMH average.

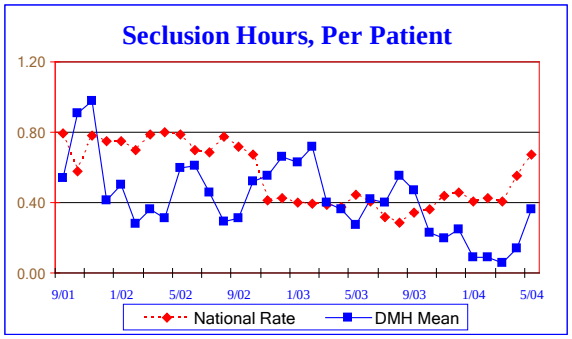


Figure 7.2-26 (Lower is Better)

h) Consumer Quality of Life Outcomes: Consumer recovery is closely tied to quality of life. Consumers want housing that is safe, affordable, and decent and employment that is productive. These two factors are major contributors to a consumer's transition from a life of dependency on the mental health system to independence and self-reliance.

In 2004, DMH exceeded the national average in employment rate for all mentally ill consumers it serves (Figure 7.2-27).

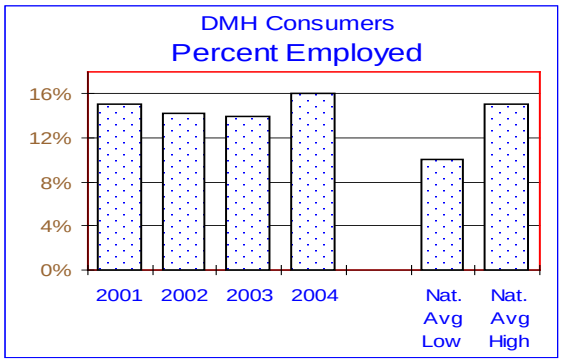


Figure 7.2-27 (Higher is Better)

DMH has made securing competitive employment for mental health consumers a high priority and has strengthened its ties to the Department of Vocational Rehabilitation, as reflected in referrals to that agency and the number of consumers classified by SCDVR as successful closures (competitively employed and stable for 90 days).

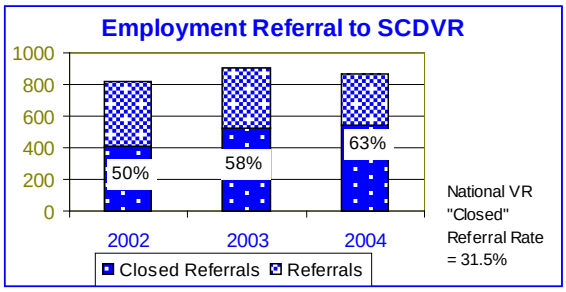


Figure 7.2-28 (Higher is Better)

While the DMH/VR partnership has produced a 63% closure rate (competitive employment), the nation competitive employment rate is 31½ % (Figure 7.2-28).

The department has also expanded the number of evidence-based employment programs, adding two (2) new programs this year.

While not yet reaching the national best-in-class program (Figure 7.2-29), the IPS Employment Programs effort in South Carolina produces an employment rate twice that of traditional supportive employment programs.

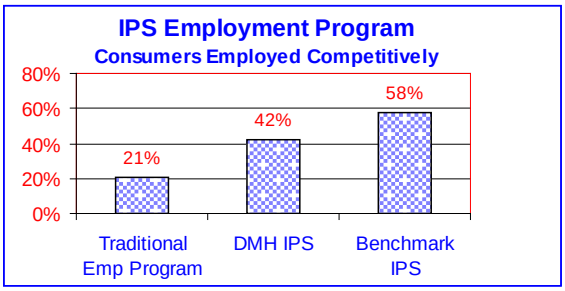


Figure 7.2-29 (Higher is Better)

The Department's Housing and Homeless Program for consumers with severe and persistent mental illness has shown major advances since inception (Figure 7.2-30). Working through partnerships with private nonprofit organizations and local mental health centers, the Department is able to finance the production of new supported housing that is affordable for consumers living in the community.

