Accountability Report Transmittal Form

Agency Name: South Carolina Department of Mental Health

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South Carolina Department of Mental Health

Accountability Report

FY 2009

September 15, 2009

Section 1 – Executive Summary

1. Mission and Values

The South Carolina Department of Mental Health's (SCDMH, the Department) mission is to support the recovery of people with mental illnesses. Its priority is serving adults and children affected by serious mental illnesses and significant emotional disorders.

We are committed to eliminating stigma, promoting recovery, achieving our goals in collaboration with all stakeholders, and in 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

During a year highlighted by state-mandated budget reductions, the department made a concerted effort to maintain quality services and evidenced-based best practices. In support of our mission, the state director and other members of the leadership team continued a successful undertaking of presentations to civic clubs and other audiences around the state, driving home the key messages about mental illnesses and how the Department strives to deliver quality services effectively and efficiently. Many of these public presentations were covered by local media, resulting in further dissemination of our key messages.

Because of our limited ability to hire new staff or to replace seasoned managers who have retired, the department implemented an Executive Leadership Development Program to groom new leadership candidates. In the first year, five participants completed the course with seven scheduled for the coming year.

Despite significant budget reductions, our school-based mental health counselors served nearly 13,000 children in 429 schools in South Carolina.

This year we saw the completed implementation of several Assertive Community Treatment Like Teams (ACT-Like) across the mental health system. Referred to as "ACT-LIKE" as they are developed in accordance to a particular model but with a higher than fidelity (trueness to program's recommended model) case loads to increase efficiency, these programs are designed to provide and coordinate treatment, rehabilitation, and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been met by traditional mental health services. Research has demonstrated that assertive community treatment (ACT) programs improve recipient outcomes. When comparing recipients before and after receiving ACT services, studies have shown ACT recipients experience greater reduction in hospitalization rates, emergency room visits, and symptoms, higher level of housing stability, and improved employment rates, satisfaction and overall quality of life. The number of clients hospitalized was reduced by 51% compared to the year before entry into the program. ACT-Like programs reduced hospital bed days by nearly 70% for clients compared to the previous year and lowered ER visits.

We continued to help people with mental illnesses find jobs and places to live. For example, our supported employment program for adults with serious mental illnesses continued to produce good results and to garner national acclaim. Working with our partner, the South Carolina

Vocational Rehabilitation Department, we now have over forty-five percent of our clients in the program gainfully employed. In addition, our housing and homeless program has now funded over 1,600 housing units, including some units for clients in the Towards Local Care (TLC) program.

At the most recent meeting of the National Coalition on Mental Health and Deaf Individuals, it was recommended that other states follow the lead of South Carolina and encourage deaf consumers to become Peer Support Specialists. Currently, South Carolina is the only state to have deaf consumers as Peer Support Specialists.

At the close of FY09, the Department continued to move closer to an eventual sale of the former downtown campus of the South Carolina State Hospital, now commonly referred to as the Bull Street property. The Department's real estate broker, NAI Avant launched formal efforts to sell the property in January 2009 with the activation of a marketing website, http://www.naiavantbullstreet.com/. Relocation of existing services off of the campus in preparation for a sale continued. With the completion of an energy plant for Tucker Center, the Department's Columbia nursing care facility was taken off-line from the Central Energy plant on the Bull Street property. The Columbia Area Mental Health Center and the DMH Administration building are also in the process of discontinuing their reliance on the Energy plant. With the completion of phase one of the roof-replacement project at Bryan Psychiatric Hospital (BPH), the remaining adult patients on the Bull Street campus were transferred from the Byrnes building to BPH, leaving the Byrnes building vacant. Efforts to identify alternative space for some staff offices and outpatient treatment services remaining on the Bull Street property are on-going. Finally, the Department has decided to retain the William S. Hall Psychiatric Institute, the agency's inpatient child and adolescent hospital, rather than construct a new hospital. Hall Institute, which comprises approximately 18 acres, or roughly 10% of the Bull Street campus, will be excluded from the sale. Instead the hospital will be renovated, to include the addition of an energy plant. Such decision means that the last significant relocation issues are in the process of being resolved. When the sale of the Bull Street property occurs, the proceeds will be reinvested in services for the Department's clients.

As is true nationally, people with mental illnesses and substance abuse disorders continued to come to local hospital emergency rooms for treatment. The Department took steps to help alleviate this on-going problem in South Carolina. For example, funds were made available to contract for open beds in the community to get patients out of our psychiatric hospitals, thus making space to admit those waiting in emergency rooms. In addition, the Department's mental health centers received funds for several projects geared towards providing crisis and other services in the community, ranging from providing on-call staff after hours, to placing staff in local emergency rooms. An ongoing challenge is that 73% of these visitors to emergency departments are either unknown or have not been a client of DMH within three years of their ED visit.

As another step towards easing the emergency room problem, the DMH Telepsychiatry Consultation Program provided the first live consultation on March 27, 2009. Since that date, DMH has placed telemedicine equipment in six local hospital emergency departments and

completed over 300 behavioral health consultations. Four full-time psychiatrists dedicated solely to this program provide daytime, evening and weekend coverage. This program was made possible by a Duke Endowment Grant. Key partnerships include the Medical University of South Carolina, the South Carolina Hospital Association, SC Office of Research and Statistics, SC Department of Health and Human Services, the University of South Carolina School of Medicine, and the Medical College of Georgia. Preliminary data indicates that one-half of those persons receiving these consultations did not require admission to the local hospital or other external facility. The most revealing comment is from Dr. Scott Parker at Palmetto Health Baptist in Easley when he said "What used to take days now only takes hours." DMH is planning to add thirteen to fifteen additional hospitals to the consultation program by the end of 2009. DMH is pursuing additional funding to extend the program.

Finally, the department celebrated a milestone with the Art of Recovery project, which recognizes the talent of people who live with mental illnesses. This effort is one of the most visible anti-stigma projects that DMH has and reaches into the community to educate and raise awareness about mental illness. This year, the Art of Recovery celebrated its fifth year exhibiting at the Columbia Museum of Art. During this fiscal year, twenty six artists sold 45 pieces of artwork for a total of $3, 154 with all of the proceeds going to the artists.

3. Key Goals

The primary focus for the Department for FY09 can be summarized as follows:

- Support the recovery of people with mental illnesses by:
  - Preparing them to them find meaningful jobs;
  - Funding safe, affordable places to live;
  - Continuing to help eliminate the stigma of mental illness.
- Continue forward progress on selling the Bull Street property by:
  - Proceeding with marketing plan and continuing to evaluate best options for relocating or renovating buildings currently in use.
- Grow services in the community for children and adolescents by:
  - Maintaining or increasing school-based services;
  - Placing Departmental staff in the offices of other human service state agencies;
  - Adding more intensive services programs;
  - Maintaining the number of children in out-of-home placements at less than one half of one percent of all children served by the Department.
- Alleviate the crisis in local emergency rooms by:
  - Implementing the grants for community crisis services awarded to community mental health centers;
  - Implementing the telemedicine psychiatric consultation services in emergency rooms around the state;
  - Transitioning patients into the community from beds in the Department's psychiatric hospitals.
- Provide workforce development initiatives through the following means:
  - Continue the mentoring program and select staff who meet the established criteria for inclusion in the program;
  - Continue the executive leadership development program until a cadre of selected staff has completed the training;

- Continue to develop online learning modules to enhance the competency of staff.

- Grow revenue opportunities through financial grants by:
  - Maintain development of newly formed grants management office;
  - Identifying grant opportunities and then applying for such.
  - Design and implanting a workable internet/intranet site.

4. Key Strategic Challenges

The Department faces many strategic challenges as it continues to move forward and offer services that are delivered in a cost effective, efficient manner. Among these challenges are the following:

- **Managing Financial Resources Wisely**. Due to changes in Medicaid Reimbursement rules for services delivered in our community mental health centers over the years, the Department has experienced a decrease in Medicaid revenue. However, Medicaid revenue is beginning to stabilize. The need for services continues to grow despite a $45 million decrease in State Appropriations since July 1, 2008.

- **Recruiting and Retaining Key Clinical Staff**. As reflected in our budget request for FY09, we believe that the Department needs almost $12 million over the next three years to hire the staff needed in our hospitals and our community mental health centers. A 2007 study by the South Carolina Budget and Control Board indicated that our clinical positions pay is 13-20 percent less than the market average for such positions as registered nurses, licensed practical nurses, and mental health counselors. Our request for these funds was not granted.

- **Enhancing Our Services in the Community for Children and Adolescents**. We must find ways to improve screening and diagnostic practices to appropriately identify and treat trauma-related symptomatology in children and adolescents. We need to maintain (and increase as funds become available) the number of our school-based mental health programs, especially in rural areas where mental health services are limited. Further, we need to improve accessibility to services by out-stationing our staff in social services offices and juvenile justice offices. Finally, we need to continue the reduction of out-of-home placements for children and help them live in the least restrictive environments.

- **Using Technology to Improve Services** to clients and to enable staff to work more efficiently. Our goal is to implement the Electronic Medical Record (EMR) in all of our community mental health centers and inpatient operations. The EMR is a significant piece in an enterprise-wide plan to improve patient care through advanced technology.

- **Providing Safe, Affordable Housing and Supported Employment Programs** in the community for our clients. We are challenged to develop additional supportive housing options for clients living in the community as well as more specialized housing for clients in our Towards Local Care (TLC) program. Further, we need to expand our supported employment program for seriously ill adults through an evidence-based best practice program called Individual Placement and Support (IPS).

- **Strengthening Staff Competencies**. Because of our limited ability to hire new staff or to replace seasoned

managers who have retired, continue the Executive Leadership Development Program to groom new leadership candidates. This is in addition to the ongoing Mentoring Program and a new program for first-time supervisors, the Supervisory Mini-Series.

- **Providing Effective Treatment for Sexually Violent Predators**. By law, we are designated to provide treatment for those people deemed by the judicial system to be sexually violent predators. We must implement measures to maintain meaningful treatment opportunities despite an increasing census for that population.
- Offering more psychiatric **Crisis Services in the Community**. Still looming as a challenge for the Department is the continued presence in emergency rooms around the state of behavioral health care patients, about three-fourths of whom are unknown to us. As the census of the state grows, so does the number of people in the emergency room waiting for evaluation and treatment and perhaps an admission to one of the Department's inpatient programs. We will continue to face this challenge by offering more crisis services in the community (when funding is available), by opening more hospital beds for acute care patients, by working with our community partners who have a stake in finding a solution, and by using innovations like telemedicine technology to provide psychiatric consultations in emergency rooms.
- **Building New Hospitals and Centers, Renovating and Maintaining Existing Buildings**. The Department has identified $184.1 million worth of capital projects that have partial funding and additional funds have been requested. Some of these projects include renovating our Child and Adolescence Hospital and Bryan Psychiatric Hospital, building a new facility for sexually violent predators, and building new Mental Health Centers for Santee-Wateree, Catawba, and Anderson/Oconee/Pickens.
- **Eliminating Stigma**. Many with mental illness are reluctant or ashamed to acknowledge their illness and seek treatment due to stigma surrounding mental illness and discrimination that often accompanies misperceptions. We are committed to eliminating stigma and to educating the public about mental illnesses; to that end, DMH has created Palmetto Media Watch. An e-mail list of individuals dedicated to fighting stigma, Palmetto Media Watch focuses on incidents of stigma in the media. Media Watchers are alerted about, and encouraged to respond to, positive and negative portrayals of mental illness.

Finally, the Department is challenged by the breadth of its mission. The South Carolina Department of Mental Health is unique among other states' departments of mental health in that we are mandated by state laws to serve a wide variety of patient populations. Included under the umbrella of our services are inpatient and outpatient services for adults and children; services to a forensics population including sexually violent predators; services to people with a substance abuse disorder; services to patients in our nursing care center; and nursing home services for South Carolina's veterans.

In spite of diminishing resources, we continue to meet this challenge everyday because we serve some of the most vulnerable citizens in our state, helping them recover from their illnesses and helping them have hope for the future.

Section II – Organizational Profile

1. Main Products and Services and Primary Delivery Mechanisms

The Department of Mental Health provides psychiatric services to adults and children through 17 comprehensive community mental health centers (CMHC) and sixty-four mental health clinics with offices in all forty-six counties. It provides inpatient psychiatric treatment to adults through two facilities and to children through a third. It operates an alcohol/drug addiction treatment facility, a community nursing home, and contracts with private entities for the operation of a forensic facility and two veterans' nursing homes.

2. Primary Client Segments and their Key requirements/ Expectations

DMH's key clients 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 success in meeting their requirements are presented in Table 1. The key processes are assessment, diagnosis, and treatment designed to meet the key requirements of our clients.

3. Key Stakeholders

Groups that have a stake in the success of the Department of Mental Health include other state agencies, in particular the Departments of Alcohol and Other Drug Abuse Services, Disabilities and Special Needs, Health and Human Services, Vocational Rehabilitation, Social Services, Corrections, Juvenile Justice, Health and Environmental Control, Continuum of Care, 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, law enforcement, and jails as they work together with DMH to identify and support clients in crisis.

Nonprofit entities, which advocate for clients such as the National Alliance on Mental Illness, the Federation of Families, the Mental Health America of SC, Protection & Advocacy for People with Disabilities, and SC 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.

4. Key Suppliers and Partners

DMH contracts with several major vendors to provide services to our clients. The Campbell Veteran's Nursing Home in Anderson, SC and the Victory House Veterans Nursing Home in Walterboro, each a 220-bed facility, are operated through contract.

DMH also contracts with Just Care, Inc. for significant segments 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 security, general nursing care, and room and board.

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 clinical and support services including local inpatient care, physician

services, and several different types of supported residential options for agency clients.

Table 1	KEY CLIENT PERFORMANCE MEASURES		
Client	**Key Requirements**	**Key Measures**	**Results Cross-Reference**
Adults with Serious Mental Illnesses	Satisfaction	Client Perception of Care (MHSIP)	7.2-1
	Functional Improvement	Clinical Assessment (GAF)	7.1-2
	Symptom Reduction		
	Employment	Number/Percent Employed	7.1-3, & 7.1-4
	Housing	No. of Units	7.1-5
Alcohol & Drug	Satisfaction	Client Perception of Care	7.2-5
	Abstinence	30 day Post-Treatment	7.1-9
Nursing Home	Satisfaction	Resident & Family Survey	7.2-4
	Health & Safety	Life Expectancy Rate Reduced Pressure Sores Decrease Fall Rate	7.1-6 7.1-7 7.1-8
Children with Severe Emotional Disturbance	Functional Improvement	Clinical Assessment (CAFAS)	7.1-1
	Symptom Reduction		
	Parental Satisfaction	Parent's Survey (MHSIP)	7.2-3
	Youth Satisfaction	Youth Survey (MHSIP)	7.2-2
KEY MEASURES OF ORGANIZATIONAL EFFECTIVENESS AND EFFICIENCY			
Domain	**Measures**		**Results Category Chart**
Community Mental Health Centers	Number Served		7.5-6
	% of Clients with Major Mental Illness		7.5-2 & 7.5-4
	Hospital Admissions Rate		7.5-7
	Avg. Days Btw Hospital Discharge & Date Seen by CMHC		7.5-13
	Emergency Room: Decreasing Waits		7.5-9
Psychiatric Inpatient	30 Day Readmission Rate		7.5-14
	Seclusion Rate		7.5-15
	Restraint Rate		7.5-16
	Decreasing >90-Day Length of Stay		7.5-17
	Bed-Day Utilization		7.5-19
Administrative and Financial	Medicaid Revenue		7.3-2
	Billable Hours of Service		7.3-5
	Bed-Day Costs		7.3-7
	Regulatory Compliance and Audits		7.6-1

5. Location of Operations

The Department of Mental Health (DMH) main administrative offices are located in Columbia – as are the

- William S. Hall Psychiatric Institute
- G. Werber Bryan Psychiatric Hospital
- Earle E. Morris, Jr. Alcohol & Drug Addiction Treatment Center
- C.M. Tucker Nursing Care Center, and
- Sexually Violent Predator Program.

Patrick B. Harris Psychiatric Hospital is located in Anderson.

DMH also operates seventeen community mental health centers (CMHCs) around the state, which serve all forty-six counties. The centers include:

- Aiken-Barnwell MHC
- Anderson-Oconee-Pickens MHC
- Beckman MHC (Greenwood)
- Berkeley MHC
- Catawba MHC (Rock Hill)
- Charleston/ Dorchester MHC
- Coastal Empire MHC (Beaufort)
- Columbia Area MHC
- Greenville MHC
- Lexington MHC
- Orangeburg MHC
- Pee Dee MHC (Florence)
- Piedmont MHC (Simpsonville)
- Santee-Wateree MHC (Sumter)
- Spartanburg Area MHC
- Tri-County MHC (Bennettsville)
- Waccamaw MHC (Conway).

6. Number of Employees

Our workforce includes 4,282 (a reduction of 424 since 2008) employees. Of these 9% are administrative, 47% in the community system, and 43% in our inpatient setting. Ninety-seven percent are in classified positions and 3% in unclassified or contractual positions. Forty-six percent of our employees are White, 52% are African-American, and 2% are of other ethnic nationalities.

7. Regulatory Environment

As a medical treatment provider expending state and federal funds, the Department of Mental Health is heavily regulated. See Figure 7.6-1 for a full listing.

8. Performance Improvement Systems

Table 2 identifies key elements of the DMH Performance Improvement System.

