South Carolina Legislative Audit Council

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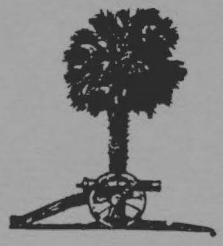
Report to the General Assembly

March 1996

A Review of the South Carolina Department of Mental Health



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Executive Summary

In 1995, members of the General Assembly, who were concerned about the management of the South Carolina Department of Mental Health (DMH), requested that we audit the agency. This audit for the most part encompasses the management decisions and practices carried out under the previous director, who resigned during the course of this review.

We found that overall, DMH management needs to ensure that agency policies and directives are carried out. In addition, better controls are needed to ensure that state resources are not expended to supplement the salaries of DMH employees who participate in the University of South Carolina School of Medicine's Clinical Faculty Practice Plan. Furthermore, DMH should strengthen its enforcement of policies designed to prevent doctors from referring patients to their own private or group practice and/or treating private patients while on state time.

Our findings are summarized as follows.

Physician Compensation

Some physicians and other employees at the William S. Hall Psychiatric Institute function in a dual role as faculty at USC's medical school and as DMH employees paid by DMH to work 37.5 hours a week. Hall Institute physicians also earn a salary supplement from the USC School of Medicine's Clinical Faculty Practice Plan. These supplements are based on the amount of fees generated by providing both inpatient and outpatient treatment to DMH clients. Even though Hall Institute physicians see these patients during normal working hours, they are allowed to deposit any professional fees earned into the practice plan, rather than remit the fees to DMH. Our review found the following:

- The practice plan does not reimburse DMH for certain expenses, such as malpractice insurance, incurred by DMH physicians who treat patients hospitalized at Hall Institute; however, these physicians collect a salary supplement based on fees charged to DMH patients (see p. 7).

- Section 72.10 of the 95-96 state appropriation act authorizes state institutions of higher learning to retain funds from approved practice plans. However, it is not clear whether the proviso extends to a practice plan operated at a DMH facility and staffed by DMH employees (see p. 7).

- DMH physicians and other professionals have not reported salary supplements to the Budget and Control Board as required by law. Our review found that only 2 of 48 employees reported receiving supplements, which ranged from $132 to $64,282 in 1994 (see p. 8).

Hall Institute operates Shearouse Pavilion, a 20-bed "deluxe accommodation" cottage for patients with the ability to pay. Although it was established to be self-supporting, Shearouse Pavilion incurred financial losses of more than $600,000 from FY 90-91 through FY 94-95 (see p. 10).

Shearouse Pavilion has admitted medicare patients whose psychiatric hospitalization benefits have been exhausted. As a result, DMH has paid for their care. However, DMH physicians at Shearouse can charge these patients a fee for services, since medicare reimbursements for physician services are not limited. These fees are deposited in the practice plan (see p. 11).

In 1994, officials at Shearouse Pavilion verbally agreed to allow clients of an insurance company to receive a discount of $125 per patient day. The agreement was not approved by DMH management, and has cost DMH more than $37,000 in lost revenue (see p. 11). DMH records indicate that the director of Shearouse Pavilion, who helped negotiate the contract, has been employed as a consultant by this insurance company since 1989 (see p. 12).

We question the appropriateness of DMH using state resources to support Shearouse Pavilion since it is not open to the general population. This facility competes with private sector psychiatric hospitals (see p. 12).

Physician Services at Community Centers

DMH physicians at various community mental health centers also have private practices. DMH has experienced difficulty ensuring that physicians conduct private practice outside of state working hours and do not engage in self-referral of DMH paying patients to their private practice (see p. 13). DMH physicians can also earn compensation through dual employment with the department (see p. 19).

DMH Contracts

DMH contracts for a variety of goods and services. We reviewed a sample of 83 contracts and found the following:

- In 26 of the 83 contracts, contractors provided services before the contracts were approved by agency management. Nineteen contracts were signed by the contractor after the contract's effective date (see p. 23).

- We could not document that services were actually provided by some contractors. For example, one contractor was paid to provide services for 41 days. DMH records indicate that only 40 days of service were provided (see p. 24).

- DMH contracted with the USC practice plan to obtain the services of USC employees. The practice plan has not fully reimbursed USC for salaries incurred when providing the services (see p. 25).