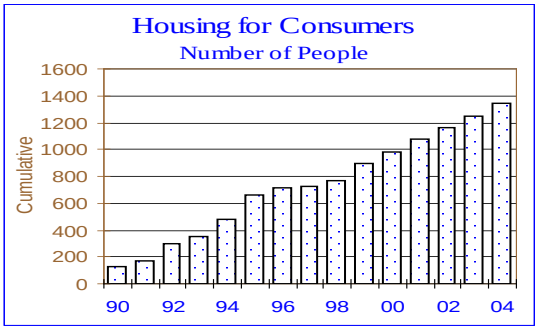


Figure 7.2-30 (Higher is Better)

The Housing Program, combined with the TLC Program, has added 216 new units of housing in the community this year for severely mentally ill individuals.

i) Program Development Outcomes: Continuing the implementation schedule established in the 2001 strategic plan, DMH made major strides in its effort to expand best-practice programs and to undertake initiatives set as priorities by stakeholders.

Figure 7.2-31 summarizes the strategic plan programmatic development goals of FY 04 and the agency's performance.

C&A Programs	FY 04 Strategic Goals	Performance
School-Based Programs	Establish 40 new Programs	Achieved
MST	Establish 3 new Programs	Not achieved
Wrap	Establish 6 new Programs	Achieved
Juvenile Justice Diversion	Establish 2 new Programs	Achieved
Trauma	Implement assessment	Achieved
	Train Staff in assessment	Achieved
	Establish 2 new Programs	Achieved
Adult Programs	**FY 04 Strategic Goals**	**Performance**
Employment	Establish 2 new Programs	Achieved
Housing	50 Additional Housing Units	Achieved
ACT/PACT	Establish 4 new Programs	Not achieved
Dual Disorders	Programs in all CMHCs	Not achieved
Criminal Justice Diversion	Establish 1 new Program	Achieved
Medication Algorithm	Evaluate fidelity of pilot project	
Recovery	Assess staff in Recovery philosophy and knowledge	Achieved
Administrative	**FY 04 Strategic Goals**	**Performance**
Public Education	Expand Speakers' Bureau	Achieved
	Develop PSAs	Achieved
Data Systems	Establish system-wide data entry & retrieval system	Partial
Cultural Competence	Assess workforce and develop curriculum	Achieved

Figure 7.2-31

Thirteen program development goals were achieved in full. Of the three marked not achieved, lack of funds was the key factor; grant funds were to be the major source of expansion funds.

While data entry scanners have been installed in a few sites for clinical data entry, they are not yet installed in CMHCs, and much of the outcomes system is still manually entered.

7.3 What are your performance levels for the key measures of financial performance?

State appropriations continued to be cut in Fiscal Year 2003-2004. After an interim budget cut, DMH's state recurring and non-recurring funds totaled $172.6 million, down from its highest point of $203.4 million in FY1999-2000 (Figure 7.3-1). Despite that fact, DMH has operated within its budget and has not run a deficit, a significant achievement considering state appropriations account for half of the DMH budget.

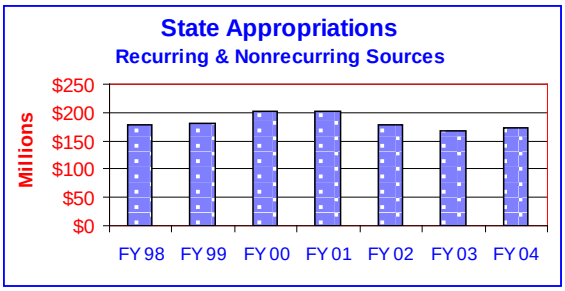


Figure 7.3-1 (Higher is Better)

Figure 7.3-2 shows how the levels of major sources of revenue for the Department have changed over the last four years. In previous years of budget cuts, the Department's concentration on its core population had brought about an increase in Medicaid revenue that made up for state budget cuts. Unfortunately, it appears that the toll from state cuts could not be abated forever, as FY2004 numbers indicate that Medicaid revenue has fallen compared to FY2003.