Table 2 **The DMH Performance Improvement System**

	Quality Improvement	Performance Improvement	Quality Assurance
Focus:	Current	Prospective	Retrospective
Initiated by:	Any Level	Upper Management	Management
Mechanisms:	Performance Improvement Teams	Performance Improvement Teams	Risk Management System
	Program Fidelity Monitoring	Key Performance Indicators	Facility Accreditation
		Outcomes Committee	Corporate Compliance
			Medicaid Audits
			Internal Audit
			Utilization Review

9.Organizational Structure

See Table 3

10. Expenditure/Appropriations Chart

See Table 4

11. Major Program Areas Chart

See Table 5

Table 3 – Updated 8-22-09

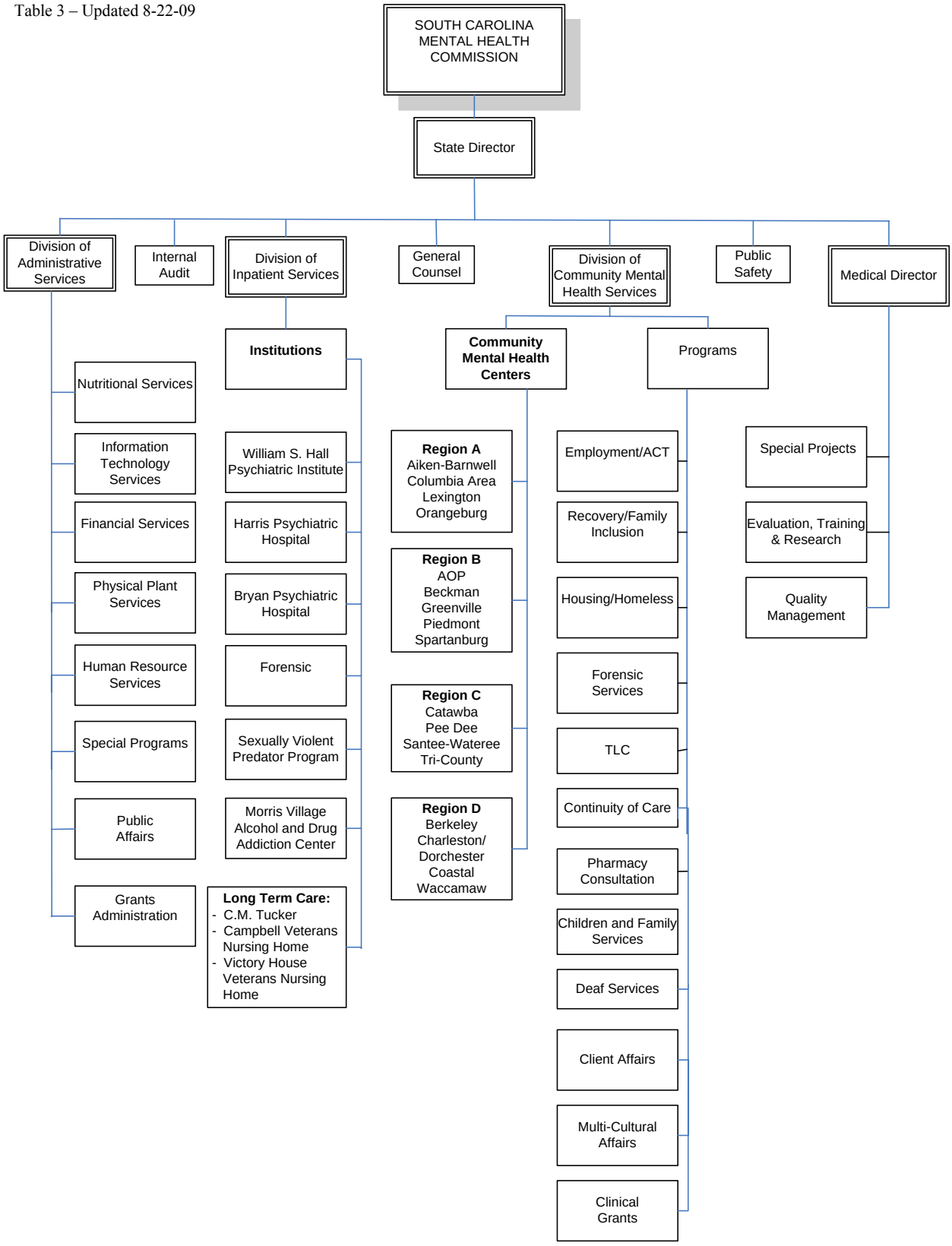


Table 4 **Accountability Report Appropriations/Expenditures Chart**

Base Budget Expenditures and Appropriations

Major Budget Categories	FY07-08 Actual Expenditures		FY08-09 Actual Expenditures		FY09-10 Appropriations Act	
	Total Funds	General Funds	Total Funds	General Funds	Total Funds	General Funds
Personal Service	$ 183,512,445	$ 131,190,379	$ 180,691,241	$ 113,263,489	$ 177,722,623	$ 110,137,353
Other Operating	$ 110,754,681	$ 38,380,106	$ 112,492,949	$ 24,551,955	$ 115,651,036	$ 21,430,809
Special Items	$ 598,000	$ 248,000	$ 316,500	$ 16,500	$ 300,000	$ -
Permanent Improvements	$ 12,034,806	$ -	$ 8,138,207	$ -	$ -	$ -
Case Services	$ 12,981,208	$ 7,464,194	$ 11,965,559	$ 3,650,223	$ 20,207,974	$ 10,598,640
Distributions to Subdivisions	$ -	$ -	$ -	$ -	$ -	$ -
Fringe Benefits	$ 57,916,577	$ 41,081,798	$ 59,512,335	$ 36,944,198	$ 54,154,380	$ 33,834,769
Non-recurring	$ 4,863,500	$ 4,863,500	$ -	$ -	$ -	$ -
Total	$ 382,661,216	$ 223,227,978	$ 373,116,790	$ 178,426,365	$ 368,036,013	$ 176,001,571

Sources of Funds	FY07-08 Actual Expenditures	FY08-09 Actual Expenditures
Supplemental Bills	$ 4,863,500	$ -
Capital Reserve Funds	$ -	$ -
Bonds	$ -	$ -

Major Program Areas								
Program Number and Title	**Major Program Area Purpose (Brief)**	**FY07-08 Budget Expenditures**			**FY08-09 Budget Expenditures**			**Key Cross References for Financial Results***
II. A. Community Mental Health Centers	Services delivered from the 17 mental health centers that include: evaluation, assessment, and intake of consumers; short-term outpatient treatment; and continuing support services.	**State:**	73,344,741.39		**State:**	58,154,340.09		
		Federal:	6,932,204.26		**Federal:**	7,109,842.47		
		Other:	61,343,248.38		**Other:**	68,639,653.22		
		Total:	141,620,194.03		**Total:**	133,903,835.78		
		% of Total Budget:		42%	**% of Total Budget:**		40%	7.3-6 7.5-5
II. B. Inpatient psych	Services delivered in a hospital setting for adult and child consumers whose conditions are severe enough that they are not able to be treated in the community.	**State:**	54,693,709.71		**State:**	40,158,885.95		
		Federal:	196,042.04		**Federal:**	237,716.40		
		Other:	32,532,054.27		**Other:**	44,269,022.06		
		Total:	87,421,806.02		**Total:**	84,665,624.41		7.3-6 7.3-7
		% of Total Budget:		26%	**% of Total Budget:**		25%	
II. D. Tucker/ Dowdy	Residential care for individuals with mental illness whose medical conditions are persistently fragile enough to require long-term nursing care.	**State:**	5,986,371.99		**State:**	4,095,153.63		
		Federal:	0.00		**Federal:**	0.00		
		Other:	14,576,989.32		**Other:**	16,319,592.75		
		Total:	20,563,361.31		**Total:**	20,414,746.38		7.3-7
		% of Total Budget:		6%	**% of Total Budget:**		6%	
II. F. Support	Nutritional services for inpatient facilities, public safety, information technology, physical plant, financial and human resources and other support services	**State:**	19,755,059.65		**State:**	19,103,501.14		
		Federal:	0.00		**Federal:**	0.00		
		Other:	1,741,535.52		**Other:**	2,363,399.29		
		Total:	21,496,595.17		**Total:**	21,466,900.43		
		% of Total Budget:		6%	**% of Total Budget:**		6%	
II. G. Veterans	Originally residential nursing care for veterans who also have a mental illness; role has now expanded beyond that so that any veteran is eligible who meets the admission criteria.	**State:**	15,085,619.91		**State:**	10,691,222.88		
		Federal:	0.00		**Federal:**	0.00		
		Other:	12,132,174.89		**Other:**	22,667,008.48		
		Total:	27,217,794.80		**Total:**	33,358,231.36		
		% of Total Budget:		8%	**% of Total Budget:**		10%	7.3-7

II. H. Sexual Predator	Treatment for civilly-committed individuals found by the courts to be sexually violent predators. Mandated by the Sexually Violent Predator Act, Section 44-48-10 et al.	**State:**	4,528,742.54		**State:**	5,489,991.03		
		Federal:	0.00		**Federal:**	0.00		
		Other:	35,149.75		**Other:**	141,127.46		
		Total:	4,563,892.29		**Total:**	5,631,118.49		
		% of Total Budget:		1%	**% of Total Budget:**		2%	7.3-7
III. Employer Contributions	Fringe benefits for all DMH employees	**State:**	41,081,798.46		**State:**	36,944,198.31		
		Federal:	1,163,452.84		**Federal:**	1,188,030.89		
		Other:	15,671,325.72		**Other:**	21,380,105.43		
		Total:	57,916,577.02		**Total:**	59,512,334.63		
		% of Total Budget:		17%	**% of Total Budget:**		18%	
Below: List any programs not included above and show the remainder of expenditures by source of funds.								
	Remainder of Expenditures:	**State:**	3,733,538.44		**State:**	3,772,571.97		
	I. Administration	**Federal:**	802,975.18		**Federal:**	923,121.10		
		Other:	73,447.39		**Other:**	1,313,598.12		
		Total:	4,609,961.01		**Total:**	6,009,291.19		
		% of Total Budget:		1%	**% of Total Budget:**		2%	
*** Key Cross-References are a link to the Category 7 - Business Results. These References provide a Chart number that is included in the 7th section of this document.**								

Section III

Category 1 – Leadership

1.1 Senior Leadership Direction

How do senior leaders set, deploy, and ensure two-way communication for:
a) Short and long term direction and organizational priorities

DMH has developed clear mission/values/ priorities statements, 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.

Some noteworthy examples of DMH leadership's alignment of mission, values, priorities, and performance include:

- a strategic plan that focuses on development of a community-based system as the primary locus of care;
- inclusion of key stakeholders in planning and policy development;
- including clients and family members on mental health center leadership teams and local mental health center boards;
- hiring clients as employees of the Department;
- publishing the minutes of all governance meetings;
- publishing newsletters and monthly internal publications;
- posting information and news articles on the Intranet and Internet sites;
- meeting with newspaper editorial boards and legislators.

These avenues of communication provide a rich engagement between leadership, stakeholders, and employees. They provide channels of information for communication up, as well as down and across, the chain of command. The bottom line is that while leadership has responsibility for promoting knowledge, setting priorities, establishing core measures, and evaluating performance, it also must ensure that all voices have a place at the table.

b) Performance expectations

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 linked to DMH goals.

c) Organizational values

Senior leadership and the Commission's commitment to organizational values are most clearly communicated by their behavior. It has been their effort that has aligned goals, priorities, outcomes, and funding with core values: Respect for the Individual, Support for Local Care, a Commitment to Quality, and Improving Public Awareness and Knowledge about Mental Illness.

Two-way communication is best represented by examples that are indicative of leadership's approach/ deployment behavior.

- The Commission holds six of its twelve monthly meetings in a local mental health center or inpatient facility. With two of the seven-person Commission members being a family member of a DMH client, there is a clear commitment to open discussion between stakeholders and the administration.
- Mental health clients, family members, advocates, and other stakeholders are invited and encouraged to be part of policy discussion, priority-setting, and program development.
- Clients of mental health services are employed as Peer Support Specialists, serve

on management teams of centers/hospitals, and participate on quality improvement teams. The mantra espoused by our client advocates – "Nothing about Us, Without Us" aptly represents the inclusive philosophy of DMH.

d) Ethical behavior

As a healthcare organization, the Department is fortunate to have codes of ethical behavior for all disciplines, giving a solid basis upon which to build agency expectations for employees. These are augmented by formal policies and standards for: corporate compliance; ethics in research; and after-the-fact quality assurance, peer review, and internal audit programs.

1.2 Focus on Clients

How do senior leaders establish and promote a focus on clients and other stakeholders?

At DMH, promoting client recovery is the agency's mission, and the "inclusive philosophy" of senior leaders ensures that clients and other stakeholders remain central to our efforts. Through client advisory boards, client employees, and direct client/family involvement in major policy and program development, the agency maintains its focus on providing excellence in client satisfaction. Further, as described in Table 1, senior management is able to review key measures to determine how well the agency, and each component, is doing with client satisfaction and client services.

1.3 Impact on Public

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

All inpatient facilities of the Department are licensed by the South Carolina Department of Health and Environmental Control (DHEC) as specialized hospitals, and all are fully accredited by either the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) or the Commission on the Accreditation of Rehabilitation Facilities (CARF).

Each year the Office of Inspector General of the federal Department of Health and Human Services identifies vulnerabilities in Medicare/Medicaid funded programs and other activities that are the focus of their program audits for the year. The DMH Corporate Compliance Committee reviews this document to determine auditing procedures that may need to be strengthened.

Further, our Office of Internal Audit regularly reviews all DMH activities (administration, inpatient, and community) to ensure fiscal responsibility, ethical behavior, accountability, and legal compliance.

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

- Individuals are rigorously assessed prior to their discharge from inpatient care;
- Clients found Not Competent to Stand Trial or Not Guilty by Reason of Insanity are treated in secure settings. Their gradual reintegration into the community is closely monitored by trained staff who are very knowledgeable of each client's treatment needs;
- An integrated system of community-based treatment with inpatient support to ensure the safety, continuity of care, and well-being

of the citizens we serve.

Also helping the Department assess its impact on the public are local CMHC boards, advocacy groups, and the South Carolina Hospital Association.

The Department subscribes to a "press summaries" service and runs a volunteer "media watch," reviewing all newspaper articles/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.

1.4 Maintaining Fiscal, Legal, and Regulatory Accountability

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

The state director, senior leadership, and the Commission review data and written evaluations on fiscal, legal, and regulatory compliance regularly. Also, the Internal Audit Division as an independent appraisal function assists members of management and the Commission in the effective discharge of their responsibilities. To this end, Internal Audit furnishes them with analyses, recommendations, counsel and information concerning activities reviewed. In FY09 the Department established a Grants Management Office to provide increased regulatory oversight for all grants.

1.5 Key Performance Measures

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

Client satisfaction, symptom reduction, functional improvement, housing and employment – all indicators deemed important by clients – are part of the key measures reviewed annually by leadership. In addition, every quarter the Commission and senior leaders review specific data on organizational efficiency and effectiveness. Table 1 presents both of these sets of measures. Copies of the performance reports are provided to all DMH management, CMHC and inpatient facility directors, CMHC board chairs, and are available to the public.

1.6 Performance Review/Feedback

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? How do their personal actions reflect a commitment to the organizational values?

The performance of all managers and administrators is evaluated annually. The state director's goals cascade into the deputy director's goals and to center/facility director's goals, creating a tiered system of alignment. Senior leadership also assesses its own performance, individually and as a group, through retreats and SWOT analyses.

1.7 Succession Planning

How do senior leaders promote and personally participate in succession planning and the development of future organizational leaders?

With an aging workforce and a large number of senior staff in the TERI Program, DMH responded proactively to ensure a smooth transition to a new cadre of agency leaders.

Additionally, an in-house Mentoring/ Succession Program was implemented. This is an eleven-month seminar that includes monthly classroom instruction lead by SCDMH senior leaders.

Last year, the department began an Executive Leadership Development

Program to groom a new generation of senior management and the Supervisory Mini-Series, for first-time supervisors.

1.8 Performance Improvement

How do senior leaders create an environment for performance improvement and the accomplishment of strategic objectives?

Clear outcome measures set the stage for an environment that promotes performance-driven behavior. In addition, strategic goals have defined targets, and Employee Performance Management System (EPMS) goals, linked to strategic goals, assist staff in remaining focused on accomplishing assignments. While the Department has promoted evidence-based practices, it has allowed programmatic freedoms to managers as long as they have outcome measures that respond to client requirements. This "freedom to innovate" has encouraged managers who believe their home-grown programs to be equally effective in producing outcomes that equal or exceed the evidence-based outcomes.

1.9 Organizational and Workforce Learning Environment

There is a concerted emphasis by the Department to transfer learning from one part of the system to other applicable areas. Senior leadership publishes outcome data, including comparative results, for use by local CMHC Boards, organizational components, and managers in improving performance. Findings from investigations of adverse events result in corrective action plans and are transferred into system-wide improvements.

At the individual employee level, senior leadership has promoted the development of on-line staff training programs, linked employee education more closely to strategic priorities, and instituted specific programs to prepare the next generation of managers, administrators, and clinicians.

1.10 Empowering and Communicating with Employees

To encourage innovation in program development, research projects are conducted to compare the outcomes of local programs to the outcomes of evidence-based practices. Conferences and stakeholder meetings feature educational reports on state-of-the-art treatment approaches, and the Department's quarterly publication, Images, routinely features model DMH programs.

1.11 Strengthening the Community

How does senior leadership actively support and strengthen the communities in which your organization operates?

The Department of Mental Health is committed to the support of the communities it serves. As a community-based, public mental health system, its primary role is to serve persons who suffer from mental illnesses. Where possible, however, the Department extends itself to be a system of support for the non-mentally ill by:

- providing education, counseling, and public information for persons dealing with life stressors;
- supporting volunteer activities by employees and senior leaders that further our stated mission; and
- developing public service announcements about mental illness and maintaining educational websites.