- One contract required DMH to pay USC medical school surgeons for services, and also required the surgeons to provide DMH with insurance billing information for patients they treated. DMH would collect medicare, medicaid, or insurance reimbursements. However, the surgeons have not provided the billing information and have themselves collected the reimbursements owed to DMH (see p. 26).

- USC and DMH contracted with a state agency to provide psychiatric services. DMH salaried psychiatrists provided the required services, but payment for DMH's services was deposited into a USC School of Medicine account (see p. 26).

We also reviewed an agreement between DMH and Richland Memorial Hospital (RMH) to transfer 23 DHEC-approved psychiatric beds. After DMH transferred the authorization for the beds, it did not monitor the terms of the agreement to ensure that RMH accepted indigent patients. DMH staff did not send indigent clients to RMH and only referred clients who had the ability to pay (see p. 30).

In 1992, the then-director of a community health center contracted for consulting services with the board chairman's wife, and subsequently hired her in a full-time position (see p. 36).

Patient Discharges and Facility and Community Resources

One of our objectives was to determine if "outside influence" was used to inappropriately keep patients in DMH hospitals. We also reviewed the discharge process from state facilities and analyzed resources provided to various DMH facilities.

DMH "flags" certain patient files. We found no evidence that these flags were placed to improperly keep patients in DMH hospitals. (We excluded from our review one case currently in litigation.) In some cases, the patients were eligible for discharge but their history of violence and a lack of community placements had kept them in the hospital (see p. 37).

DMH efforts to ensure that discharged patients kept appointments with community mental health centers could be improved. Care at the community level helps keep patients out of more costly inpatient facilities (see p. 42).

DMH expenditures for community mental health centers have increased by 81% from FY 89-90 through FY 94-95. Patient contacts at these centers have increased by 92% during the same time period. Expenditures also have increased at DMH hospital facilities, although institutional patient populations have generally decreased (see p. 44).

DMH has experienced problems meeting certain federal certification staffing standards. Certification is necessary in order to participate in federal medicare and medicaid programs (see p. 47).

We identified two areas which DMH management should further review:

- The Byrnes Center for Geriatric Medicine, Education, and Research is a 166-bed hospital. It provides various emergency outpatient and inpatient services. However, the number of inpatients served has declined; the average daily census for FY 94-95 was 37. DMH should review expenditures for this facility and determine if services could be provided more economically at local hospitals (see p. 49).

- Some significant policy decisions were not brought before the DMH commission. For example, the DMH commission did not vote on the staff decision to designate Shearouse Pavilion as a facility only for patients with the ability to pay (see p. 50).

Introduction and Background

Audit Objectives

Members of the General Assembly requested that we audit the South Carolina Department of Mental Health (DMH). We were asked to focus our review on the following objectives:

- Determine the amount of time DMH physicians spend working for the University of South Carolina School of Medicine's Clinical Faculty Practice Plan, the amount of compensation earned by physicians, the amount of state resources used to support the plan, and the propriety of the arrangement.
- Determine if DMH physicians are earning excessive compensation through contracts with DMH, medical schools, dual employment, on-call pay, or other means. Determine if physician compensation is in compliance with applicable state law, personnel regulations, and ethics opinions.
- Review DMH contracts to determine if they were properly procured, if services procured were needed, and if services were provided.
- Determine if any patients in state mental hospitals have been retained or prevented from being discharged due to inappropriate interference by outside interests.
- Determine if DMH ensures proper follow-up care once a patient is discharged from a state hospital.
- Determine if DMH has allocated its funds in accordance with decreases in institutional populations and increases in the number of clients treated at community mental health centers.

Scope and Methodology

Our review was limited to the above objectives and covered the time period from 1990 to November 1995; we also examined some decisions that were made in the 1980s.

To conduct this audit, we examined financial and administrative records maintained by the Department of Mental Health. We interviewed DMH staff and staff of other state agencies, including the University of South Carolina School of Medicine and the Medical University of South Carolina. We reviewed agency internal audit reports, DMH contracts, and patient billing information. In addition, we reviewed patient records at South Carolina State Hospital and Crafts-Farrow State Hospital, and records of patients discharged from the G. Werber Bryan and Patrick B. Harris psychiatric hospitals.

We also examined financial records and physician salary records maintained by the University of South Carolina, as well as payroll records maintained by DMH.