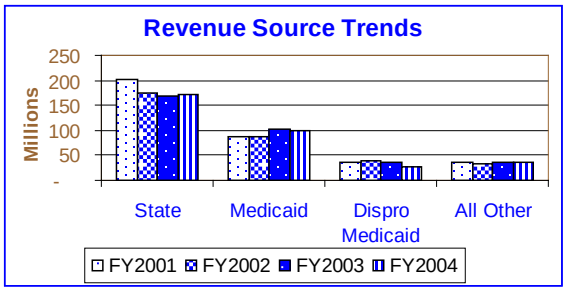


Figure 7.3-2 (Higher is Better)

Other sources of revenue are so much smaller in comparison to state appropriations, Medicaid, and disproportionate share Medicaid that fluctuations in the other revenues' levels barely affect the bottom line. DMH has to maintain its state funding, which in turn matches Medicaid revenue, to keep financial results at a level that will maintain services.

The Department has made some gains to offset these losses through an aggressive grant-seeking campaign, generating additional revenue from non-state sources, and reducing the use of expensive inpatient bed utilization by expanding community crisis programs.

In FY 2004, DMH was awarded $8.7 million new grant dollars (Figure 7.3-3) to expand best practice programs, a major accomplishment in a time of diminishing resources, federal, as well as state.

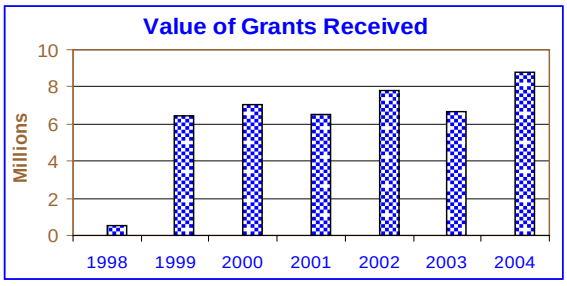


Figure 7.3-3 (Higher is Better)

In an effort to generate non-state revenue, the Department has successfully increased Medicaid reimbursable services to priority populations. Through contracts with Health and Human Services, DMH bills for services rendered to Medicaid eligible mental health consumers served in community programs.

For example, approximately 55% of the patients admitted to community crisis units are Medicaid-eligible. While inpatient psychiatric care cannot be billed to Medicaid, community crisis stabilization units can.

The average cost of an admission to a psychiatric hospital is $3,052, versus $975 for the cost of admission to a local crisis stabilization unit. Expanding community programs and reducing inpatient use not only conforms to stakeholder expectations, but it is also more cost effective.

Figure 7.3-4 shows that DMH has actually increased billable hours of service to its priority populations: severely mentally ill adults and emotionally disturbed children, in essence, providing more services to key customer groups with less money.

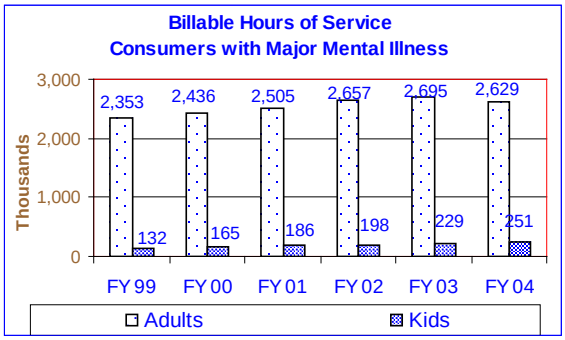


Figure 7.3-4 (Higher is Better)

The TLC program, begun in 1991, is designed to return long-term psychiatric inpatient consumers to live in the community through intensive support from CMHCs. To date, over 1,210 long-term inpatient residents have participated.

Not only is community-based treatment the right thing to do, it is also financially a much more efficient use of fiscal resources.