Category 2 – Strategic Planning

2.1 Strategic Planning Process

What is your Strategic Planning process, including KEY participants, and how does it address:

a. Organizational strengths, weaknesses, opportunities and threats
b. Financial, regulatory, societal and other potential risks
c. Shifts in technology or the regulatory environment
d. Workforce capabilities and needs
e. Organizational continuity in emergencies
f. Ability to execute the strategic plan

With the department's budget request due eleven months prior to the beginning of the fiscal year, work on prioritizing needs is started a full nineteen months before the fiscal year begins (Figure 2.1-1). Planning begins with a SWOT analysis (Strengths, Weaknesses, Opportunities, and Threats), involving senior leaders, representative CMHC directors, and inpatient directors. The most recent SWOT included leadership of the advocacy groups.

Potential issues for the strategic plan are rank ordered based on the urgency and degree of threat, and each priority is assessed for what action is most appropriate to address the issue.: (1) Additional funds (a potential budget request item); (2) Legislation; (3) Improved Relationships; (4) Staff Training; and/or (5) Internal Policy or Management Actions.

Using this assessment, key staff responsible for the priority area submits draft objectives for the goal, budget requirements, a time-table for implementation, and outcomes.

The DMH Executive Committee identified the draft goals in March as part of the FY09 Budget Request Process and distributed them for public comment. They were posted on the web and distributed to advocacy groups, CMHC/inpatient facility management and staff, and CMHC Boards. The State Planning Council (a 45-member group that includes 14 clients, 9 family members, 4 representatives of advocacy groups, 13 state employees) reviewed the goals (late March through mid-May) and made recommendations to the Department in written and face-to-face interactions.

The strategic planning process calls for full stakeholder participation every three years.

Figure 2.1-1 **FY10 PLANNING PROCESS**

Budget Development	
Nov-Dec '08	"Major Risks Assessment" (S.W.O.T) by senior leadership
Jan '08	FY10 & FY11 Budget Priorities Draft set by senior leadership
June '08	State Planning Council Submits Recommendations
Jun-July '08	Senior leadership and Commission Approve FY10 Draft Budget
Aug '08	FY10 Budget Submitted
Program Development	
Oct '08	Leadership sets strategic priorities other than budget request items
Jan '09	Cost Figures Developed (if needed)
Feb 09	Leadership approves all priorities, timetable, and outcomes
Mar 09	Draft plan developed
June '09	State Planning Council Critiques
Jun '09	Gen Assembly Passes FY10 Appropriations
July '09	Senior leadership and Commission Approve State Plan
July 1, 2009	FY10 Plan Implementation Begins

During these events, statewide input is obtained from the community mental health center local Boards, citizen advisory groups numbering approximately 270 people.

In addition, CMHCs and Boards conduct public forums with 700-800 local family members, clients, advocates, sister agency staff, private practitioners, and community activists. Employee input is solicited through the administration at individual centers and facilities.

Although our schedule would have called for statewide focus groups this year, no new money was expected from the Legislature and senior leadership elected to delay the cycle.

DMH leadership and the Commission make the final decision on strategic goals, subject to modifications based on annual budget request approvals.

Disaster management planning for DMH is a separate process. Each CMHC and hospital has free standing plans for internal emergencies, and each dove-tails with the DMH plan to provide for cross facility coverage and statewide emergencies. In FY09, CMHCs and hospitals participated in a statewide terrorist drill to evaluate their disaster planning. All operations tasked to DMH were successfully met.

Administratively, there is an established emergency leadership succession plan, including transfer of leadership to Harris Hospital in Anderson in the event Columbia facilities can not function. All data services are mirrored at the Crafts Farrow Campus and could be online with only slightly reduced services in the event of the loss of the DMH Central Office. Similarly, the DMH Disaster Response Team has alternate sites for responding to emergency situations from either Crafts Farrow or Harris Hospital.

2.2 Addressing Challenges through the Strategic Goals

With little prospects for new funding in FY09 for clinical initiatives, the Department focused its programmatic planning on areas that were under its control, those areas that did not require new funding. Therefore, it is intentional that not all challenges (identified the Organizational Profile – Section I, Question 4) fully correspond to goals presented in Figure 2.1-5.

2.3 Developing and Tracking Action Plans

How do you develop and track action plans that address your key strategic objectives and how do you allocate resources to ensure accomplishment of the plan?

Statewide action plans include specification of budget and human resource requirements and measurable outcomes to evaluate the final product. The draft plan flags any goal that is "funding dependent."

Senior leadership assumes individual responsibility for statewide implementation and deployment of specific goals, and has a designated program staff member who assumes day-to-day oversight for the initiative. The State Planning Council, the Commission, and senior leadership receive progress reports on the goals on a schedule dictated by the nature of the goal.

2.4 Communication and Deployment

How do you communicate and deploy your strategic objectives, action plans and related performance measures?

Each division, community mental health center, and inpatient facility assigned to contribute to a particular objective has a designated person responsible for accomplishing that portion of the objective. State-wide program staff work closely with the organizational components to ensure that the action plan is on track for completion.

To communicate the 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 Quarterly Stakeholder

Meetings, and Internet and Intranet web postings are a few of the avenues that DMH leadership uses to keep all staff and management teams aware of activities and progress toward goals.

2.5 Measuring Progress

How do you measure progress on your action plans?

All strategic plan goals have a defined, measurable outcome, a timetable for implementation, and specified key deliverables. The lead staff for each goal assists the owner of said goal in state-wide coordination and tracking.

2.6 Evaluation of Planning Process

How do you evaluate and improve your strategic planning process?

DMH leadership, center/facility directors, lead staff, the State Planning Council, and stakeholder-participants critique each strategic planning cycle. Significant improvements to the planning process in the past three years include:

- Bringing the plan development timetable into line with the state's annual budget request timetable;
- Eliminating multiple plans by integrating the key clinical, administrative, and physical plant plans into one coherent document;
- Sponsoring childcare facilities at local meeting sites and providing transportation to clients to promote participation; and
- Adopting a three-year cycle to conduct a full stakeholder survey of priorities.

2.7 Strategic Plan Availability

The SCDMH homepage includes a link to the strategic plan (http://www.state.sc.us/dmh/). Other homepage links are to client resources, clinical information, clinical services, career opportunities, and timely events and news.

FY09 Strategic Goals and Accomplishments

Figure 2.1-3 FY09 Strategic Planning Chart				Key Cross
Program Number and Title		Supported Agency Strategic Planning Goal/Objective	Related FY08-09 Key Agency Action Plan/Initiative(s) and Timeline for Accomplishment*	References for Performance Measures**
General	Sale of Bull Street Property	Develop and implement marketing plan for sale of Bull Street property	The Department's real estate broker, NAI Avant launched formal efforts to sell the property in January, 2009 with the activation of a marketing website, http://www.naiavantbullstreet.com/.	
	Maintain Quality Services	Maintain CARF Accreditation of all CMHCs	All 17 CMHC are CARF accredited. Eleven (11) Centers are up for recertification this year: Aiken, AOP, Beckman, Chas., Coastal, Greenville, Pee Dee, Piedmont, Santee-Wateree, Spartanburg and Tri-County. The other centers' accreditation expire in 2010 (Berkeley and Catawba) and 2011 (Lexington and Waccamaw).	7.6-1
	Research and Funding Development	Identify, contact, and submit application to at least two philanthropic organizations for support to improve DMH services	Applications were submitted to the Robert Woods Johnson Foundation and Sonoco Corporation this past year. We will continue to pursue and follow-up on various philanthropic funding opportunities	

Community C&A Services	Improve Access to Care	Increase the number of school-based programs by 10 with focus on rural area schools from 178 to 188.	Lost four (4) positions during recent budget cuts - Staff currently out stationed in five counties.	
		Increase out-stationed DMH staff by 3 DSS County Offices (from 18 counties to 21 counties)	As of Jan 2009, DMH out stationed staff are in place in 12 DSS county offices. Seven of these counties were added a as result of the Rural Initiative funding, thus enabling the department to minimize some of the impact of the budget cuts.	
		Sustain the current DJJ out-stationed staff in 9 counties	On target - We are piloting a universal screening tool in eight counties - developing a plan for statewide implementation.	
		Add one (1) new MST programs (Greenville) for total of 7, and add 1 IFS team in 1 rural county	Below Target = Core competencies training provided to 25% or less of CAF staff - will continue to work on this goal. Developing training modules that can be done on web and by video conference due to travel restrictions.	
		Pilot the development of a universal screening/assessment tool for the adolescent co-occurring population in conjunction with other partner agencies.	On target - We are piloting a universal screening tool in eight counties - developing a plan for statewide implementation.	
	Staff Development	Develop core competencies required for agency staff providing co-occurring services to children/adolescents and provide training through ETR to 25% of CAF Staff.	Below target - Core competencies training provided to 25% or less of CAF staff - will continue to work on this goal. Developing training modules that can be done on web and by video conference due to travel restrictions.	
		In conjunction with ETR, train all 17 Community DMH Centers on an Evidence-Based Best Practice Model for Children/Adolescent Treatment.	On target - all CAF centers have been trained and continue to be trained in CBT.	
		Fund one training position in ETR through the OASIS grant to provide core competency training and evidence-based practices training to CMHCs	On target. We have funded one training position through ETR - working on the above 10 & 11 goals.	

	Reduce Out-of-Home Placements	Out-of-Home Placements: Maintain the percentage of children in out-of-home placements at an average yearly census that is less than .5% of the children served in all DMH programs (N=175)	On track; FY2008 average census =154 children in placement compared to 30,310 unduplicated children in all DMH program (N=175)	7.5-5
C&A Trauma	Increase Access to Services	Implement C&A Trauma Assessment at two additional CMHCs (From 9 to 11)	Partial: Beckman Center for Mental health Services has begun implementing assessment instruments with graduates of training.	
		Complete Trauma Treatment Training for majority of CAF Clinicians at two additional CMHCs (From 6 to 8) with continued trainings at previously trained centers to maintain target level of staff trained in TF-CBT.	Partial: A first round of staff at Beckman Center for Mental Health Services completed the Hands On TF-CBT Training (three part series) for CAF services	
Adult Trauma	Increase Access to Services	Implement Trauma Assessment at 2 additional CMHCs (From 9 to 11)	Partial: Beckman Center for Mental health Services has begun implementing assessment instruments with graduates of training.	
		The Majority of Adult Services Clinicians will Complete the Trauma Treatment Training at 5 CMHCs (From 6 to 11) with continued trainings at previously trained centers to maintain target level of staff trained	Partial: Hands On TF-CBT Phase One Training (three part series) has been provided at one center (Beckman Center For Mental Health Services). The Hands On TF-CBT Phase One Training (four part series) was provided to new staff at Coastal Empire Mental Health Center.	
COSIG/Co-Occurring Programs	Increase Access to Services	Pilot sites (Waccamaw & Charleston) with DMH, VR, & DOADAS staff become operational, use common definition of co-occurring disorder, and use joint screening tool	Goal met.	
Electronic Medical Record	Using Technology to Improve Services	Implement EMR in 2 New CMHCs (Total to equal 7)	The Hands On TF-CBT Phase One Training (four part series) was provided to new staff at Coastal Empire Mental Health Center.	
		Develop implementation plan for Tucker Center EMR by 7/30/09	On Hold	
		Develop implementation plan for BPH, acute, EMR by 7/30/09	On Hold	

CMHS Requirements		Redesign all CMHCs' Rehabilitative Programs based on Levels of Care	Cancelled: Due to changes in CMS/Medicaid requirements.	
Housing	Increase Key Quality of Life Conditions for Severely Mentally Ill Patients	Develop 40 additional housing units	Due to budget reductions, the FY2009 housing goal will not be met. Expect to fund 23 additional housing units by June 30, 2009. Proposed FY2010 Housing and Homeless Program Goals: Develop 40 additional housing units. Contingent upon funding	7.1-5
		CRCFs: Implement Legislative Study Committee recommendations on specific services to be provided and the manner in which they should be provided	A CRCF Legislative Study Committed was initiated and the Task Force completed its study with recommendations	
		Maintain TLC statewide occupancy rate at 98% or 1,017.	Toward Local Care Programs have a reputation of exceeding the statewide capacity, as the staff philosophy is to serve the clients by transitioning patients out to the hospital or maintaining them in the community. TLC statewide occupancy rate has exceeded the goal between July 2008 and January 2009 with the average monthly occupancy rate of 1,048 with a range from 1,033-1,070. Over the last couple of years of budget cuts, TLC has lost the following placement options: Intensive Residential Program/CRCF-52, Homeshare-8. The intensive Residential Programs have been the hardest hit because they are the most expensive to operate. Although programmatic cuts are still occurring, the "right now" capacity of TLC is 1,010.	7.3-5
		Survey DMH long term inpatient clients for identification of community development residential and treatment needs in preparation for FY10 goal.	On Hold	
Staff Competencies	Recruitment & Retention	Implement an Executive Leadership Development Program designed to groom at least 5 new senior DMH leaders	Completed.	
		Implement elements of programs needed to increase licensed clinical staff (class work, supervision, etc.)	Ongoing. Have contacted licensing authorities and received permission to use teleconferencing as an adjunct to face-to-face supervision.	

		Develop staff training on Recovery, based on results of recently completed Recovery Attitude Survey (Carry-over goal from FY08)	Currently on hold pending funding and identification of regional trainers. ETR to implement an on-line Recovery module before the end of the fiscal year A clinical recovery module will be establish by the end of the calendar year. Currently the department contracts with SC SHARE to not only provide the training for services such as WRAP (Wellness Recovery Action Plans) and RFL (Recovery for Life) but to implement the service at centers as well.	
SVP	Provide Appropriate Services	Implement measures to maintain meaningful treatment opportunities for Sexually Violent Predator residents despite increasing census	Increased number of groups held with the opening of the SVP Day Program.	
Crisis Services	Promote Crisis Services in Community Settings	Implement telepsychiatry between 25 community hospital Emergency departments (EDs). Report number of patients diverted from inpatient admission, quantitative information on the diagnosis of MH/substance abuse and/or co-occurring disorders, and reduction in average length of stay (LOS) in the EDs.	Partial: Telepsychiatry implemented at 6 community hospital emergency departments resulting in over 300 consults between March 27 and June 30, 2009.	
		Reduce the average weekly snapshot # of people waiting statewide in EDs who have a mental health &/or substance abuse issue from the FY08 statewide weekly average of 59.4 to at least 53.46 (10% reduction).	FY09 average # of people waiting in ED's was 59 persons waiting per week at 8:30 am each Monday, however the average and median wait times are decreasing. Additionally, the # of people waiting at 5:00 PM each Monday has decreased to an average of 37.	7.5-9
		Reduce the average weekly snapshot maximum # of hours people with a mental health or substance abuse issue wait for disposition in EDs from the FY08 statewide weekly average of 132 hours to at least 118 (10% reduction).	Beginning the last quarter of FY09, the benchmark for wait times in ED's was changed to an actual average and median # of hours of persons waiting statewide for state inpatient mental health or substance use treatment. The average for that quarter was 52 hours and the average median wait time was 46 hours.	

		Improve overall reliability and validity of outcomes as reported by centers for quarterly report to Governor.	Both reliability and validity improved significantly by concretely redefining outcomes of crisis programs and funding spent per quarter. Have revamped reporting tool used by centers each quarter to report data to director of crisis stabilization. Funds are monitored for appropriate utilization on an ongoing basis. Cost effectiveness now more accurately attainable.	
		Allocate crisis funding to all CMHCs based on past performance and current needs in order to maximize outcomes and cost benefit.	Have demonstrated significant outcomes per dollars spent for FY09. Statewide 7,303 persons were averted from non essential ER admissions via direct interventions of funded crisis intervention and co occurring programs. Additionally, 5,122 persons who had already been admitted to an ER were successfully diverted to more appropriate and cost efficient treatment settings during FY09 by funded crisis stabilization initiatives.	
Peer Support Specialists		Conduct a minimum of three (3) Peer Support Certification classes certifying at least 15 possible DMH Peer Support Specialist candidates	Completed (3) trainings this year; one more training is set before the end of this fiscal year. On target for next year	
		Establish one (1) Certified Peer Support Specialist (PSS) position in three of the six mental health centers that are currently without an established position, pending adequate funding	The only center that added a Peer Support Specialist this year was Orangeburg but due to budget cuts the position was eliminated. Centers without PSS are Greenville, Pee Dee, Catawba, Coastal Empire, Piedmont and soon to be Orangeburg. Greenville hired a PSS one years ago and sent her to training but then would let her function as a peer, Coastal Empire was suppose to have someone through MHA, but that has not happened yet. Pee Dee had a peer support specialist in Feb/March 2005, Catawba had one, actually two (2), they have hired but neither worked as a PSS; and Piedmont has never had a PSS.	
Employment	Improve Quality of Life for Clients	Expand Evidenced-Based Best Practice IPS programs in CMHCs without existing IPS programs (from 9 to 10 CMHCs)	IPS programs remain in 9 sites. Unable to accomplish goal because of budget cuts.	
		Create at least one (1) more funding opportunities for IPS/SE Programs	Ticket-to-Work funding to help sustain and enhance the Evidenced-Based Best Practice IPS programs has been delayed due to lack funding.	
		Develop a formula to determine the Return On Investment (ROI) for IPS/SE clients working in the community.	A committee has been convened to develop a method to determine ROI. A spreadsheet has been sent to all IPS supervisors to place data need to determine ROI. IPS supervisors have until the middle of March to complete the spreadsheet and submit to central office.	