We obtained computer-generated data for contracts, patient billings, patient discharges, and DMH salaries. We compared samples drawn from these data to agency documents and found some inconsistencies. However, when these data are reviewed in context with other relevant evidence, we believe the opinions, conclusions and recommendations in this report are valid. We also obtained financial information provided by DMH's Office of Planning. We did not test the reliability of these data, but found no evidence that this information is inaccurate.

DMH's performance was evaluated based on state law, state appropriation acts, and agency policy.

This audit was conducted in accordance with generally accepted government auditing standards.

Background and History

South Carolina, the second state in the nation to build a state-supported hospital for the mentally ill, established the Department of Mental Health in 1821. By the early 1960s, the population of South Carolina State Hospital and Crafts-Farrow State Hospital grew to approximately 6,000.

Medication to treat mentally ill persons has allowed many patients to be returned to their communities. By September 1995, the populations of South Carolina State Hospital and Crafts-Farrow State Hospital were reduced to approximately 500. (This excludes patients hospitalized at acute-care hospitals.)

South Carolina is divided into 17 geographic zones called "catchment areas." Each area has a comprehensive community mental health center which is governed by a local board. There are 42 offices and 30 outreach programs in the communities. Community mental health centers are the entry point into the mental health system. When center resources cannot meet patients' needs, patients are referred to one of DMH's nine inpatient facilities.

Short-term psychiatric care is provided primarily by two hospitals, G. Werber Bryan Psychiatric Hospital, a 266-bed hospital in Columbia, and Patrick B. Harris Psychiatric Hospital, a 206-bed hospital in Anderson. Long-term psychiatric care is provided by the South Carolina State Hospital; patients 60 years of age and older are served at Crafts-Farrow State Hospital. The department is in the process of consolidating Crafts-Farrow and State Hospital.

Morris Village in Columbia is a 146-bed inpatient alcohol and drug treatment facility for persons 13 years of age and older. The William S. Hall Psychiatric Institute, also in Columbia, is a 233-bed teaching and research hospital for both children and adults. It also serves as the base of the Department of Neuropsychiatry and Behavioral Science of the USC School of Medicine. The Byrnes Medical Center, a 166-bed medical hospital in Columbia, serves DMH patients and patients referred by other state agencies.

The department also provides nursing home care. The Tucker/Dowdy-Gardner center is a 668-bed facility in Columbia. The Dowdy-Gardner Nursing Care Center in Rock Hill is a 220-bed facility managed under a contract with an independent health care contractor. The Richard M. Campbell Veterans Nursing Home in Anderson, a 220-bed facility, also is operated under a contract with a private contractor.

The Department of Mental Health is governed by a seven-member commission appointed for five-year terms by the Governor with the consent of the Senate. The state director of mental health directs the agency's day-to-day operations. Central administration, located in Columbia, provides support services including long-range planning, performance and clinical standards, quality assurance, personnel management and training, legal counsel, financial services, procurement, plant maintenance, public safety, transportation, and food services.

In FY 95-96, DMH had a budget of approximately $315 million and more than 6,300 full-time equivalent positions, and approximately 2,200 patients in short-term and long-term care facilities.

Physician Compensation

In this chapter, we discuss ways physicians earn extra compensation. Overall, we found that state resources are used to supplement DMH physician salaries, salary supplements are not being reported, and DMH physicians have referred DMH patients to their private practices. We also determined that DMH employees receive additional compensation through dual employment within the department.

William S. Hall Psychiatric Institute and the USC Medical School Practice Plan

Department of Mental Health physicians, psychologists, and other professionals employed at the William S. Hall Psychiatric Institute receive salary supplements from the University of South Carolina School of Medicine's Clinical Faculty Practice Plan. The practice plan receives revenue in part by billing patients hospitalized at Hall Institute (or their insurance carriers and other third-party payers such as medicare) for professional fees.

Hall Institute is different from other DMH facilities in that it is required by statute (§44-11-10) to serve as the teaching and research hospital of the Department of Mental Health. Hall Institute has 233 beds to provide inpatient psychiatric care, and the facility also provides various outpatient psychiatric services. Children as well as adults with neurological disorders and Alzheimer's disease are among the clients admitted to Hall Institute.

To further its teaching and research mission, in 1974 Hall Institute entered into an agreement with the University of South Carolina School of Medicine to provide neuropsychiatry training for medical students. The director of Hall Institute also serves as chairman of USC medical school's neuropsychiatry department, which is based at Hall Institute.