Data compiled last year compared Pre-TLC hospitalization costs to all costs associated with an individual's TLC enrollment (hospitalizations, CMHC case management,

etc.). For all TLC individuals there was a $34M cost savings directly attributable to TLC Program participation (Figure 7.3-5).

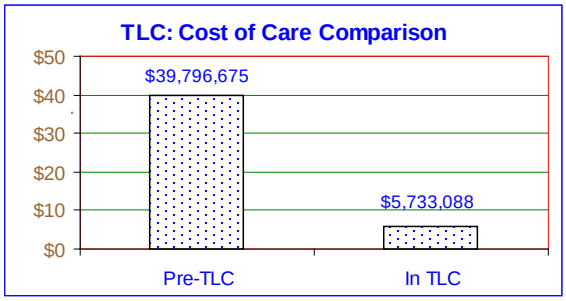


Figure 7.3-5 (Lower is Better)

Figure 7.3-6 illustrates these figures on an average, per person basis. The Department is able to spend an average of $93,833 less on each consumer by providing intensive community-based services than it spent providing institutional care.

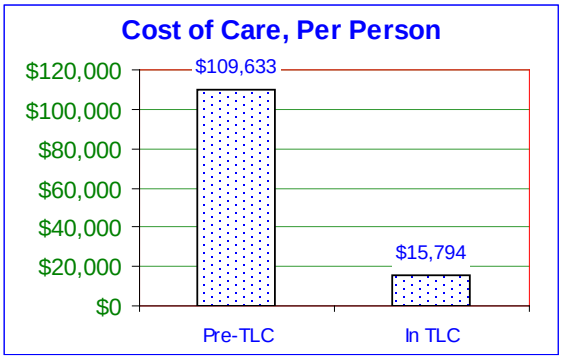


Figure 7.3-6 (Lower is Better)

It is for all of these reasons that the Department aggressively promotes crisis programs in the community to prevent unnecessary hospitalizations and promotes community preparation programs in the inpatient facilities to assist consumers in learning the life skills they need to succeed in their community transition.

Community expansion has not been achieved at the expense of inpatient programs, but through new dollars and Medicaid revenue (Figure 7.3-7). Community expenditures have risen, while inpatient expenditures have decreased slightly.

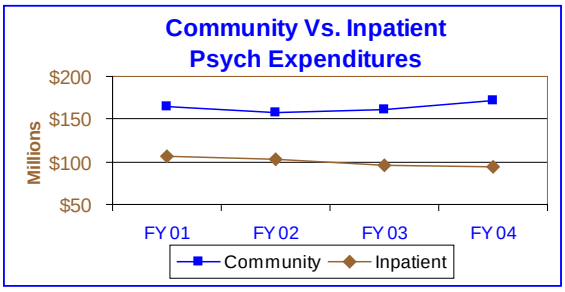


Figure 7.3-7 (Higher is Better for Community; Lower is Better for Inpatient)

The commitment to community-based services has allowed DMH to reduce hospital beds, close wards, and move funding into the community to generate new programs.

In keeping with its mission, the priorities of its stakeholders, and its responsibility as a good steward of the public dollars, DMH is Making Recovery Real for the mentally ill citizens of South Carolina.

7.4 ***What are your performance levels and trends for the key measures of human resource results (performance measurement, employee satisfaction, well-being, learning and development, employee diversity, and retention)?***

In FY 04, SCDMH conducted an employee satisfaction survey to assess workforce issues and establish baseline data for improvements. In the area of employee satisfaction (Figure 7.4-1), 86% of employees reported that they were satisfied or very satisfied with their job.

Figure 7.4-1 (Higher is Better)

This level of staff job satisfaction is particularly impressive when considered within the context of the stresses and insecurities produced by budget cuts in recent years. Despite enormous budget cuts in the

past five years that resulted in the loss of over 900 employees, our turn-over rate is below the average of other human service agencies (Figure 7.4-2).