Acute Inpatient		Opening Beds at Harris and Bryan Acute. Maintain current capacity at Morris Village, Hall, and Wellspring.	Not Met: Although Harris opened beds during the year, the net result was the loss of 11 beds at Harris due to budget reductions.	
Interagency Partnerships	Improve Interagency Relationships to Better Serve Mentally Ill People	Establish plans with advocacy groups, DAODAS and the WJB Dorn VA Hospital to develop a professional inter-agency S.C. Peer Support Network	Partially Completed. Planning is on-going with all partners committed to achieving goal.	
		Complete interagency partnership with the WJB Dorn VA Hospital and DAODAS to provide the basic peer support certification training to all potential SC peer support specialists candidates by editing/updating the current training manual and by clarifying and defining agency variants (i.e. Medicaid documentation, service descriptions, agency policies & procedures and continuing education requirements).	Goal met.	
		Compile listing of all MOAs between DMH (both state and local) and other agencies/ organizations to assess extent of formal collaborations, partnerships, and joint service provision	Preliminary list has been prepared and is now a part of each center director's EPMS.	

Public Relations and Anti-Stigma Initiatives	Reduce Stigma and Educate Public Concerning Mental Illness	DMH Senior Leadership and Center Directors will conduct public presentations to educate citizens and constituent groups about mental health and addictions issues, emphasizing that mental illness is a medical problem and that treatment works. Presentations will also educate the public about SCDMH and how the agency provides taxpayers' a good return on their investment.	The Office of Public Affairs promotes these projects through coverage in the Department's newsletter, IMAGES; DMH Speakers Bureau; press releases; SC.GOV website; and presentations made by the State Director at professional and public engagements.	
		Conduct the "Art of Recovery Program" with public exhibitions of art work by citizens with mental illness, promote positive media relations, and coordinate the Palmetto Media Watch Program.	FY09: The "Art of Recovery" had exhibitions at 7 locations including The Columbia Museum of Art, Richland County Public Library and Irmo Library with one-day exhibitions at Heroes in the Fight and Mental Health America Annual Conference. Palmetto Media Watch: The Office of Public Affairs researches instances of stigma in the media, gathering applicable contact information, for media watchers to remit comments. A database has been built to maintain a contact list of media watchers so that alerts can be sent out.	
Outcome Measurement		Develop measures, including financial, for obtaining outcomes for at least five (5) of the CMHC Programs	A Monthly Business Report has been developed for the CMHCs. It is currently under review by Senior Management.	
		Test effectiveness of the CBCL as replacement instrument for CAFAS in two CMHCs	Goal Accomplished: All of the Centers began using the CBCL on July 1, 2009. It has replaced the CAFAS.	
Financial Management		SAP Conversion: In conjunction with state CIO, develop "blueprints" of system needs, plan for data conversion, and testing of new SAP system	Staff have attended all meetings and submitted numerous "blueprint" documents. It is anticipated that meetings and additional documentation will continue throughout the year.	
		Review current financial reports available from Centers, Facilities, IT and develop a monthly management package	Standard management and Commission reports have been developed. A variety of analytical reports are developed on demand.	
Contract Mgmt		Form a Contract Administration Oversight Committee	Contingent upon decision to develop in-house or acquire externally (DHHS, DSS, OnBase).	

		Develop database that tracks specifics on proposed and executed contracts, from initiation, through review, approval, monitoring and renewal	Blueprints for data elements, tables and screenshots have been developed. Further development contingent upon decision to develop in-house or acquire externally (DHHS, DSS, OnBase)	
Grants Management	Research and Funding Development	Establish an office of Grants Administration and provide fiscal oversight for all grants	Office of Grants Administration has been established and has begun providing fiscal oversight for all grants.	7.3-3
		Train all appropriate employees in compliance with DMH, state, and federal regulations	Office of Grants Administration provided multiple training sessions at multiple DMH sites on regulatory requirements of grants.	
Veteran's Services		Determine if developing/providing services to military personnel (and their families) returning from Iraq and other theaters of war is feasible and in the best interest of all parties. Determine availability of grant fund through SAMHSA's Application Policy Academy	Partial - All Community Mental Health Centers are now on the Veteran's Administration list of "Non-VA Providers of Mental Health Services" list. Additional means of contracting for services for veterans continues to be explored.	
Capital Projects	Effective and Efficient Use of Resources to Develop and Maintain Assets	Hall Institute: Acquisition of funds to re-build. Resume design services.	Hall will be renovated instead of replaced.	
		Construct Charleston MHC Children's Addition.	Complete.	
		Award Construction Contract for Columbia Area MHC Phase II	Goal met. Construction contract awarded.	
		Columbia Area MHC master plan Phase III. Request funding through budget request.	Request was number 6 of 14 on Department's Capital Budget Request.	
		Continue replacement of the fire retardant treated wood (FRTW) in the Bryan lodges and Support Buildings. Complete Phase I contract and award Phase II contract. Request funding for Phase III.	Phase I contract complete. Phase II completed. Phase III funding requests was number 1 of 14 on Department's Capital Budget Request.	

		High priority deferred maintenance issues for both community and inpatient buildings. Request funding through budget request.	Request was number 3 and 4 of 14 on Department's Capital Budget Request. Not funded.	
		Construct McCormick Clinic. Request funding through budget request.	Request was number 5 of 14 on Department's Capital Budget Request. Not funded.	
		Pee Dee Crisis Center Construction. Request funding through budget request.	Request was number 7 of 14 on Department's Capital Budget Request. Not funded.	
		Sexually Violent Predator Facility. Request funding through budget request.	Request was number 8 of 14 on Department's Capital Budget Request. Not funded.	
		New water & electrical services for Tucker Center, Columbia Area MHC, & DMH Administration Building independent of the Bull St. campus systems. Complete electrical service for Tucker Center and Columbia Area. Request funding for Tucker water and Admin Bldg electrical through budget request.	Both Tucker and Columbia Area electrical service feeds are underway. Estimated completion date in early FY10.	
		Construct additional treatment facility for Bryan & Morris Village. Request funding through budget request.	Request was number 10 of 14 on Department's Capital Budget Request. FY10: Contingent upon receipt of funds.	
		Addition to the Holly Hill Clinic. Requests funding through budget request.	Request was number 11 of 14 on Department's Capital Budget Request. FY10: Contingent upon receipt of funds.	
		Construct Community Mental Health Centers for Santee-Wateree, A-O-P, and Catawba MHCs. Request funding through budget request.	Request was number 12, 13 and 14 of 14 on Department's Capital Budget Request.	
		Address Life Safety & Deferred Maintenance issues in Columbia Area MHC Carter Street apartments and adjoining support buildings. Request funding through budget request.	Request was number 3 of 14 on Department's Capital Budget Request. FY10: Contingent upon receipt of funds.	

		Harris Life Safety Renovations: Complete renovations.	Life Safety work is complete. Goal met.	
		Campbell VA Home Renovations: Complete design, finalize VA grant, and start construction.	Design was completed and bids received on February 3, 2009. Grant documents sent to Federal VA on February 11, 2009. Waiting award of grant.	
* June 30, 2009 is target date for all goals.				
** Key Cross-References are a link to the Category 7 - Business Results.				

Category 3 – Customer Focus

3.1 Determining Key Clients and their Requirements

How do you determine who your clients are and what their key requirements are?

Our client base is defined, in part, by legislative mandates and the SC Code of Laws which gives the Department jurisdiction over the state's mental hospitals and community mental health centers. We receive our clients voluntarily and involuntarily, through family members, through the court system, and through law enforcement. We also embed staff into schools, other agencies, and hospital emergency rooms to promote ease of access and reduce the stigma often associated with receiving mental health services. To become a client of the Department of Mental Health, one must have a diagnosable mental illness.

Our key clients are adults, children, and their families who are affected by serious mental illnesses and significant emotional disorders. These priority populations, established by stakeholders through the strategic planning process, were affirmed by senior management and the Commission who adopted federal definitions of specific diagnostic categories for serious mental illness and significant emotional disorder.

The key client requirements for adults with severe mental illness have been defined by our clients 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; achieving functional improvement; actively pursuing goals and aspirations in the areas of affordable housing, education, employment and social supports; and living a higher quality life.

These requirements are operationalized by SCDMH as: symptom reduction, functional improvement; satisfaction; meaningful employment; and housing which is safe, affordable, and decent.

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 that meets the requirements of its clients.

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.

3.2 Keeping Current with Changing Needs

How do you keep your listening and learning methods current with changing client/business needs and expectations?

The Department believes that to promote recovery for people with mental illnesses, it is essential to have clients – people with mental illnesses and their families – involved in the planning, evaluation, and delivery of care. All major planning committees of the Department have clients, family members, and advocacy organization representatives, and advocacy groups are among those who attend monthly Assembly meetings and Commission meetings.

Each CMHC has a Client Affairs Coordinator, a self-identified mental health client who participates in management meetings and decision-making to provide a voice for the client and there is a statewide Client Advisory Committee operated by the Office of Client Affairs.

To gain a broader perspective on evolving health care service needs and directions, the agency 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. Their feedback to the agency offers insight into current perspectives on health care trends. Additionally, many staff are surveyors for major accrediting bodies, bringing innovative approaches back to South Carolina, and training other staff in new approaches to service delivery.

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 the appropriate division head, as well as the state director.

3.3 Key Client Access Mechanisms

What are your Key Client access mechanisms, and how do these access mechanisms enable clients to seek information, conduct business, and make complaints?

In keeping with the department's value of "Support for Local Care," primary access to DMH services is through 17 strategically placed Community Mental Health Centers and sixty-four mental health clinics with offices in every county.

In addition, DMH is steadily expanding services into the natural environment of the child and their families. Staff is out-stationed in almost half of all South Carolina's public schools, in twelve county DSS offices and four county DJJ offices. Further, Assertive Community Treatment (ACT) Teams, Family Preservation and MultiSystemic Therapy Programs deliver case management and direct treatment in the client's home.

SCDMH is available to clients 24/7 via telephone, in emergency rooms across the state, through evening appointments at most CMHCs, and through the web. All CMHCs and inpatient hospitals have client advocates available to resolve complaints not satisfied by local staff, and the state office has an 800 number hot-line manned by a clinician during normal business hours and a statewide client advocate available.

3.4 Measuring Satisfaction

How do you measure client/stakeholder satisfaction and dissatisfaction, and use this information to improve?

The Department collects data on key indicators that reflect client satisfaction. We were initial participants in the Mental Health Statistical Improvement Project (MHSIP) to develop national comparative data on client perceptions of satisfaction with access to services, appropriateness of services, and outcomes. The MHSIP Surveys are conducted annually with clients, youth, and family members.

A patient complaint system tracks client dissatisfaction. All CMHC and inpatient facilities have client/patient advocates who receive complaints, pursue incident details, and follow to resolution.

The data is analyzed, stratified, and aggregated to promote systems knowledge, and the DMH Commission reviews summary information monthly on Client Advocate interventions and resolutions.

3.5 Using Feedback Information

How do you use information from clients/stakeholders to keep services or programs relevant and provide for continuous improvement?

The state 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 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. By including stakeholders in the fabric of the Department's operations, stakeholder satisfaction levels are assessed more diligently than could be obtained simply through periodic surveys or questionnaires.

SCDMH is only the second state in the country to have peer-support services as a Medicaid billable service. A peer support person is a self-identified client of mental health with a diagnosed mental illness who delivers mental health services to other adult clients. In FY09, 21 certified peer support specialists are working in community mental health centers, a 28% reduction from FY08. This is primarily due to budgetary concerns with some positions being eliminated and others simply unfilled.

3.6 Building Positive Relationships

How do you build positive relationships with clients and stakeholders? Indicate any key distinctions between different client groups.

The culture of the Department is one of *inclusion*. Advocates, clients, family members, and all stakeholders have an active place at the DMH table. Members from all major stakeholder groups are represented in the State Planning Council and other planning/policy bodies.

The Department has a patient advocacy system with representatives in every hospital and community mental health center. These advocates ensure that clients/patients are presented with their "bill of rights" during orientation, intervene on behalf of clients in complaint/grievance issues, and report complaints (resolved and unresolved) to Center/Facility leadership and DMH senior leadership.

The Department actively encourages employees to participate in advocacy groups and stakeholder organizations at the state and local level. It believes in partnerships, each organization contributing to the effectiveness of the other.

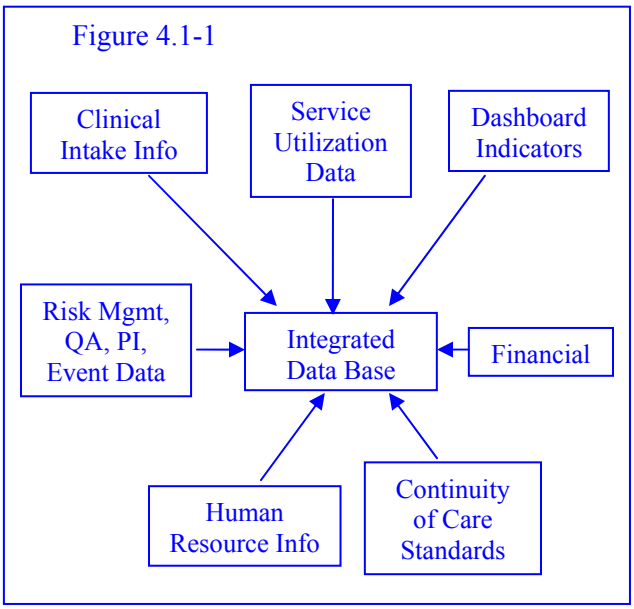
Category 4 – Measurement, Analysis, and Knowledge Management

4.1 Determination of Measures

How do you decide which operations, processes and systems to measure for tracking financial and operational performance, including progress relative to strategic objectives and action plans?

The Department's Management Information System (MIS) includes an integrated database consisting of data on all clients served by its hospitals and CMHCs. This includes demographic and clinical data on clients, service utilization, expenditures, event data, human resource data, and operational costs (Figure 4.1-1)

Figure 4.1-1



Senior leadership, with affirmation of the DMH Commission, decides which operations and/or processes to measure at the Departmental level. At the division, center, and hospital levels, the manager may make decisions on additional data elements to collect and aggregate to help track daily operations.

Clearly, the Department chooses to measure key requirements of the client, program performance and client outcomes. These are the services and programs most important to the stakeholders.

Accrediting bodies mandate many of our performance measures for our inpatient system. These measures, called ORYX, give 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 quarterly, 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.

4.2 Using Data and Information in Decision Making

How do you select, collect, align, and integrate data/information for analysis to provide effective support for decision making and innovation throughout your organization?

Centralized data is compiled on a weekly, monthly, quarterly, and/or yearly basis, and 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 client care and organizational performance.

The Department's Key Performance Measures identified in Table 1 provide both trend and comparative data across time and against standards. These elements, combined with the risk management analysis described in Category 6, provide managers with measures on key client requirements for client groups and measures on program effectiveness, and efficiency.

Management staff in CMHCs, hospitals, and administration also produces 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 also 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.

4.3 Key Measures

What are your key measures, how do you review them, and how do you keep them current with business needs and direction?

Table 1 identifies key measures. Senior leadership using input from CMHC and hospital directors, local Boards, the State Planning Council, and advocacy groups routinely assesses the utility of the measures.

The SCDMH Outcomes Office participates in national forums to develop and improve the core performance measures for public mental health systems across the country. Our criteria include areas such as client perception of care, penetration rates, populations served, service utilization, and program performance data.

4.4 Comparative Data Use

How do you select and use key comparative data and information to support operational and strategic decision making and innovation?

ORYX provides comparative data on inpatient measures, and sponsors of the MHSIP provide comparative client satisfaction data. Evidence-based practices are detailed in "toolkits" which contain the program standards as well as key measures and comparative data.

For other measures, finding comparative data becomes very difficult because each state defines its programs differently and assesses them with different standards.

4.5 Data Quality, Reliability, Availability

How do you ensure data integrity, timeliness, accuracy, security and availability for decision making?

A client information system provides individual data sets on clients. 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 (AVATAR) and outpatient (CIS) databases together, resulting in a major reduction in duplicate client identifiers and facilitating the tracking of clients across all service programs.

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.

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

Access to the Department's database 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. SCDMH has fully implemented HIPAA requirements.

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

4.6 Priorities for Improvement

How do you translate organizational performance review findings into priorities for continuous improvement?

In its monthly review of Key Performance Indicators, the Department uses a three-month trend standard for initiating a corrective action. Any measure (statewide, CMHC, or inpatient) which exceeds standards for three consecutive months triggers an automatic performance improvement response. Additionally, any negative internal audit finding requires a corrective action plan and includes a follow-up report to the Commission on corrections achieved.

Other components of the performance improvement system are identified in Table 2 of Section II.

4.7 Management of Organizational Knowledge/Best Practices

How do you collect, transfer, and maintain organizational and employee knowledge (your knowledge assets)? How do you identify and share best practices?

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

- The Key Performance Indicator Report is sent to senior leadership, CMHC board chairs, the Commission, center and facility directors, and other DMH management. It is then discussed at various meetings.
- In FY04, DMH senior leadership 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.
- An Executive Leadership development Program began last year to prepare a new generation of senior leaders. Five people successfully completed the training in FY09.
- The DMH Risk Manager has made presentations to the center directors and the Commission on key findings, recommendations, and actions.
- Progress reports on clinical and administrative initiatives are made at quarterly CMHC/Inpatient Directors' meetings.
- Reports are available on the Intranet for key indicators, hospital data, service data, center data, CAFAS, GAF, MHSIP, etc
- Best practice programs are featured in Images, the DMH newsletter published quarterly.

Category 5 – Human Resources

5.1 Organization of Work Systems

How do you organize and measure work: to enable workforce to develop to their full potential, aligned with the organization's objectives, strategies, and action plans; and 2) promote cooperation, initiative, empowerment, teamwork, innovation and your desired organizational culture?

Job classifications and position descriptions are designed to support service delivery and the needs of the agency's clients. The work of employees is monitored by supervisors and managers to ensure that employee job classifications reflect the level of work that is done. Position descriptions reflect job responsibilities and are used to reinforce job classifications.