DMH physicians (and other professionals such as psychologists) care for patients hospitalized at Hall Institute and also serve as faculty of the medical school's neuropsychiatry department. The USC School of Medicine also employs staff who work at Hall Institute. In addition, some salaries are funded jointly by USC and DMH.

Physician Compensation

Full-time employees of Hall Institute are paid a state salary to work 37.5 hours each week, and their work hours are generally 8 a.m. to 4:30 p.m. In FY 94-95, the annual state salaries of physicians at Hall Institute generally ranged from approximately $90,000 to $119,000. Physicians care for patients hospitalized at Hall Institute as well as supervise residents. DMH bills these patients (or their insurance companies) for their care. Hospital bills have two principal components: hospital charges (including the cost for the room, supplies, and nursing care), and physician and other professional fees. Revenue that DMH generates from hospital charges is used to fund DMH operations. However, the professional fees generated by DMH patients at Hall Institute are not collected by DMH. Rather, the physicians are allowed to bill independently for these fees, which are deposited in the USC School of Medicine practice plan account. Physicians are then paid salary supplements which averaged approximately $15,000 in 1994 from this account.

The practice plan, adopted by the USC School of Medicine in 1990, governs the disposition of income generated by providing medical care. Participation in the plan is mandatory for faculty members. Practice plan revenue is used to supplement physicians' salaries, pay for a supplemental retirement plan for physicians, pay administrative costs to operate the plan, and provide revenue for joint DMH and medical school projects. The practice plan consists of nine departments of the medical school including neuropsychiatry, pediatrics, and surgery. Neuropsychiatry is the only department based at Hall Institute. Practice plans are common in medical schools, and Hall Institute administrators report that the salary supplements provided by practice plans are necessary to recruit and retain competent psychiatrists.

In addition to providing care for patients hospitalized at Hall Institute, DMH physicians and other professionals care for patients on an outpatient basis at Hall Institute clinics, both during state working hours and after working hours. DMH does not receive all professional fees generated for these services; most of these fees are deposited into the practice plan.

DMH Expenses Not Reimbursed

The practice plan has not reimbursed DMH for overhead costs incurred by participating physicians. For example, DMH pays the malpractice insurance for Hall Institute physicians. DMH also pays the clinical costs incurred in caring for Hall Institute clients. However, the fees doctors generate are deposited in the practice plan and are not used to offset some of these costs.

Since the USC School of Medicine's practice plan does not reimburse DMH for costs incurred by the department, state funds, in effect, are used to subsidize the medical school practice plan.

As a comparison, the Medical University of South Carolina in Charleston has a practice plan which allows state-employed physicians to care for patients to supplement their state salaries. According to the director of the plan, that plan reimburses the medical university for 100% of that university's malpractice insurance premiums, rent associated with treating patients in state-owned facilities, and other costs.

In 1994, the neuropsychiatry department, based at Hall Institute and consisting primarily of DMH physicians, generated more than $1 million in revenue for the USC practice plan. Practice plan records indicate that psychiatrists and other professionals received $649,000 in salary supplements in 1994. The remainder was used for the medical school dean's fund and other operating expenses for the plan.

From January 1995 through June 1995, the practice plan also expended $38,705 to fund a supplemental pension plan for the participants.

Authority for DMH Participation

The state appropriation act authorizes funds to be retained from approved private practice plans at state institutions of higher learning. However, it is not clear whether the proviso extends to a practice plan operated at a DMH facility and staffed by DMH employees.

Section 129.10 of the FY 94-95 appropriation act (and §72.10 of the 95-96 act) specifically allows colleges and universities to retain and expend certain funds that they generate, including funds generated by medical school practice plans; funds must be expended in accordance with policies developed by the institutions' boards of trustees. However, this proviso applies only to institutions of higher learning; it does not expressly include other state agencies, such as the Department of Mental Health. The DMH arrangement is probably unique in that Hall Institute physicians are, at the same time, both USC faculty and DMH salaried employees.

Salary Supplements Not Reported

We found that physicians, psychologists, and other professionals employed by DMH at Hall Institute are not reporting salary supplements paid through the USC School of Medicine's practice plan, as required by law. The amount of annual supplements in 1994 ranged from $130 to $64,282.

Sections 17G.8 of the FY 94-95 appropriation act and 17C.5 of the 95-96 act require that state employees report salary supplements, including supplements from practice plans, to:

> . . . the Division of Budget and Analyses of the Budget and Control Board. The report must include the amount, source, and any condition of the supplement. Any change in the amount, source or condition must be reported to the division by the employee.