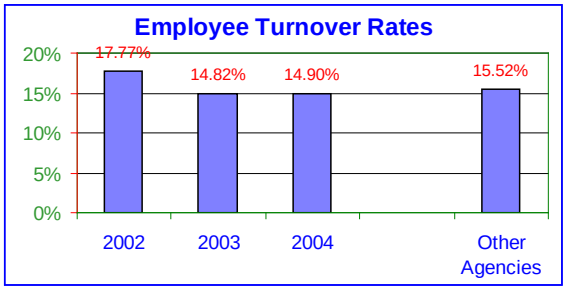


Figure 7.4-2 (Lower is Better)

In keeping with the Department's strategic plan and its commitment to serve consumers in their local community, the agency has shielded its community system from these reductions by reducing the size of its inpatient and administrative workforce (Figure 7.4-3).

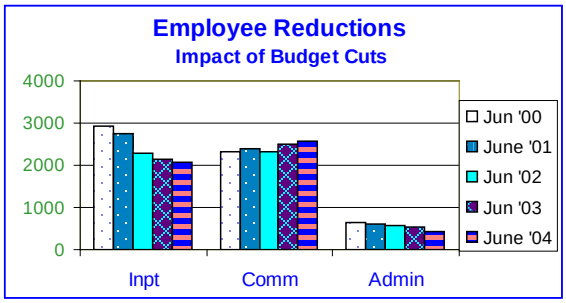


Figure 7.4-3

These staff reductions, in areas serving non-priority consumer groups (central administration and inpatient), were accomplished, for the most part, through attrition, or staff were offered reassignment to positions vacated through attrition.

In the FY 04 employee satisfaction survey, 77% agreed or strongly agreed with the statement that they perceived their work as contributing to the mission of the agency (Figure 7.4-4), a measure of an employee's sense of involvement.

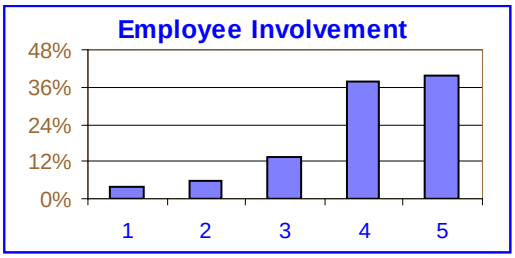


Figure 7.4-4 (Higher is Better)

All employees are rated annually using the state Employee Performance Management System (EPMS). Figure 7.4-5 displays the performance rating over the past three years.

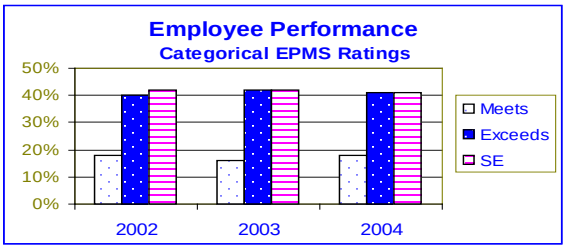


Figure 7.4-5

In the area of staff development, 60% of employees responded in the FY 04 Satisfaction Survey that they received adequate training to perform their job (Figure 7.4-6).

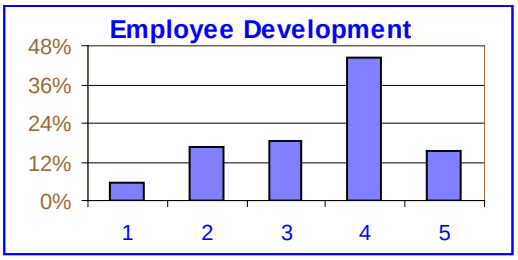


Figure 7.4-6 (Higher is Better)

The Staff Development and Training section in FY 04 offered 458 hours of training conducted either through classroom instructions, or on-line modules Figure 7.4-7).