The Employee Performance Management System (EPMS) is the measurement tool that is used to define and track employees' job performance on an annual basis. This tool sets forth measurable success criteria that enable the employee and the supervisor to know expectations for good performance. If, at any time during the review period, the supervisor detects that the employee is not meeting expectations, a meeting is held to counsel the employee regarding those deficiencies and an improvement plan is implemented.

5.2 Knowledge Transfer

How do you achieve effective communication and knowledge/skill/best practice sharing across departments, jobs, and locations?

In addition to employee training events which usually include participants from multiple locations and serve as a forum for idea exchange, the Department hosts topic-specific events focusing on best practice methodology, Grand Rounds Lecture Series, and multi-agency seminars.

5.3 Recruitment and Retention

How does management recruit, hire, place, and retain new employees? Describe any barriers that you may encounter.

Recruitment of employees is a joint effort between the central Human Resources Office and the agency's centers and hospitals. In February 2008, the agency implemented an e-recruitment process that now enables the Department to respond more quickly to filling vacancies and allows for broader outreach to applicants. DMH Office of Human Resources staff attends targeted job fairs, and last year restarted recruitment efforts to attract psychiatrists by attending the annual American Psychiatric Association conference in Washington, DC. Participation in the Healthcare Retention and Recruitment Pilot Program has been instrumental in the recruitment of psychiatrists.

The agency's most challenging barrier to recruiting, hiring, and retaining employees is a lack of competitiveness in compensation. As our workforce continues to age, it is more and more difficult to attract new employees, especially nurses, psychiatrists, mental health professionals (counselors) and mental health specialists. With our primary competitors in the local markets being hospitals, we have not been able to be salary competitive.

5.4 Workforce Capability and Capacity Assessment

How do you assess your workforce capability and capacity needs, including skills, competencies, and staffing levels?

The Division of Evaluation, Training and Research (ETR) is responsible for meeting the training needs for strategic priorities of

SCDMH and training needs of employees that exceed the expertise/capabilities of individual units . While the strategic plan and accrediting body standards drive the agency's training plan, ETR 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.

Each year ETR sends out a Needs Assessment Survey throughout the agency. Since SCDMH is a health care agency, many of the staff are clinicians. Therefore, one survey is sent out to physicians and another is sent out to non-physician clinical staff. The results of the surveys are used to develop the training calendar for the next year.

In order to meet accrediting standards nursing staff complete annual competency verification in a lab setting. Other staff competency is verified by their supervisor and documented in their annual performance evaluation.

5.5 EPMS Supports High Performance

How does your workforce performance management system, including feedback to and from individual members of the workforce, support high performance work and contribute to the achievement of your action plans?

All staff receive performance evaluations at least annually. The information included on the EPMS is developed from the position description and outlines the performance criteria that the employee is expected to meet. The criteria conform to programmatic needs and customer requirements.

Employees and their supervisors meet at least once during the rating period to discuss the employee's performance and to identify problems that may be impeding optimum performance. Supervisors are encouraged to use this time to coach their employees and to discuss the potential they see for their employees to achieve professional goals.

5.6 Leadership Development

How does your development and learning system for leaders address the following?

a. Development of personal leadership attributes. b. Development of organizational knowledge. c. Ethical Practices. d. Your core competencies, strategic challenges, and accomplishment of action plans

In February 2004, SCDMH designed, developed, and implemented a Mentoring Program, discussed elsewhere in this report, to prepare staff to assume positions of leadership to replace those senior staff leaving though the TERI plan. The program, now in its sixth year, is an eleven month seminar (that will become a nine-month course beginning FY10) that includes monthly classroom instruction lead by SCDMH senior leaders and out-of-class homework assignments which are supervised by mentors at the participants' home locations. Three participants have become our newest CMHC directors, and several others have been promoted within the organization.

In 2008, SCDMH developed an Executive Leadership Development Program to prepare a cadre of qualified individuals to assume Executive Leadership positions within the agency. This program is aimed at improving the effectiveness of both the individual and SCDMH as a whole. The program is 14 weeks long, and has a written assignment and program evaluation process built into it. A program guide focuses on developing the knowledge of the organization among participants. The guide includes discussion of ethical practices and issues and strategic goals and challenges facing SCDMH.

Participants are required to complete a written project and oral presentation on a Management Improvement Project. The projects focus on methods to create a new management initiative or improve or add value to one that is already in place in SCDMH. This allows the program facilitators to assess the knowledge of the participants about the organization and the competencies required of executive leadership positions.

In 2008 a Supervisory Mini Series was developed. The purpose of the program is to prepare new supervisors to function effectively in SCDMH. Two graduates from this program have assumed deputy director positions.

5.7 Key Developmental and Training Needs Identification

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

Key developmental training needs for the workforce are identified and addressed statewide through strategic planning and the SCDMH Training Council. Locally, needs are identified and addressed through the organizational component, the supervisor, and the employee. All training participants are queried to determine additional trainings that staffs need to enhance their job skills.

One hundred percent of all new employees receive new employee orientation. SCDMH also has an on-line learning system that provides fifty modules or courses to address a variety of issues including fire safety, cultural competence, performance improvement, and annual recertification for required training. Additional training needs are identified through on site observation of staff and through requirements of accrediting and licensing bodies.

Opportunities for training are advertised through e-mail announcements and brochures. Staff, in consultation with their supervisor, registers for training through Pathlore, the Department's Intranet Training Management System, which tracks all classes to be held, enrollment, and completed training.

The Department also utilizes traditional approaches to staff education and training – classroom instruction. In FY07ETR began using the SCDMH videoconferencing system to provide live trainings. This**,** also, has reduced the need for travel and has resulted in significant cost savings for the CMHCs and facilities. In addition, the agency offers specific training for employees to prepare them for professional license exams and license renewal.

5.8 Transferring Training to the Job

How do you encourage on the job use of the new knowledge and skills?

Supervisors are integral to the education and training of staff. Employees are encouraged not only to use the new knowledge and skills that they receive through training, but are also encouraged to share that information with other staff. Patient care is a top priority of the agency and all training efforts are tied not only to enhancing the knowledge, skills and competencies of staff, but also toward positive patient care outcomes. Staff is able to see the linkage between their knowledge and abilities and excellence in patient care delivery.

5.9 Training Directed Toward Goals

How does employee training contribute to the achievement of your action plan?

At the end of each fiscal year, the agency sets its priorities for the coming year. The training calendar is developed using the

results of the needs assessment and strategic goals. All training is two-pronged in that it is designed to meet the needs of the staff and the mission and strategic plan of the agency. Throughout the year ETR assesses where they are in meeting those priorities and makes changes in their direction as needed.

5.10 Evaluating Training Effectiveness

How do you evaluate the effectiveness of your workforce and leader training and development system?

Evaluation of the workforce and leader training and development system is an ongoing and multifaceted process. Participants are asked to evaluate training programs. Their mentor and facilitators are asked to evaluate the program. ETR also does periodic surveys of program participants to determine if they have had a promotion or increase in responsibilities following their completion of the program.

5.12 Employee Well-Being and Satisfaction Measures

What formal and/or informal assessment methods and measures do you use to determine workforce well being, satisfaction, and motivation? How do you use other measures such as employee retention and grievances? How do you use this information?

The Department conducts random satisfaction surveys every two years. Additionally, the state director and other members of senior management, visit the state's seventeen (17) CMHCs and the inpatient facilities during the year to speak with staff, learn their concerns and keep them abreast of information about the Department that is of interest to them.

The DMH Commission conducts its monthly meeting in a community mental health center or inpatient hospital every other month, touring the facilities, talking with staff and hearing presentations on programmatic initiatives of the visited location. These face-to-face contacts with line staff enhance open communication between administration and employees.

The Department continues to maintain its "Hotline" that allows employees to ask questions about policies and procedures or rumors.

The Exit Interview serves as a valuable tool in providing feedback regarding why employees leave our system. This information is provided to appropriate center/facility directors or division deputy directors for use in improving communication and tackling issues that may not be readily evident.

The DMH grievance process uses a check and balance system that affords an employee the opportunity to seek redress for grievable issues. Employee grievance panel members work independently from the location where the grievant works, and have wide discretion and latitude in making recommendations to the State Director. It is this independence that provides the employee a sense of well-being in knowing that they will be treated fairly.

5.13 Promoting Career Progression

How do you manage effective career progression and effective succession planning for your entire workforce throughout the organization?

Career progression and succession planning is integral to the agency. The Mentoring/ Succession program prepares middle management staff for positions of increased responsibility. This year, a Supervisory Mini-Series has been added to address the needs of new supervisors. The Executive Leadership Development Program has been added to prepare individuals to assume executive leadership positions in the agency.

Participants are selected in collaboration with the leadership at the center or hospital from which the participants are chosen.

5.14 Maintaining Safe and Healthy Work Environment

How do you maintain a safe, secure, and healthy work environment? (Include your workplace preparedness for emergencies and disasters.)

Workplace environment (safety, health, security, etc.) is important to clients, management, and staff, and considerable energy is devoted to maintaining and improving the facilities and the condition of the workplace. Employees serve on a wide variety of committees to identify workplace hazards and conditions that would improve the health and safety of clients and staff.

Accrediting bodies have explicit standards on the workplace environment and provide feedback on any deficiencies. Facilities with safety violations do not receive accreditation. The standards are segmented based on the needs of the persons served by the facility or program, so the performance measures may differ by a "persons served" criteria. All SCDMH facilities are fully accredited.

Supplementing our own inspections, the Department takes full advantage of the health and safety inspections provided by the numerous accrediting bodies who survey each of our community mental health centers and our hospitals.

Other examples of our own initiatives in this area include:

- the development of a "Violence in the Workplace" directive;
- pre-employment tuberculosis testing;
- annual employee health screenings;
- annual employee health clinic free flu shots;
- annual wellness related activities;
- a program to treat injured employees with the goal of providing them with immediate quality care and returning the employee to work as quickly as possible;
- pre-employment drug testing;
- air quality and hazardous chemical inspections of buildings;
- inspections by quality assurance teams, Internal Audit, and Public Safety;
- ongoing monitoring of community residential care facilities that provide residences for clients in local communities;
- specialized safety training conducted by safety experts from the State Accident Fund;
- preferred provider agreements with healthcare practitioners to assist employees with job related injuries;
- safety inspections of all Department facilities by fire and safety officers;
- Fire/Safety committees composed of employees and fire/safety officers; and
- Employee clinic that, in addition to caring for and tracking work related injuries, provides immunizations, vaccines, and blood pressure readings.

Facilities that require locked doors for the security of persons in treatment have "panic buttons" to summon internal staff assistance and notify our public safety office who responds immediately. Receptionists in crisis areas have electronic buzzer systems to unlock doors.

All staff in treatment areas receive annual, competency-based training in de-escalation techniques and therapeutic physical intervention skills to manage potentially violent situations. Clinical staff in the children's programs receive specialized self-defense and intervention training appropriate to the population they serve, as do

employees working with the geriatric and the forensic populations. Maintenance and ancillary staff also receive training specialized to meet their need.

Workman's compensation data and incident reports strongly influence who receives what kind of training, the frequency, and the length. In fact, the training actually exceeds the need; it is provided because staff focus groups report that when they feel competent to handle an escalating situation they are much more likely to apply de-escalation strategies, rather than over-react or call pubic safety

Category 6 – Process Management

6.1 Core Competencies

How do you determine and what are your organization's core competencies, and how do they relate to your mission, competitive environment, and action plans?

The organization's core competencies (those capabilities that provide a strategic advantage in our service environment) flow from the agency's mission, values, and legislative mandates. They are determined by assessing client expectations and by input from the organization's State Planning Council and DMH Division Directors.

The core competencies are identified as:

1. **Integrated Continuum of Care that Includes Inpatient and Outpatient Services**

   SCDMH is the only provider of mental health services in South Carolina (and one of only a few in the country) with a unified system of care: both community centers and inpatient hospitals under a central authority with all staff being state employees. This promotes consistency of services provided across the state to ensure both continuity of care and standards of care.

2. **Citizen and Stakeholder Involvement**

   Embedded into the fabric of SCDMH, at the administrative and operational level, is a philosophy of inclusiveness. This includes:

   - Governance by a Commission of appointed citizens
   - Local mental health center Boards appointed by the legislature
   - State Planning Council composed of clients, family members, advocates, and sister-agency service providers
   - Stakeholder participation in all major policy and program development decisions

3. **Comprehensive, Wrap-Around Programming**

   As a not-for-profit, state-supported public health system, SCDMH can be much more responsive than the private sector in providing a full range of services needed by patients with severe mental illnesses.

   As such, the agency can identify and do whatever has to be done to prepare long-term, institutionalized patients to return to a life in the community and prevent unnecessary re-hospitalization.

   DMH focuses on the full scope of the client's needs, not only symptom reduction and disease management, but also housing, employment, and social skills.

   The Department responds anywhere in the state, 24/7, when there is a mental health crisis, reaching into schools, homes, emergency rooms, jails, or even out-stationing our staff into sister agencies.

   DMH hires self-identified mental health clients as Peer Support Specialists because we believe they can offer unique

services, provide hope and inspiration to other clients, strengthen our knowledge of our own system, and because it is the right thing to do.

4. **Integrated Data System**

   The SCDMH data system allows the integration and retrieval of all clinical, financial, demographic, historical, and outcome data for an individual client, for a facility, or for the Department. It links the community and the inpatient systems, and the statistical software provides routine reports on performance measures within and across the Department. Implementation of the EMR will further enhance these capabilities.

Almost all strategic goals are linked to at least one of the above core competencies.

These core competencies give SCDMH the ability to accomplish its mission: To support the recovery of people with mental illness – in the cities and in the rural areas of our state. We are the safety net for those less fortunate, and aim to be the provider of choice for behavioral health for all citizens of South Carolina.

6.2 Key Processes

How do you determine and what are your key work processes that produce, create, or add value for your clients and your organization, and how do they relate to your core competencies? How do you ensure that these processes are used?

Key processes include assessment, diagnosis, and treatment of adults and children with serious mental illness and emotional disturbances.

Value is created by designing services to meet need, as defined by the client, the family, and our partners, and client perceived value is ensured by:

- including clients in their treatment planning and goal-setting process;
- continually monitoring client satisfaction and program outcomes;
- having Client Advocates in Centers and hospitals to assist clients and resolve issues;
- including all stakeholders in Departmental policy and program activities;
- focusing on client Recovery; and
- monitoring of processes through QA audits, peer review, utilization review, and Medicaid audits.

6.3 Incorporating Efficiency and Effectiveness Measures into Processes

How do you incorporate organizational knowledge, new technology, changing client and mission-related requirements, cost controls, and other efficiency and effectiveness factors such as cycle time into process design and delivery?

The design of programs is based upon best practice or evidence-based technology that is proven to show improvement in the quality of life of our clients as well as reducing their symptoms in a shorter period of time than more traditional services.

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 (Figure 6.1-1).

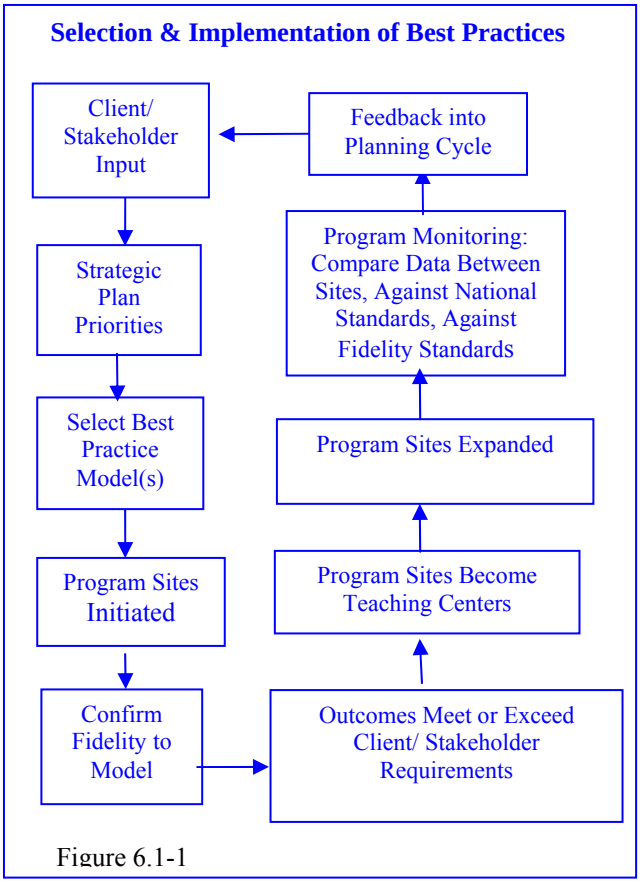


Figure 6.1-1

The Department's telepsychiatry and video conferencing system has produced substantial cost-savings and has proven to be an effective means of communicating. Each DMH hospital and CMHC has the necessary equipment performing at 384 kbpm, permitting proper visual and verbal communication.

The telepsychiatry system delivers one-on-one behavioral health services to clients across the state, both hearing and deaf. The same system allows for state-wide links for training and administrative meetings.

In FY08 the Department received a $3.7M grant from Duke Endowment that will significantly expand our use of telepsychiatry. Our goal is to link DMH to all emergency departments in the state, using state-of-the-art video and voice equipment. DMH psychiatrists will be available 24/7 to provide "face-to-face" consultations to emergency room staff.

The DMH Intranet system augments the performance and knowledge-base of our employees. It provides secure access to clinical records of clients, a client pharmacy system that ensures that medications are compatible and within accepted dosage limits, and a complete pharmacology system to aid in medication reference.

The Department conducts comparative studies on treatment approaches such as Multi-systemic Therapy (MST) and Family Preservation, or IPS and other Employment models. These studies improve the cost-efficiency and effectiveness of our programs

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.