Only 2 of 48 employees of Hall Institute reported salary supplements as required by law.

We obtained a list of supplements paid in 1994 to 48 employees of Hall Institute. We compared this list to supplements reported to the division of budget and analysis from January 1993 through August 1995 and found that only 2 of the 48 employees who received supplements reported them.

When supplements are not reported, the public does not have access to information about the total earnings of state employees. Also, the appropriation act requirement that salary supplements be reported needs to be clarified. For example, the proviso does not specify a deadline for reporting supplements, and there are no penalties for failing to report supplements.

Lease Arrangement

In January 1994, officials with Hall Institute leased office space to the USC School of Medicine's practice plan at a below-market rate.

DMH agreed to lease 2,330 square feet of office space, for use in patient billing, to the practice plan for $322 per month, or $1.65 per square foot. According to DMH documents, the monthly payment was below fair market value, and the lease was not processed through the contracts department as required by DMH policy. In July 1995, DMH officials requested that the lease be renegotiated at fair market value.

In September 1995, after reviewing the lease agreement, DMH cited other benefits that have accrued to the department as a result of the lease, including DMH's use of the practice plan's computer billing system. The department then decided not to renegotiate the lease.

We did not determine if the benefits received by DMH for the use of the practice plan's computer system compensated for revenue lost due to the below-market lease.

Recommendations

1. The Department of Mental Health may wish to obtain specific legislative authority to allow its employees to participate in the USC School of Medicine's practice plan.

2. The Department of Mental Health should require the practice plan to pay for certain expenses such as malpractice insurance and other costs associated with caring for private patients at Hall Institute.

3. The Department of Mental Health should ensure that leases are processed through its contracts department.

4. The General Assembly may wish to modify the supplemental salary reporting requirement (17C.5 of the 95-96 appropriation act) to specify deadlines for reporting and penalties for not reporting.

5. Department of Mental Health employees should report salary supplements as required by law.

Shearouse Pavilion

Shearouse Pavilion is a 20-bed acute care psychiatric facility located at Hall Institute in Columbia. In 1987, DMH established Shearouse Pavilion as a self-supporting facility for private paying patients, providing "deluxe accommodations and services." It competes with private sector and county psychiatric hospitals for patients with insurance or other means of payment.

Shearouse Has Not Been Profitable

Shearouse Pavilion has not been self-supporting as intended, and has experienced financial losses of more than $600,000 from FY 90-91 through FY 94-95 (see Table 2.1).

Table 2.1: Summary of Financial Status of Shearouse Pavilion FY 90-91 through FY 94-95

	FY 90-91	FY 91-92	FY 92-93	FY 93-94	FY 94-95
Revenues	$848,506	$700,095	$668,399	$621,450	$1,019,471
Expenditures	$838,967	$826,472	$904,386	$870,342	$1,054,054
Profit (Loss)	$9,540	($126,377)	($235,986)	($248,892)	($34,583)

Source: DMH financial records.

According to a 1993 DMH internal audit, the facility has not been self-supporting for several reasons. First, it has not admitted a sufficient number of clients with resources to pay. In FY 94-95, it had an average daily census of 10 patients (50% occupancy). In addition, medicare will not pay all charges because it is a "deluxe accommodations" facility, and patients have not always paid the remainder of the charges. Further, medicare limits reimbursements for psychiatric hospitalization.

Patients Without Medicare Admitted

Our review indicated that patients without adequate insurance, including those who have exhausted their medicare psychiatric hospitalization benefits, have been admitted to Shearouse Pavilion. Medicare limits payments for psychiatric services provided in a hospital to 190 days in a patient's lifetime. However, physician fees, which are billed separately, are not limited. Since physicians who care for patients at Shearouse Pavilion are allowed to supplement their salaries by billing patients, there is less incentive to deny an admission since medicare will pay physician fees after psychiatric hospitalization benefits have been exhausted.

Shearouse Pavilion has admitted patients whose medicare benefits were exhausted.

We reviewed records of ten medicare patients who were admitted to Shearouse Pavilion in FY 94-95 after their medicare hospitalization benefits had been exhausted. These clients incurred charges of more than $55,000. DMH will not be reimbursed for these services and the state will absorb the costs of treating these patients.