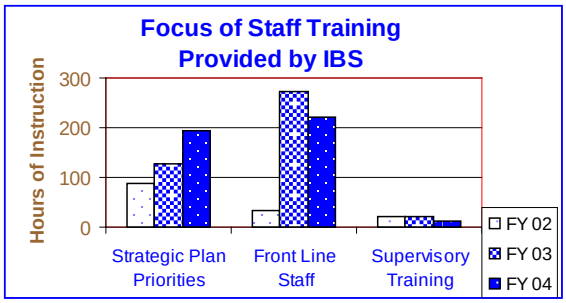


Figure 7.4-7 (Higher is Better)

There were 194 hours directly related to meeting the needs of the strategic plan, and 222 hours focused on development of front line staff. In addition, 12 hours of supervisory training and 30 hours of mentoring/succession training were offered.

Concern for employee safety and actions to improve the working environment are reflected in reduced Workers' Compensation claims (Figure 7.4-8).

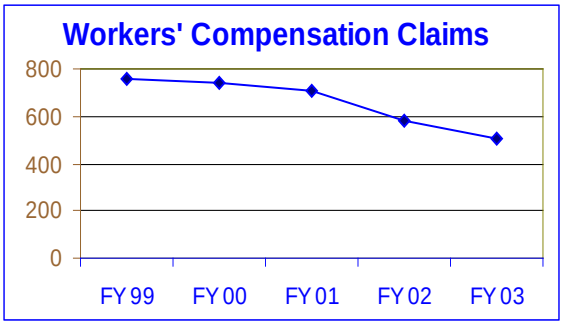


Figure 7.4-8 (Lower is Better)

In affirmative action, DMH continues to be a leader among large state agencies, moving from a ranking of 10th in FY 02, to 8th in FY 03, to 7th in FY 04.

Figure 7.4-9 illustrates the percent of affirmative action goals met by the agency since FY 02.

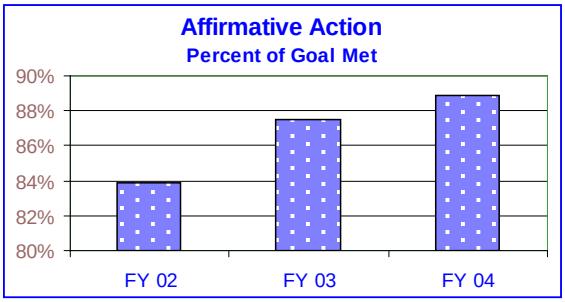


Figure 7.4-9 (Higher is Better)

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

DMH is subject to review/audit/survey by a wide variety of bodies. Figure 7.5-1 provides an overview of many of these bodies, their function, and the status of our most recent review.

All community mental health centers, all inpatient facilities, and all administrative functions are in compliance and fully accredited in all of the areas noted in the table.

Figure 7.5-2 identifies the department's key support processes, many of which are subject to regulatory compliance. Each process includes the key requirements for the process and a summary statement noting its compliance.

Figure 7.5-1	**Legal and Regulatory Compliance**	
AGENCY OR ENTITY	**FUNCTION**	**Current Status**
CARF	National Accreditation	All CMHCs accredited
JCAHCO	National Accreditation	All inpatient facilities accredited
VA	National Accreditation of Veterans' Nursing Homes	In compliance
HHS Program Integrity Audit	Medicaid Division of Corporate Compliance	In compliance
HHS Program Staff Field Review	Review of programs and documentation to identify training and compliance issues.	In compliance
DMH Quality Assurance Team	Review of client care practices and medical records documentation for quality of care, accreditation and corporate compliance issues.	In compliance or action plan to achieve compliance
DMH Internal Audit	Review of administrative practices, policies and procedures for compliance with DoFS, Human Resources, and other regulations.	In compliance or action plan to achieve compliance
DMH Corporate Compliance	Regular review by DMH for conformance with DMH Corporate Compliance Plan	In compliance
DHEC	Inspection of CRCFs operated by Centers for conformance with regulations.	In compliance
DHEC	Inspection of day programs preparing food for conformance with sanitation regulations.	In compliance
DHEC	Inspections of inpatient facilities for compliance with regulations.	In compliance
Fire Marshal	Inspection of facilities for fire safety	In compliance
Medicare Professional Review Organization	Review of medical records to determine appropriateness of Medicare reimbursement—contract organization of SC Blue Cross Blue Shield	In compliance
ADA	Regulation of access for disabled	In compliance