6.4 Daily Operations: Meeting Key Performance Requirements

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

All of our service processes are defined, measured, and managed through our Quality Assurance and Performance Improvement programs, underpinned by the accreditation standards of the Joint Commission, CARF, and Medicaid requirements.

The elements of accreditation standards are made operational through policy documents, the Continuity of Care Standards Manual, the CMHC Operating Standards Manual, case record reviews, Quality Assurance (QA), local and state office level audits, corporate compliance audits, risk management system, and utilization review. Our standards are frequently higher than those set by accrediting bodies.

Electronic transactions between hospital and centers on client discharge information are monitored daily by the Department with same day corrective actions initiated on any errors noted.

6.5 Process Evaluation and Improvement

How do you systematically evaluate and improve your key product and service related processes?

The QA process retrospectively assesses the appropriateness of care, conformance to accreditation, corporate compliance, and utilization review standards, and DMH/ DHHS (Department of Health and Human Services) contract stipulations on an annual basis. The results of the reviews identify strengths in the clinical operations at the inpatient and CMHC levels, as well as opportunities for improvements.

Facilities and centers generate corrective actions plans based on their audit reports. The implementation of their corrective actions is monitored every six months.

In addition to front-end performance improvement efforts and back-end quality assurance audits, the Department has a comprehensive Risk Management Information System that tracks all adverse incidents in the Department. Any event in over 20 categories (attacks, deaths, injury, contraband, medical emergency, elopements, etc) is reported immediately to the departmental risk management office.

The event investigations are tracked, and a determination is made whether to initiate a Quality of Care Review Board (QCRB).

These ad hoc boards, composed of DMH professionals and advocacy representatives, assess the root cause of the occurrence and make recommendations for corrective actions.

The state director, the medical director, the director of community mental health services, the risk manager, or any facility or CMHC director may initiate a QCRB. All QCRB recommendations are tracked, and experiences from one part of the system are applied to all other appropriate components.

6.6 Key Support Processes

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

Key support processes include:

- Finance
- Human Resources
- Information Technology
- Nutritional Services
- Physical Plant
- Vehicle Management
- Special Programs

All key processes are designed based on end-user requirements and state government standards as a starting point. While some processes may be "off the shelf" purchases, most processes are designed by employees, with assistance from end-users and, sometimes, consultants. All key processes undergo field-testing prior to implementation.

7.1 Mission Accomplishment Results

The DMH measures for mission accomplishment may be grouped, as follows:

a) Child & Adolescent Clinical Outcomes
b) Adult Clinical Outcomes
c) Client Quality Of Life Outcomes
d) Nursing Home Clinical Outcomes
e) Alcohol and Drug Addiction Outcomes

a) Clinical Outcomes: Child and Adolescent Services

The science of mental health treatment has gone far beyond traditional views of psychiatric treatment. In addition to assessing clinical symptoms, treatment effectiveness focuses on assessing primary life criteria reflective of mental health: How is the child functioning in his/her world: Is the child living at home with family? Are they in school? Are they out-of-trouble? These are mental health outcome standards that were not possible until recently.

Our child clinical instrument is the CAFAS, and assessments are conducted at admission, six-month intervals, and discharge. CAFAS scores are classified into four categorical levels (Minimal, Mild, Moderate and Severe). The Moderate and Severely Impaired individuals meet the DMH definition as a priority population: severely emotionally disturbed.

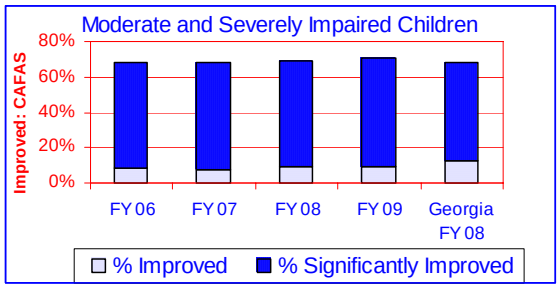


Figure 7.1-1 (Higher is Better)

Sixty percent (60%) of all children served had an initial score that placed them in the most impaired categories (moderate or severely impaired) at intake. Figure 7.1-1 shows the degree of improvement for these children following treatment. Over 64% of the Moderate and Severe rated children improved their CAFAS scores at least one category level between admission and discharge.

The effectiveness of treatment for the most emotionally disturbed children continues to increase. Sixty percent (60%) significantly improved their scores (at least 2 category levels, i.e. moved from Severe to Mild, or moved from Moderate to Minimal).

b) Clinical Outcomes: Adults Services.

Adult clients are clinically assessed using the GAF (Global Assessment of Functioning Scale) at admission, six- or twelve-month intervals (depending on how long the person is in treatment), and discharge.

Figure 7.1-2 shows the change in psychiatric symptom scores and level of functioning for adult clients. The data reflects paired admission and discharge scores of the same persons.

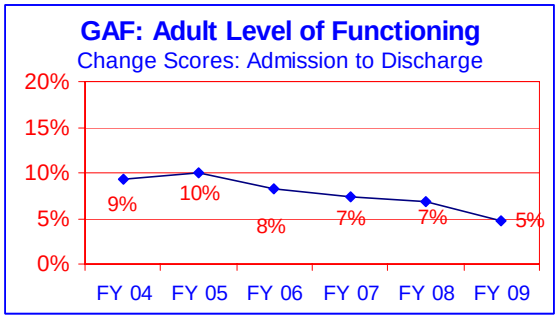


Figure 7.1-2 (Higher is Better)

DMH is still exploring the utility of this measure and how to configure the data. By using paired scores, the figure includes discharge scores that may skew the results. Many of our clients, those with the severest illness, are not discharged; they remain in continued treatment. Limiting the data to

clients who are discharged probably includes those persons with less severe illnesses and whose change score would be the smallest.

c) Client Quality of Life Outcomes

Client recovery is closely tied to quality of life. Clients need housing that is safe, affordable, and decent and employment that is meaningful. These two factors are major contributors to a client's transition from a life of dependency on the mental health system to independence, self-reliance, and feelings of self-worth.

In FY09, DMH again exceeded the national average in employment rate for all mentally ill clients it serves (Figure 7.1-3).

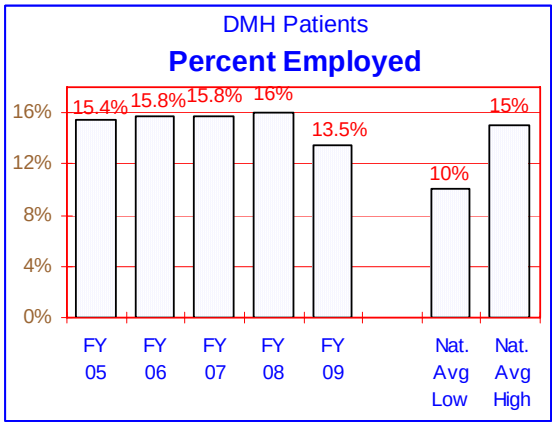


Figure 7.1-3 (Higher is Better)

In addition to standard employment programs for all clients, DMH has initiated evidence-based employment programs (IPS) designed for severely mentally ill clients who are unemployed and want to work.

The IPS Employment Programs produce an employment rate two and a half times that of traditional employment programs (Figure 7.1-4) and the SCDMH rate exceeds the national best-in-class employment rate.

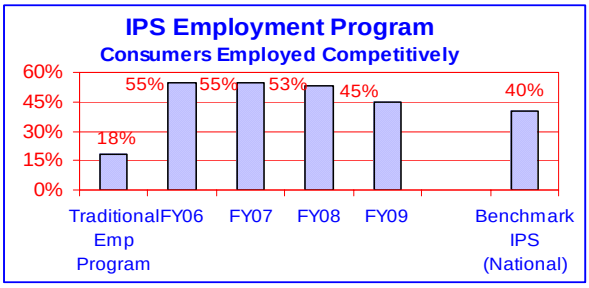


Figure 7.1-4 (Higher is Better)

Working through partnerships with private nonprofits and local CMHCs, the Department's Housing and Homeless Program is able to finance the production of new supportive housing that is affordable for clients living in the community. This effort has continued to show major advances since its inception (Figure 7.1-5).

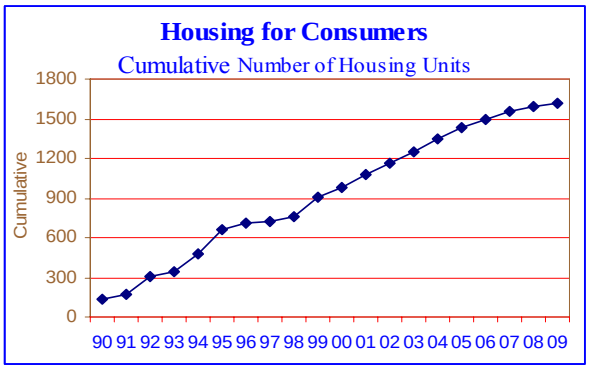


Figure 7.1-5 (Higher is Better)

While not all clients require assistance with housing or employment, for those that do these factors can be key determinates in their ability to live in the community. The Housing Program funded 23 new units of housing in the community this year.

d) Clinical Outcomes: Nursing Home Residents.

The most fundamental measure of clinical effectiveness for a nursing home is that of Health/Safety. Nationally, life expectancy following admission to a nursing care facility is slightly over two years. At Tucker Nursing Care Center, residents average over 4 years (Figure 7.1-6).

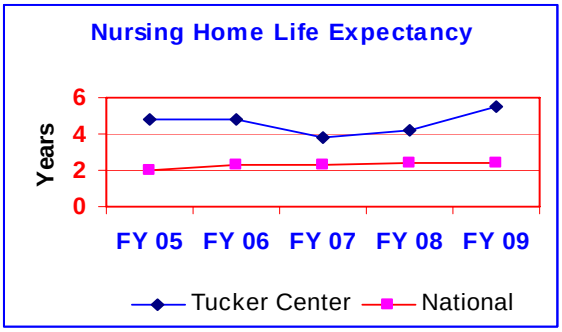


Figure 7.1-6 (Higher is Better)

Two critical factors impacting the increased longevity of Tucker Center residents are the low incidence of bed sores (Figure 7.1-7) and the low rate of falls (Figure 7.1-8), both common occurrences in homes for the elderly, and both life-threatening.

Tucker Center residents acquire fewer decubidi ulcers (bedsores) than the state average. In FY07 Tucker Center altered its standard for reporting bedsores, to match national reporting criteria. Even so, occurrences remain below state norms.

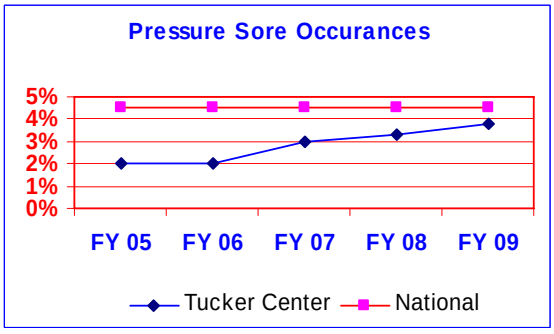


Figure 7.1-7 (Lower is Better)

Tucker Center has also placed considerable energy into reducing injuries from falls. The rate has shown a steady decrease, while the state average has remained constant.

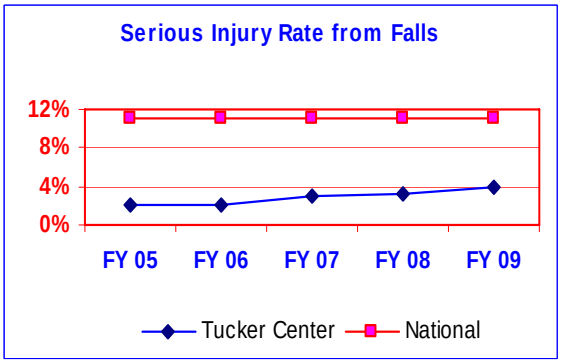


Figure 7.1-8 (Lower is Better)

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

The key measure for effectiveness with A&D clients is abstinence following treatment (Figure 7.1-9). Sixty-four percent (64%) of Morris Village residents were abstinent at 30-day follow-up in FY09, a decrease compared to recent years. While the reasons for this are not entirely apparent, a major factor skewing the data is the paucity of responses to surveys over the past year.

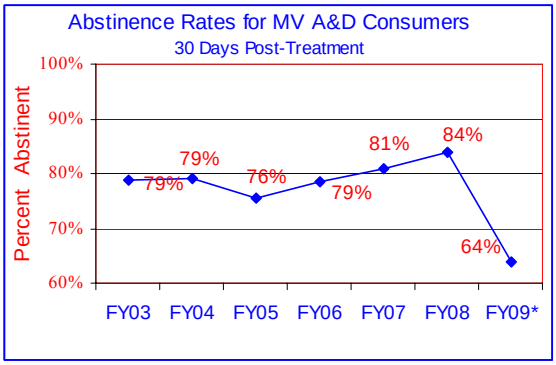


Figure 7.1-9 (Higher is Better) *Through March '09

No comparative data is available for a state-operated, mostly involuntary, alcohol and drug addiction treatment facility. Private facilities do not release this information, and national accreditation bodies do not require this basic measure of program effectiveness.

7.2 Client Satisfaction Results

DMH measures client satisfaction through:

a) Adult Perception of Care;
b) Youth and Family Perception of Care;
c) Nursing Home Resident and Family Satisfaction; and
d) Morris Village (Alcohol and Drug Addiction Inpatient Services) Resident Satisfaction.

a) Adult Client Perception of Care:

Client perception of care is assessed with the MHSIP Client Satisfaction Survey, and DMH is rated by clients at a level equal to the national average (Figure 7.2-1). Changes in survey collection methodology resulted in no data being collected in FY07.

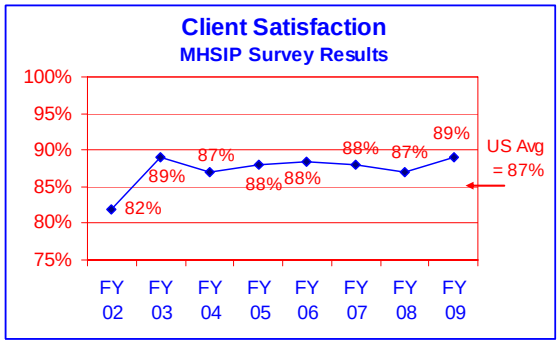


Figure 7.2-1 (Higher is Better)

b) Youth and Family Perception of Care:

The MHSIP Youth Services Survey and the Family Satisfaction Survey were introduced in FY05. The DMH Youth Survey (Figure 7.2-2) satisfaction level was 88%; National Youth MHSIP comparison data has not yet been released.

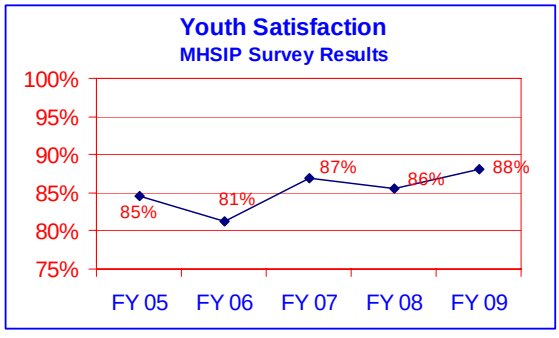


Figure 7.2-2 (Higher is Better)

The Family Satisfaction score was 89%, identical to last year and well above the national average (Figure 7.2-3).

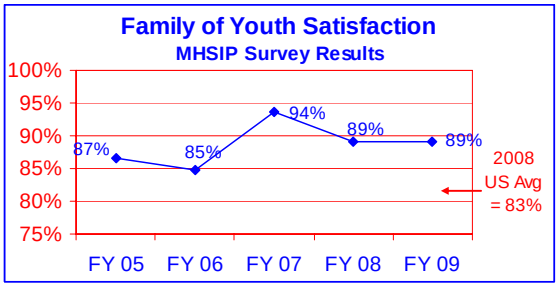


Figure 7.2-3 (Higher is Better)

c) Nursing Home Resident and Family Satisfaction

Both residents and their family members are assessed at Tucker Nursing Care Center for level of satisfaction. Results ("Usually Satisfied" or "Exceptionally Satisfied") over the past three years remain at levels above the three previous years. (Figure 7.2-4).

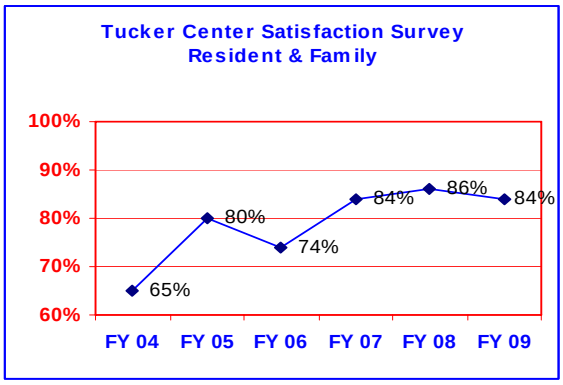


Figure 7.2-4 (Higher is Better)

d) Alcohol and Drug Addiction Inpatient Services:

Morris Village residents, 65% of whom are involuntarily committed to treatment, report satisfaction with the services they receive at 95%. (Figure 7.2-5).

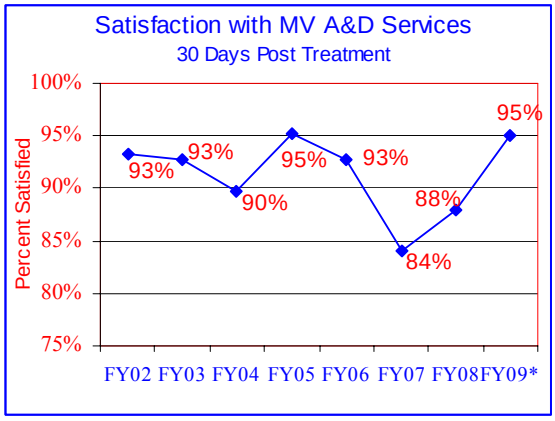


Figure 7.2-5 (Higher is Better) *Through March '09

7.3 Financial Performance Results

The Department's operating revenue (all fund sources) shows significant fluctuation from FY01 through FY09 (Figure 7.3-1). Even with these fluctuations, DMH has operated within its budget and has never run a deficit.