However, the physicians caring for these clients collected $2,710 in medicare fees. For example, one patient who was admitted to Shearouse in 1995 had exhausted his inpatient psychiatric benefits in 1992. Therefore, medicare will not pay his bill of approximately $12,000; however, his physician collected $725.57 for providing care, and these fees were deposited in the USC practice plan.

Agreement With Private Insurance Company

In 1994, Hall Institute officials entered into a verbal agreement with a private insurance company. This verbal agreement allowed the insurance company's policy holders to obtain care at Shearouse Pavilion at a rate which was below DMH's cost. The agreement was not reviewed by DMH's legal department or contracts section to ensure that it complied with all relevant requirements. In November 1995, the agreement was formalized in writing.

The verbal agreement allowed the insurance company's clients to receive care for $350 per day, effective January 1, 1994, instead of the rate of $475 per day, which had been approved by the DMH commission effective January 1, 1994. This reduced rate does not include physician charges which are billed separately. Because $475 per day is based on the cost of operating and staffing Shearouse Pavilion, DMH loses money for each patient it cares for under this agreement.

From January 1994 through December 7, 1995, DMH waived charges totalling $37,757 for 33 patients with this insurance. As a result state funds were used to subsidize the care for these patients. This agreement has contributed to the financial deficit at Shearouse Pavilion.

Potential Conflict of Interest

Since 1989, the director of Shearouse also has been employed to provide psychiatric consultations by the private insurance company that received the discounted rate. According to documents we reviewed, the director has been involved in negotiating the agreement with this company since he began his employment at Shearouse Pavilion in June 1994. This company received discounts totalling $37,757 in 1994 and 1995.

The director of Shearouse Pavilion has been employed, to provide psychiatric consultations, by a private insurance company which obtained a discounted rate for its policy holders.

Section 8-13-700(B) of the State Ethics Act states:

> No public official, public member, or public employee may make, participate in making, or in any way attempt to use his office, membership, or employment to influence a governmental decision in which he, a member of his immediate family, an individual with whom he is associated, or a business with which he is associated has an economic interest.

Competition With Other Psychiatric Hospitals

We question the appropriateness of DMH expending state resources to operate a facility that provides deluxe accommodations, does not serve all of the public, and competes with private sector psychiatric facilities. Shearouse Pavilion charges most patients $475 per day for hospital services. In comparison, acute-care psychiatric services provided at other wards at Hall Institute cost patients only $140 per day. Bryan Psychiatric Hospital, an acute care hospital operated by DMH, also charges patients $140 per day.

Recommendations

6. The Department of Mental Health should discontinue supplementing the cost of treating patients hospitalized at Shearouse Pavilion.

7. The State Ethics Commission should determine whether the director of Shearouse Pavilion violated the State Ethics Act by participating in contract negotiations with a private insurance company for which he performed services.

8. The Department of Mental Health should evaluate the appropriateness of providing state resources for a facility that provides deluxe accommodations and competes with other psychiatric hospitals in the community.

Private Practice by Community Mental Health Physicians

In addition to their state salaries, DMH physicians can earn extra compensation primarily in two ways—by receiving fees for treating clients in their private practice and through dual employment within the department by working after-hours, weekends, and holidays at DMH facilities and centers. As of September 1995, 32 physicians reported they had a private practice; this is 19% of the 167 doctors employed by DMH (excluding Hall Institute doctors as discussed on pp. 5-7). All but 6 of the 32 doctors were employed by DMH mental health centers as opposed to a DMH inpatient facility.

Our objective was to determine if DMH management controls ensured adequate oversight of the use of state time and patient referrals involving private practice activities. DMH has experienced problems in this area in the past and in response has instituted more internal controls. In general, we found:

- It is difficult to ensure that doctors conduct only state business on state time and do not see their private patients during working hours.

- It is difficult to ensure that physicians are referring patients for treatment, especially treatment outside of DMH facilities or clinics, solely on the basis of psychiatric needs and are not influenced by the possibility of extra compensation.

Background

DMH policy allows private practice as long as it is limited to off-duty hours. Support personnel and supplies of DMH may not be used for any private practice. Employees must notify their facility or center director in writing of their intent to engage in private practice. In addition, DMH employees are subject to the provisions of the State Ethics Act, which prohibits public employees from using their state employment for private financial gain (§8-13-700). Department guidelines explicitly state that a center physician should not refer a patient to his or her own private practice.