Figure 7.5-2	**Key Support Processes**	
Process	**Key Requirements**	**Status**
DOAS (as a whole)	The Division of Administrative Services (DOAS) will not overspend its budget.	Goal met in FY 04.
Accounting	No significant audit findings as a result of the Agreed Upon Procedures Audit by State Auditors	No significant findings in most recent (June 30, 2002) audit.
	STARS reconciliations are performed accurately and timely (during the month following the reconciliation period).	DMH has reconciled with STARS as of June 30, 2003.
	Composite bank account reconciliation's are performed within 30 days after receipt of the bank statement.	Goal being met.
Procurement	Process procurement request up to $10k within 5 working days; $10k and $25k within 15 working days; and above $25 k within 28 working days	Goals are being met
Contracts	Processing time for contracts at four days or less.	Average processing time is 3.5 days
	Utilize the RFP process to test/control the use of sole source contracts.	25 RFPs processed in FY04
Information Technology	Database applications will be backed up sufficient to recover any database up to the most recent log file.	No significant data loses reported.
	Protect user data from virus infection using real-time virus protection software.	100% of infected files are cleaned, quarantined or deleted.
	Client Systems must comply with Federal HIPAA regulations by October 2003.	Tested 837+835 Medicare transactions and codes. Need to test with Medicaid
	Archive vital medical and financial records.	Goal met.
Nutritional Services	Provide nutritious, appetizing and satisfying meals for all of DMH consumers within annual budget.	Goals are being met
	Provide up-to date, culturally sensitive patient/ family nutrition opportunities and materials per JACHO standards.	Goals are being met
	Complete nutrient analysis of current menus and assure that therapeutic menus are consistent with SC Dietetic Association diet manual.	Goal met
	Maximize Sales (revenue) for department through, CF Canteen, CAMHC programs and special events.	Goal met
	Minimize the annual operation loss for CF Canteen, by increasing sales, labor optimization / productivity and internal control.	Goal met
Physical Plant	Insure that all capital projects are completed within approved budgets.	Goal met
	Provide living environments in compliance with all regulatory requirements and standards.	Goal met
	Provide efficient, cost effective building and grounds maintenance.	Costs per square foot were 35% less than industry average and 23% less than that reported by General Services
Vehicle Management	Ensure that all vehicles and equipment repairs are conducted in the most cost efficient manner.	Cost per vehicle mile was 38% less than overall state agency average. High value repairs 46% below industry average.
Human Resources	See Category 7.4 for HR discussion	See Category 7.4 for HR results.

Glossary of Terms and Abbreviations

ACT/PACT/RBHS – a set of case management programs delivered out of the CMHC offices, in the natural living environment of the consumer, urban or rural.

All-Hands Meeting – Quarterly meeting with State Director, open to all employees, to discuss the state of the Department.

Assembly – State Director's monthly meeting of CMHC/facility directors, advocacy representatives and senior leadership. Quarterly, the Assembly includes CMHC Board representatives.

BASIS 32 – a 32 item assessment, made by the adult mental health consumer, of their symptoms and level of functioning.

BPH – Bryan Psychiatric Hospital, an acute care inpatient facility in the Columbia area.

CAFAS – Child and Adolescent Functional Assessment Scale, used by the clinician to evaluate the level of functioning and degree of symptoms in children and adolescents.

CARF – Commission on Accreditation of Rehabilitation facilities, one on the bodies which accredit DMH facilities.

CCET – Consumer-to-Consumer Evaluation Team, a consumer satisfaction measurement system run by fellow consumers.

Chapter 22 – Medicaid policies and procedures for mental health providers of community mental health services.

CIS – Client Information System, data-base containing consumer information.

CLM – Computer Learning Modules, a computerized system for presenting and evaluating knowledge of standardized educational materials.