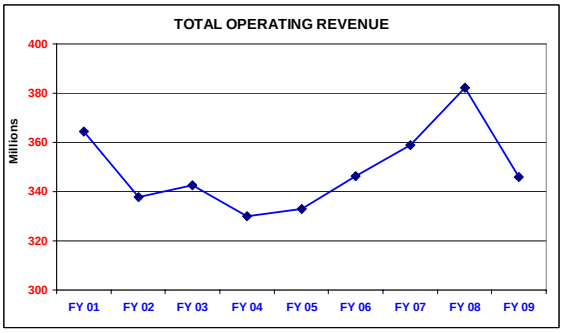


Figure 7.3-1 (Higher is Better)

Figure 7.3-2 shows the relative magnitude of the different funding sources and how the levels of all major sources of revenue for the Department have changed over the last five years.

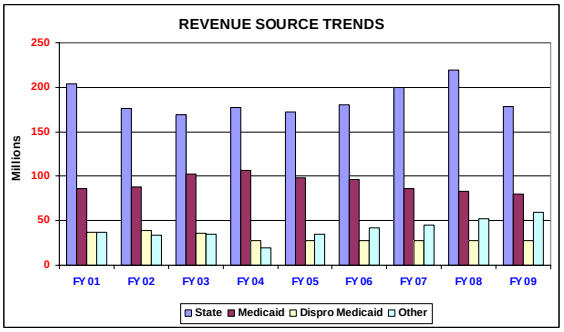


Figure 7.3-2 (Higher is Better)

In FY09, DMH was awarded over $8.8 million new grant dollars (Figure 7.3-3), a major accomplishment in a time of diminishing resources, federal as well as state.

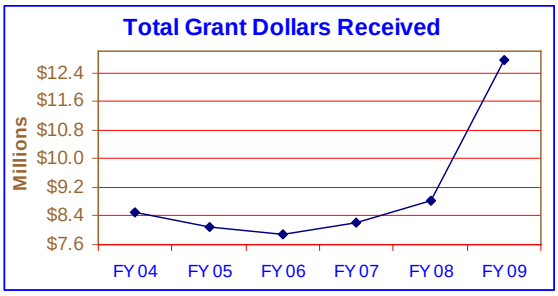


Figure 7.3-3 (Higher is Better)

State Accident Fund Premiums have risen dramatically in the past nine years. While the number of claims is down over 40% since FY2000, the increases in medical costs have continued to push the premiums upward by more than 260% during this same period (Figure 7.3-4).

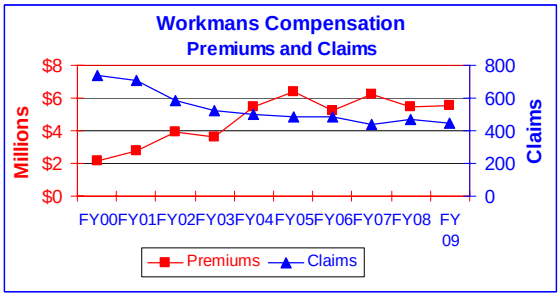


Figure 7.3-4 (Lower is Better)

Expanding community programs and reducing inpatient use not only conforms to stakeholder expectations, but also is also

more cost effective. 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.

Further, 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.

The TLC program, begun in 1991, is designed to return long-term psychiatric inpatient clients to live in the community through intensive support from CMHCs. To date, 2,516 clients with serious and persistent mental illness, 1,882 from an institutional setting, have participated in the program.

Figure 7.3-5 compares the average one-year cost of maintaining a client in the hospital with the cost associated with TLC community enrollment.

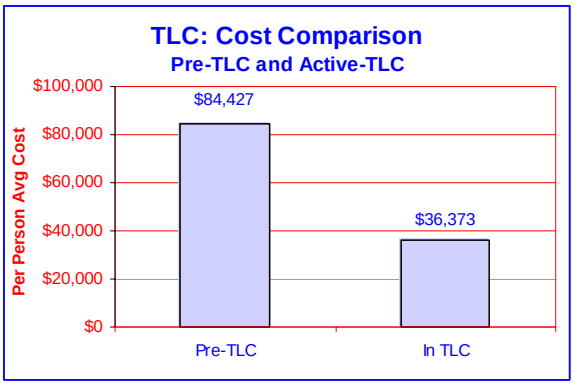


Figure 7.3-5 (Lower is Better)

For the 93 individuals enrolled in the TLC program one year ago, there was a $4.4M cost savings (or redirection) directly attributable to TLC Program participation. The costs reflect their actual hospital costs in the year before TLC with the actual net costs during their first year in the TLC Program (CMHC case management, hospitalizations, etc.).

Not only is community-based treatment the right thing to do, it is also financially a much more efficient use of fiscal resources. It is for 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 clients 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, Medicaid revenue, and re-direction of cost-savings (Figure 7.3-6).

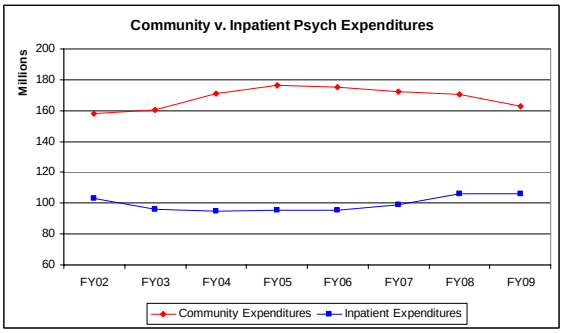


Figure 7.3-6 (Higher is Better for Community; Lower is Better for Inpatient)

The Department actively seeks to contain the costs associated with inpatient care. Bed-Day costs (Figure 7.3-7) reflect the expenses of providing inpatient care within the specialized facilities.

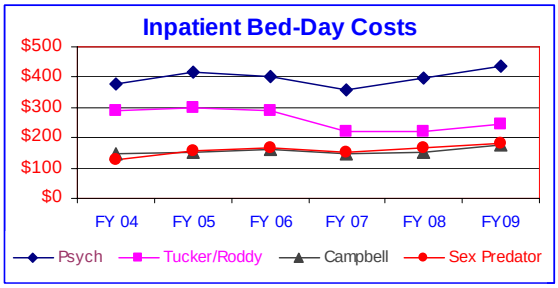


Figure 7.3-7 (Lower is Better)

DMH has done well to hold down the rising cost of expensive inpatient care. Figure 7.3-8 shows the per day cost of DMH acute care facilities compared to the average cost DMH

pays through contract to private psychiatric facilities.

While the costs are about equal, DMH has promoted the expansion of local inpatient capacity because it is the preference of stakeholders, and it is in keeping with the Department's commitment to local care alternatives for crisis stabilization and diversion programming.

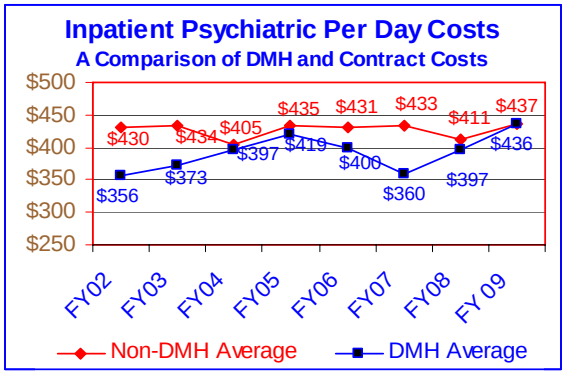


Figure 7.3-8 (Lower is Better)

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.

The commitment to a community system has spurred DMH to enter into housing development, partnering with housing authorities and non-profit organizations to create single and multi-family residences for clients who, otherwise, may have no alternative outside of institutional life. DMH has achieved a 4:1 leveraging of its housing funds, a rate not exceeded by any other state.

Finally, the commitment to community care means decreasing the number of children who are placed in out-of-home care and the dollars associated with this level of care. The 54% reduction in the number of children placed in out-of-home care (Figure 7.5-5) has resulted in a 75% reduction in the overall costs (Figure 7.3-9).

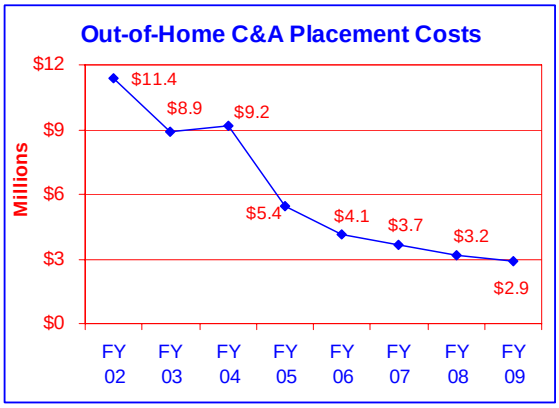


Figure 7.3-9 (Lower is Better)

7.4 Workforce Results

SCDMH conducts a formal assessment of workforce issues through a satisfaction survey on a two-year cycle. The survey was completed in 2008 and due again in 2010.

To summarize the information from last year's Accountability Report, 60% of employees reported that they were satisfied or very satisfied with their job, eighty percent of employees surveyed agreed or strongly agreed that they perceive their work as contributing to the mission of the agency, and 52% of employees responded that they received adequate training to perform their job.

DMH provided 17,794.92 hours of employee training in FY09 with 47,228 participants. Included in those numbers were 162 hours of training conducted via videoconferencing with 1,176 participants.

By using videoconferencing for training DMH is able to reach a larger audience and eliminate the need for staff to travel to attend training. This reduces the costs associated with travel and allows clinical staff to see patients before and/or after the training, thereby allowing them to continue to bill for services.

Similarly, the SCDMH Computer Learning Modules (CLM) include 50 on-line courses

available to staff. Of those 50, there are 44 that are mandatory to meet accrediting and regulatory standards. If the modules were not available, staff would have 44 hours of in-classroom training to take, not including travel time. For the clinical staff, this would have a negative impact on their productivity and billable hours. The estimated man-hour cost savings to SCDMH for the on-line learning modules for FY07/08 was $4,283,796 (based on 5,100 employees at an average hourly wage of $19.09).

DMH provided 2,500 hours of employee training directly related to meeting the goals of the strategic plan in FY09 (Figure 7.4-1), a 17% increase since FY08.

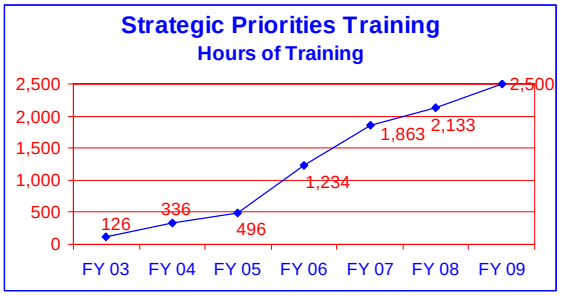


Figure 7.4-1 (Higher is Better)

DMH's actions to improve the working environment are reflected in reduced workers' compensation claims. Figure 7.4-2 shows a 37% reduction in the number of claims since FY01.

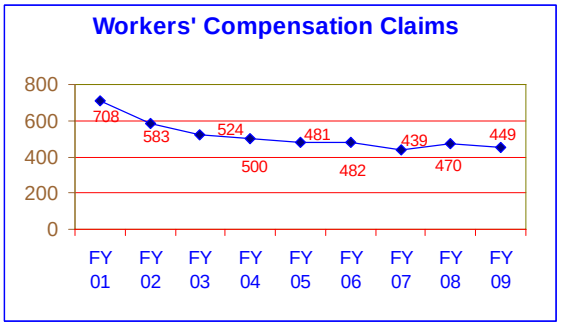


Figure 7.4-2 (Lower is Better)

Employee turn-over rate is 16.5% for FY09 (Figure 7.4-3), two years of small decreases and below comparable state agencies.

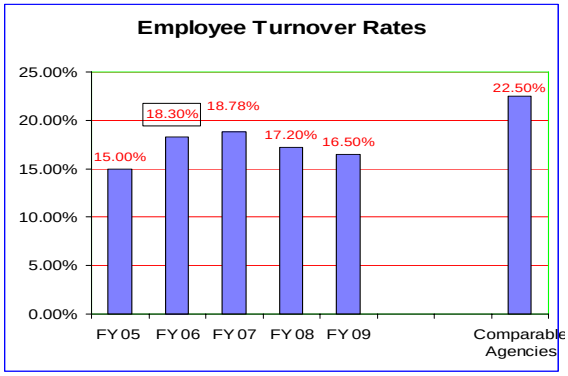


Figure 7.4-3 (Lower is Better)

In affirmative action, DMH ranks 9th among large state agencies for percentage of goals met. Figure 7.4-4 shows the percent of affirmative action goals met by the agency each year since FY04.

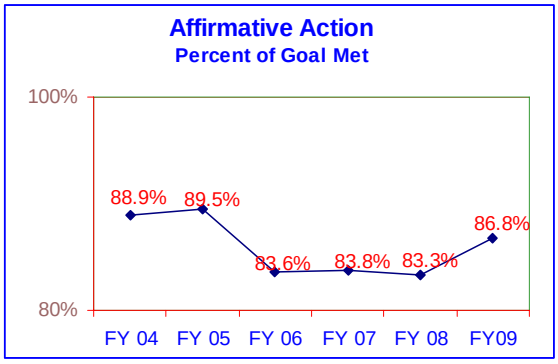


Figure 7.447 (Higher is Better)

7.5 Organizational Effectiveness and Efficiency Results

The DMH measures for organizational effectiveness may be grouped, as follows:

a) Community Services to Priority Populations

b) CMH Services Clinical Effectiveness

c) Inpatient Services Clinical Effectiveness

d) Support Processes Outcomes

a) Community Services to Priority Populations:

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 five strategic plans. DMH assesses the extent to which it reaches the adults and children who

need mental health services (penetration rate), and compares its efforts to the "level of penetration" of other states.

DMH has, for the past three years, hovered at slightly less than the national average in the number of adults served per 1,000 population (Figure 7.5-1).

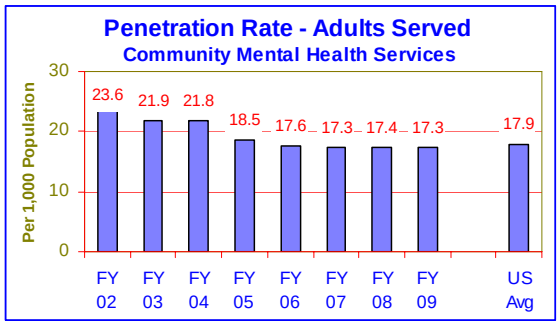


Figure 7.5-1 (Higher is Better)

The gradual decrease in the adult penetration rate most likely reflects the Department's focused reduction in treating persons who are not severely mentally ill and intensifying services to those who meet the criteria for severely mentally ill (SMI) and seriously and persistently mentally ill (SPMI). Alternatively, these numbers may reflect the growing population vs. the relatively stable number of adults we have served over the years.

Eighty-eight percent of all DMH adult clients meet the definition of SMI, and 85% of all FY09 adult client contacts are with SMI clients (Figure 7.5-2).

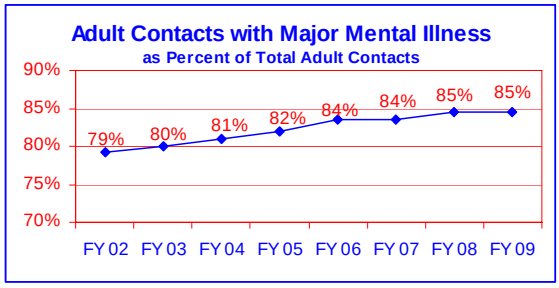


Figure 7.5-2 (Higher is Better)

DMH has also continued to increase its focus on providing services to children and adolescents. Penetration data (Figure 7.5-3) shows that we continue to significantly exceed the national average in children served under the age of 17.

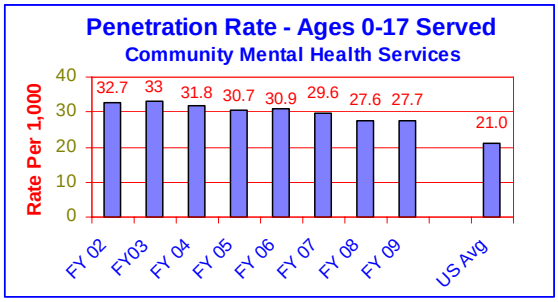


Figure 7.5-3 (Higher is Better)

As with adults, DMH continues to increase its focus on services to the more seriously disturbed children (Figure 7.5-4). Fifty percent of all C&A clinical contacts are with seriously emotionally disturbed children.

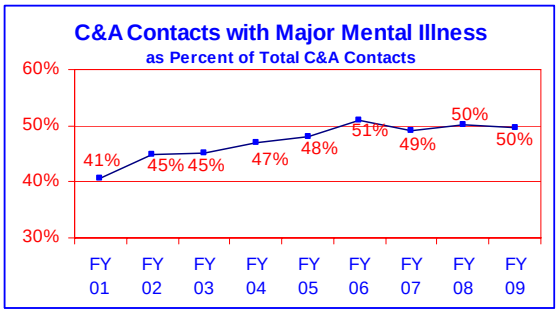


Figure 7.5-4 (Higher is Better)

SCDMH believes that children should be treated within the family system, and removing the child from the family unit should be a last resort. As such, reducing out-of-home placements has been a goal across all CMHCs. Figure 7.5-5 shows a 54% decrease in average number of children in an out-of-home placement over the past six years.