In 1987, DMH internal auditors found that six psychiatrists employed by the Columbia Area Mental Health Center (CAMHC) and Hall Institute, including the medical director, were billing DMH for services rendered to center patients hospitalized in Richland Memorial Hospital's "11-East" (RMH's psychiatric unit, now called Richland Springs). The auditors found evidence that the CAMHC doctors were seeing hospitalized patients during their normal working hours. The doctors typically made rounds at RMH from 8:30 a.m. to 10 a.m. daily. Therefore, the doctors were receiving fees for services provided to CAMHC clients during the same hours that they were also receiving pay as full-time employees of CAMHC.

Also during this time, up until 1993, the executive director of CAMHC, the medical director, and one other physician were salaried employees of Richland Memorial Hospital's Department of Education for Psychiatry.

The internal audit report concluded that these practices represented a conflict of interest and a violation of §44-11-100 (repealed in 1990) which provided that "No member of the Department of Mental Health or officer or employee of any State mental health facility shall be financially benefited by any contract or purchase made by any State mental health facility."

In 1994, according to another internal audit and related documents, CAMHC doctors were still associated with RMH/Richland Springs Psychiatric Hospital in several ways:

- CAMHC doctors, as part of their private practice, were treating CAMHC clients hospitalized at Richland Springs. They received fees by billing either the patients' insurance company, medicare or medicaid. The audit found that CAMHC granted doctors ½ day per week for "administrative" time; however, the doctors did not have to be present at the center during this time. Most of the CAMHC doctors also saw private patients as members of the same private practice association.

- CAMHC physicians were receiving compensation from DMH to be "on-call" during evening and weekend hours; these same physicians were also receiving on-call pay from Richland Memorial Hospital for the same nights they were on-call for DMH. They also were receiving compensation from Richland Springs for supervising the rotation of medical school residents in the RMH Emergency Department. (During normal working hours, CAMHC maintains its own emergency services center. After-hours and on weekends, clients needing immediate mental health services can go to the Richland Memorial Hospital emergency room. DMH mental health professionals are on-site in the emergency room, and the doctors are on-call in the event their services will be needed.)

- Three DMH physicians were also salaried employees of RMH/Richland Springs.

DMH internal audits of the Columbia Area Mental Health Center, conducted between 1987 and 1994, found that the department needed clearer guidelines concerning private practice.

The internal auditors concluded that DMH needed to "establish an effective written code of conduct which contains clear guidelines on conflicts of interest and compliance with laws." The executive director of CAMHC resigned in March 1994, prior to the publication of the internal audit report.

As of December 1995, the medical director at CAMHC as well as at least seven other DMH doctors are treating DMH patients on a private-paying basis at Richland Springs.

In response to the internal audit, the new CAMHC executive director added policies concerning private practice and the use of state time by center physicians. The department also established guidelines for patient referral, which state that if a patient needs treatment in an outpatient private setting or in a nonstate hospital/residential facility, center doctors who have an economic interest in the private outpatient practice or nonstate hospital cannot make the decision to refer or admit. DMH primarily uses a "hospital and physician selection form" as a means of ensuring that this policy is followed. The patient or the patient's guardians document their choice of hospital and/or physician with this form.

Private Practice at Other Mental Health Centers

We did not review doctors' time sheets and patient selection forms to test for current compliance to these policies. We also determined that CAMHC was not the only mental health center where psychiatrists' state employment and private practice have overlapped.

Santee-Wateree

One psychiatrist at this center has his private practice at an area hospital, where he also is the director of the private psychiatric unit there. He is in the position to refer Santee-Wateree clients who need in-hospital treatment to either the private psychiatric unit or a DMH facility in Columbia. DMH records indicate that, for the months of April through October 1995, 95% of this doctor's Santee-Wateree patients referred to the private psychiatric unit had insurance. On average, this doctor had ten center patients a day in the private psychiatric unit.

Orangeburg Mental Health Center

Four of the five psychiatrists on staff have their private practice at the psychiatric unit of the regional medical center in Orangeburg. When Orangeburg clients need hospitalization for psychiatric stabilization, the doctors can refer them either to a DMH facility in Columbia or to the Orangeburg regional hospital. According to the Orangeburg MHC director, the doctors work a flexible schedule according to state guidelines, which allows them time to see their private patients.