CME – Continuing Medical Education, physician continuing education credits.

CMHC – Community Mental Health Center.

Commission – a seven-member body designated by the state to oversee the Department of Mental Health.

Community Development Plan – the DMH strategic plan, also called "Making Recovery Real."

Consumer – Person with mental illness served by the DMH.

Continuity of Care – a set of standards governing the provision of treatment to ensure seamless care is provided through hospital and community based care.

Corporate Compliance – process by which third party payers are assured that reimbursed clinical services are delivered as described.

CPM – Certified Public Manager, a managerial training program offered through state government.

DMH – South Carolina Department of Mental Health.

Dual Diagnosed – consumer diagnosed with more than one major psychiatric disorder: mental illness and alcohol/drug addiction.

EPMS – Employee Performance management System, the state's annual employee appraisal system.

ETV – the state's Educational Television Network, used by the Department to broadcast closed-circuit educational and interactive programming.

GAF – Global Assessment of Functioning, a clinical evaluation instrument used by the clinician to assess consumer level of functioning and symptoms.

Governing Council – the 11 member senior leadership of the agency. Members are the State Director, Chief of Staff, Chief of Security, Medical Director, General Counsel, and the Directors of Community Care Systems, Program Services, Communications, Administrative Services, and the Institute of Behavioral Sciences.

HPH – Harris Psychiatric Hospital, an acute care inpatient facility in the Anderson area.

IBS – Institute for Behavioral Science, the agency's division for outcomes, training, research, and best practice development. Formerly, ETR, Education, Training and research

IQ – Intelligent Querry, a software package used by the agency to extract computer data into reports.

IT – Information Technology, the mainframe, area networks, and data systems of the agency.

JCAHO – Joint Commission on Accreditation of Healthcare Organizations.

MST – Multi-Systemic Therapy, an in-home, intensive service to children and their families.

MHSIP – Mental Health Statistical Improvement Project, a multi-state project to design consumer satisfaction surveys for mental health consumers.

ORYX – JCAHCO required set of data required to be submitted monthly on the performance of inpatient facilities.

Pathlore – a computerized employee training registration and documentation system.

PIC – Performance Improvement Committee.

QCRB – Quality of Care Review Board, a convened group of experts charged with analyzing the events leading up to and through an outcome deemed adverse and making recommendations to the Department to prevent the event from recurring at the original site and throughout the agency.

QA – Quality Assurance, the process by which clinical services or documentation is monitored for adherence to standards, e.g., Medicaid, CARF, JCAHCO.

Recovery – A philosophy of mental health systems, supporting consumers' ability to overcome the debilitating, stigmatizing effects of their disorder and assisting their empowerment.

Risk Management – the process by which potential clinical adverse outcomes are minimized in frequency or severity, or actual adverse outcomes are appropriately responded to as opportunities to improve services (root cause analysis, QCRBs, etc.).

SAP – computerized financial management system.

School-Based – Services delivered by mental health professionals within the walls of the school system.

SHARE – Consumer advocacy and self-help organization.

State Plan – document required annually by federal government that specifies specific goals for expenditure of Block Grant monies.

State Planning Council – Stakeholder group who plans expenditures of federal Block Grant funds. The council is required to have at least 50% of its membership be non-DMH stakeholders.

Trauma – treatment and assessment, directed toward children and adults, to reduce the traumatic effects of psychiatric hospitalizations and previous life traumas.

TLC – Toward Local Care, a program to return long term psychiatric inpatient consumers to life in the community with intensive support from CMHCs.

Transition Council – Stakeholder group who plan and oversee the TLC program.

Utilization Review, the process by which clinical services or documentation are monitored to assure delivery of clinically appropriate treatment (a.k.a., clinical pertinence).

WSHPI – William S. Hall Psychiatric Institute, a specialty inpatient facility in the Columbia area, serving children and forensic populations.

Wrap – Intensive services, primarily for children, that "wrap" the individual in a full range of services to meet the psychiatric, emotional, social, and academic need