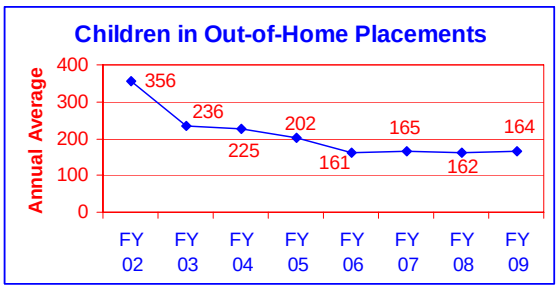


Figure 7.5-5 (Lower is Better)

The actual number of persons, all ages, served through the community centers from FY03 - FY09 is shown in Figure 7.5-6.

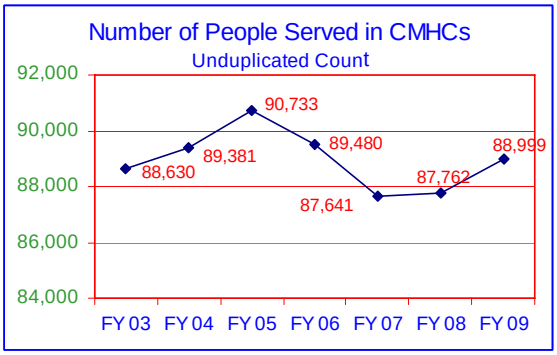


Figure 7.5-6 (Higher is Better)

b) CMHC Services: Clinical Effectiveness

In a community-based system of care, it is important for CMHCs to have an array of services to stabilize individuals in crisis and divert admissions to hospitals when clinically appropriate. As such, the Department monitors inpatient admissions weekly and has viewed their reduction (Figure 7.5-7) as evidence of expanded community capabilities.

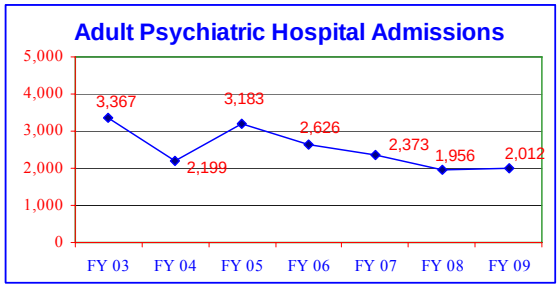


Figure 7.5-7 (Lower is Better)

In fact, there are probably multiple reasons for the 37% decrease in psychiatric hospital admissions in the past five years, some desirable and some not so desirable:

- Improved crisis stabilization and crisis diversion programs in the community;
- The ongoing departmental funding of community based, inpatient treatment, both substance abuse and psychiatric, for those in crisis.
- The increase in the percentage of patients who stay in the hospital longer than 90 days, resulting in a decrease in acute care beds available to admit short- term patients.
- The agency is operating fewer in-patient beds than in previous years.

South Carolina has paralleled the country with a phenomenal growth in Emergency Department (ED) use by persons in crisis, both behavioral health and all other categories. This increase in emergency department use has had a major impact on the public healthcare system and the Department of Mental Health.

While the number of persons waiting is important, it is the length of any wait that is even more important to the client and to our ED partners.

In FY09 DMH funded special initiatives totaling $4.5M to reduce the burden placed on these hospitals emergency departments. The funding is dedicated to a variety of crisis initiatives throughout the state. These programs include crisis stabilization teams, the provision of staffing in local emergency departments, and treatment teams who provide services to those with co occurring mental illness and substance abuse disorders. Additionally, dedicated crisis funding can be utilized to divert those in emergency departments to local private inpatient facilities for short-term stabilization. Contracting for short-term use of beds in non-DMH hospitals not only reduces the need for DMH inpatient beds, it also provides crisis care near the patient's home and enhances local, community-based options. Figure 7.5-8 shows the growing trend in this treatment option.

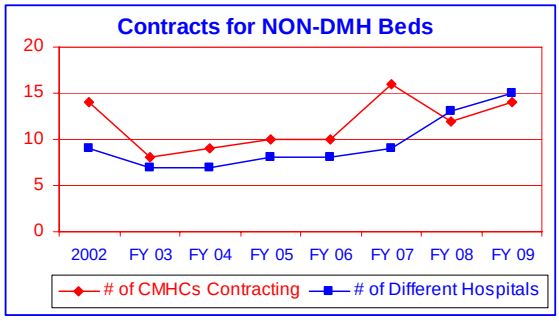


Figure 7.5-8 (Higher is Better)

Even with these efforts, the number of persons waiting in the ED longer than 24-hours has continued to average about 37, according to our Monday morning snap-shot count (Figure 7.5-9).

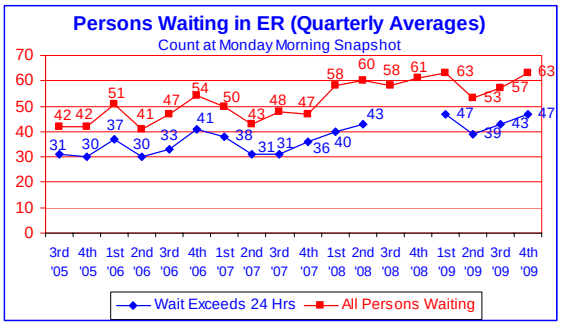


Figure 7.5-9 (Lower is Better)

Particularly challenging to DMH is that a significant number of persons who present themselves in the EDs with a primary diagnosis of mental illness and/or alcohol/drug are unknown to DMH. Seventy-three percent of those seen in EDs with a primary diagnosis of mental illness and/or alcohol/drug were not served by DMH during the three year period prior to the year they were in the ED. (Figure 7.5-10).

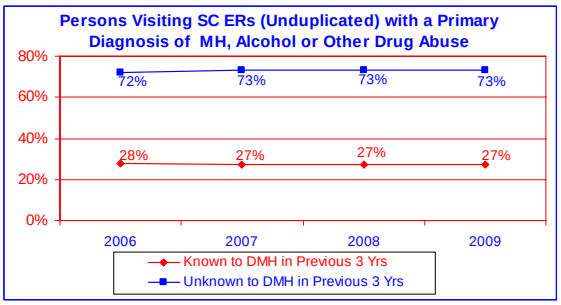


Figure 7.5-10

Long-term solutions will require a concerted effort with our key partners: South Carolina hospitals, the Department of Alcohol and Other Drug Services, and client advocacy groups.

While advances in community crisis stabilization programs and increased staffing in the EDs help to control the hospital admissions, the Department has also concentrated on assisting long-term psychiatric inpatients move out of the hospital into less restrictive community settings.

Individuals identified for the TLC Program receive intensive support through the CMHCs, helping them adjust to community life and secure daily living skills. Figure 7.5-11 shows the capacity of the TLC program.

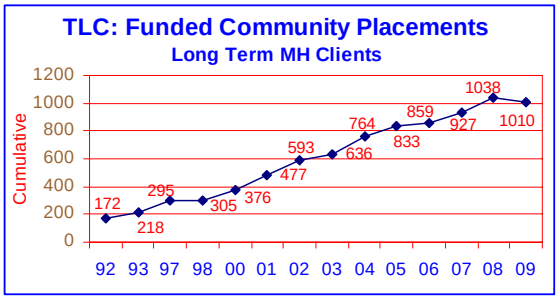


Figure 7.5-11 (Higher is Better)

For the first year since its inception, the TLC program experienced a net loss of awarded placements due to budget reductions. Yet TLC continues to serve over a thousand long-term, severely mentally ill clients in the community, reflecting the shrinking census of hospitalized, long-term psychiatric patients (Figure 7.5-12).

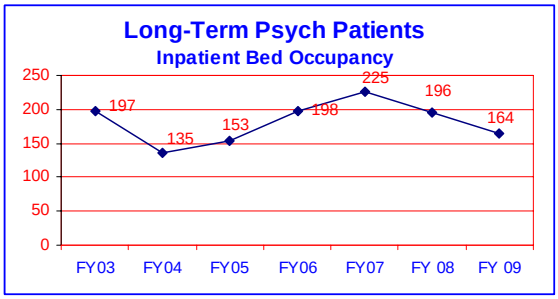


Figure 7.5-12 (Lower is Better)

When persons do require hospitalization, research indicates that the sooner the person is seen by the community mental health center following discharge from an inpatient facility, the less likely the client will be readmitted for subsequent inpatient care.

The DMH Continuity of Care Manual sets our standard as "clients will be seen by a CMHC for a follow-up appointment within seven days of discharge from an inpatient facility."

Senior management and the Commission review data quarterly on the number of days between inpatient discharge and the date of their first appointment at a local community mental health center (Figure 7.5-13).

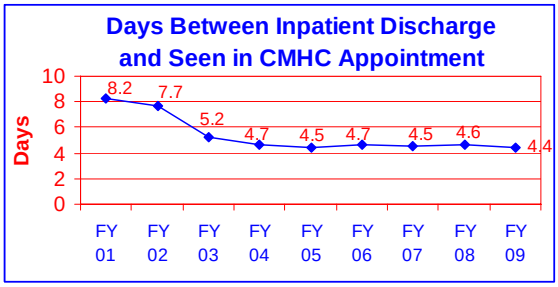


Figure 7.5-13 (Lower is Better)

SCDMH's average of 4.4 days has a range of 4.0 to 5.3 days, well under our seven-day standard.

c) Inpatient Services: Clinical Effectiveness

Senior leadership reviews key performance data for each inpatient facility. The measures are broad indicators of the quality of inpatient care and are part of the ORYX measures emphasized by accrediting bodies.

A low 30-day psychiatric re-admission rate reflects adequacy of inpatient treatment, as well as solid follow-up and maintenance in the community following discharge. Figure 7.5-14 shows that DMH remains below the national average.

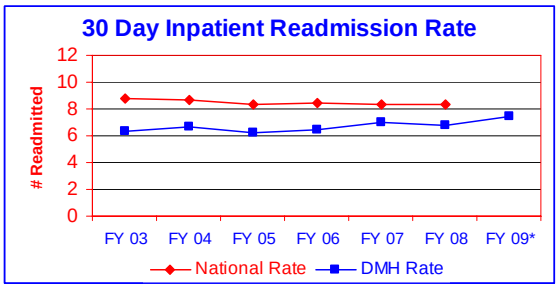


Figure 7.5-14 (Lower is Better) * 10 Months data

Other key ORYX measures for inpatient facilities include the use of restraint and seclusion, defined as the number of hours clients spent in restraint or seclusion for every 1,000 inpatient patient hours (Figures 7.5-15 and 16). DMH consistently scores below the national average on both of these measures.

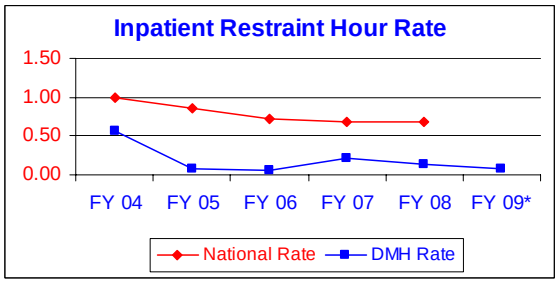


Figure 7.5-15 (Lower is Better) * 10 Months data

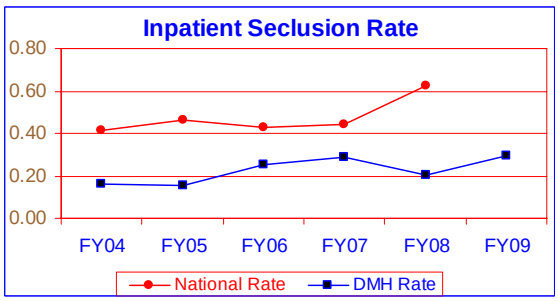


Figure 7.5-16 (Lower is Better) * 10 Months data

Senior leadership also monitors inpatient bed availability weekly. The impact of long-term patients in short-term beds erodes

DMH's capacity to admit new patients, creates problems for EDs, and raises the costs of inpatient services (Figure 7.5-17). This number has been rising for eight years.

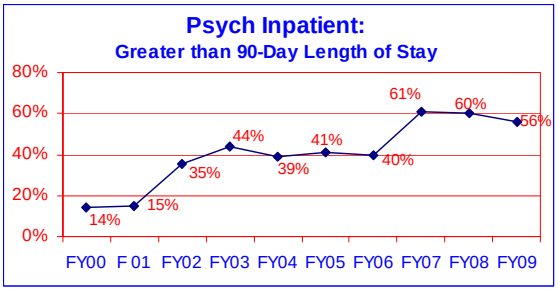


Figure 7.5-17 (Lower is Better)

The Department also monitors the waiting list for persons being held in jails who are in need of inpatient services. The two primary groups: 1) those needing Pre-Trial Evaluation or who have been referred for acute treatment in an effort to restore their competency to stand trial; and 2) those committed for longer-term treatment (Psychosocial Rehabilitation Program: PRP) after being deemed incompetent and unlikely to be restored or being found not guilty by reason of insanity.

After a marked rise in the number of persons needing admission and the increased length of their wait, the Department responded with several initiatives. The result has been a dramatic reduction in the average wait for both the Psychosocial Rehabilitation Program and the Pre-Trial Unit, with the exception of one anomaly in the 3rd quarter of 2008. (Figure 7.5-18). Data is not available for PRP in the final FY09 quarter as no clients added to the PRP list in that quarter have been admitted.

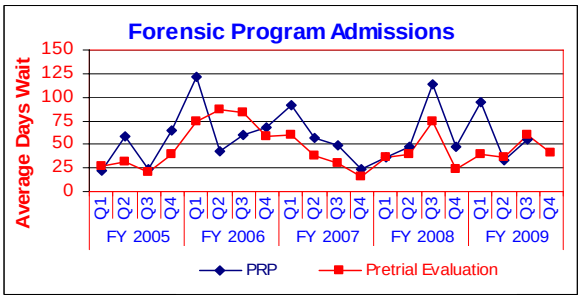


Figure 7.5-18 (Lower is Better)

d) Support Processes Outcomes

Figure 7.5-20 identifies the Department's key support/business processes and the performance level of each.

Figure 7.5-20	**Key Business and Support Processes**	
Process	**Key Requirements**	**Status**
DOAS (as a whole)	The Division of Administrative Services (DOAS) will not overspend its budget.	FY09 Goal met.
Finance	No significant audit findings by State Auditors	No significant findings in most recent SFY audit.
	Invoices paid with 3 business days	Goal met.
	Limit of 5 payroll errors per pay period	Goal met.
	Composite bank account reconciliation's are performed within 30 days after receipt of the bank statement.	Goal met.
	Process procurement request up to $10k within 5 working days; $10k and $25k within 15 working days; and above $25k within 28 working days	Goals being met when necessary purchasing information is furnished by the requestor.
Information Technology	Database applications will be backed up sufficient to recover any database up to the most recent log file.	No significant data losses reported.
	Protect user data from virus infection using real-time virus protection software.	100% of infected files are cleaned, quarantined or deleted.
	Archive vital medical and financial records.	Goal met.
	User satisfaction	Most categories of users in the 2006 survey show improvement over 2004 survey. Overall satisfaction is 89%
Nutritional Services	Provide nutritious, appetizing and satisfying meals for all of DMH clients within annual budget.	Goal met
	Provide up-to date, culturally sensitive patient/ family nutrition opportunities and materials per Joint Commission standards.	Goal 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, providing/selling meal service to other state agencies / private sector organization.	Goal met
Physical Plant	Insure that all capital projects are completed within approved budgets.	Goal met: 8 Projects were closed in FY09 with $33,095 remaining balance.
	Provide living environments in compliance with all regulatory requirements and standards.	There were no JOINT COMMISSION surveys during this time frame. Results of DHEC surveys were satisfactory.
	Provide efficient, cost effective building and grounds maintenance.	Building maintenance costs per square foot were 8.5% less than the national average. Grounds maintenance & custodial costs were significantly less than industry average due to the use of inmate labor
Vehicle Management	Ensure that all vehicles and equipment repairs are conducted in the most cost efficient manner.	The Vehicle Maintenance Shop passed State Fleet certification for 2009 with no issues
Human Resources	See Category 7.4 for HR discussion	See Category 7.4 for HR results.

Figure 7.6-1	**Legal and Regulatory Compliance**	
AGENCY OR ENTITY	**FUNCTION**	**Current Status**
CARF/Joint Commission	National Accreditation	All CMHCs & Inpatient accredited
VA	National Accreditation of Veterans' Nursing Homes	In compliance
HHS Program Integrity Audit	Medicaid Division of Corporate Compliance	In compliance
HHS Program 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

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 client, urban or rural.

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

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.

CIS – Client Information System, data-base containing client 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.

CRCF – Community Care Residential Facility

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

Client – 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.

Co-Occurring Disorder – client diagnosed with more than one major psychiatric disorder: mental illness and alcohol/drug addiction.

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.

CRCF – Community Care Residential Facility, a DHEC licensed facility providing room, board, and personal assistance to persons 18 years old, or older.

DMH – South Carolina Department of Mental Health.

ETR – Evaluation, Training and Research, the agency's division for outcomes, training, research, and best practice development.

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

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

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

IPS – Individual Placement and Support.

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

Joint Commission – a hospital accrediting body formerly called Joint Commission on Accreditation of Healthcare Organizations or JCAHCO.

MHA – Mental Health Association.

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 satisfaction surveys for mental health clients, youth, and family members.

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

Pathlore – a computerized employee training registration and documentation system.

QCRB – Quality of Care Review Board, a convened group of experts charged with analyzing an adverse event 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, JOINT COMMISSION.

Recovery – a process by which a person overcomes the challenges presented by a mental illness to live a life of meaning and purpose

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.).

SAMHSA – Substance Abuse and Mental Health Services Administration.

SAP – computerized financial management system.

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

SHARE – Self-Help Association Regarding Emotion, a client 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.

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

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.