Spartanburg Mental Health Center

The executive director as well as two other psychiatrists have their private practice in the regional medical hospital which is located next door to the mental health center. As with the other centers, the doctors can refer patients needing treatment to either the hospital or a DMH facility. The Spartanburg MHC doctors use compensatory time to see their private patients at the hospital. They earn one hour of compensatory time for every eight hours of "on-call" duty.

The following table shows the private practice activities of a judgmental sample of DMH doctors.

Table 2.2: State Salaries and Private Practice for Selected DMH Physicians

DMH Doctor Employed Full-Time	State Salary	Location: Mental Health Center or DMH Facility	Dual Employment With DMH Amount Earned FY 94-95	Treats DMH Clients in His/Her Private Practice	Other Outside Employment[a]
Doctor A	$116,964	Orangeburg	$3,500	Yes	Yes
Doctor B	$116,382	Columbia Area	$2,250	Yes	Yes
Doctor C	$118,301	Spartanburg	$0	Yes	Unknown
Doctor D	$110,000	Orangeburg	$35,795	Yes	Yes
Doctor E	$90,000	Hall Institute	$1,700	Yes	Yes

a This includes dual employment with other state agencies, outpatient private practice, compensation from non-DMH hospitals for services, or participation in the USCSOM Clinical Faculty Practice Plan.

Source: DMH records.

Self-Referrals

A goal of the department is to channel patients from state hospitals and treat them in a local setting whenever possible. However, this allows for self-referral, whereby a center physician can send a DMH client to his private practice group or to the local hospital, and earn extra compensation by billing the patient for his services. If the patient was sent to a DMH facility such as Bryan Psychiatric Hospital, staff doctors at Bryan Hospital would treat that patient and the referring physician would not receive extra compensation.

Based on information from DMH, we determined that, of the 357 CAMHC clients referred to Richland Springs in FY 94-95, 96% had insurance, medicare, or medicaid. The CAMHC doctors involved in providing services to these patients are part of the same private-practice group. However, of the 1,284 admissions of CAMHC patients to Bryan Psychiatric Hospital during FY 94-95, 70% had no insurance, medicare, medicaid or any other third-party payment source.

We noted that other factors are considered by doctors when referring patients needing hospital care. For example, most non-DMH hospitals cannot treat patients who are violent or need a locked ward. From the patient's point of

view, treatment in a local hospital as opposed to a state facility may be more desirable. Also, Bryan Hospital cannot bill medicaid for adult services so it may be more cost-effective to refer medicaid patients to non-DMH hospitals when appropriate for their treatment needs.

Conclusion

Although DMH has taken steps to control when and how DMH doctors are conducting their private practice, oversight of this area remains difficult and cumbersome. Since doctors are using compensatory time and annual leave time to see private patients, the hours earned/used must be tracked on a daily basis. When state employment and private employment are conducted during the same day, scheduling becomes complicated, and it may be difficult for supervisory and timekeeping staff to know where a doctor is supposed to be at any given time. The patient selection forms involve more paperwork and staff, and may not be effective in preventing self-referrals in cases where all or most of a center's doctors work in the same private practice group. The potential for self-referral exists in any mental health center where the physicians have a private practice, since many DMH patients are treated in private or community hospitals. Fifteen of the seventeen mental health centers have a contract or a memorandum of agreement with a local hospital to provide acute inpatient care or crisis stabilization for DMH clients.

DMH's internal auditors review employees' compliance with private practice policies. We found, however, that central DMH does not keep data showing (1) which physicians are engaged in private practice, (2) the number of DMH patients seen by DMH doctors as part of their private practice, and (3) whether paying patients are being channeled to nonstate facilities. In addition, DMH does not have data to show if any center physicians are also referring, treating, and billing DMH patients for services delivered in an outpatient setting. Neither state law nor DMH policies require DMH doctors to report the amount of income received by treating DMH clients referred to themselves or their private practice group. In contrast, DMH doctors who receive extra income through a state practice plan are required by the appropriation act (17C.5 of the FY 95-96 appropriation act) to report this income to the State Budget and Control Board.

Recommendations

9. DMH internal auditors, as part of their regular audits, should continue to review center staff for compliance with private practice policies; this should also include reviewing doctors schedules, treatment records, and patient selection forms.

10. The General Assembly may wish to require DMH doctors, who treat DMH clients as part of their private practice or group practice, to report to the State Budget and Control Board on the number of such clients seen and the revenue earned from these patients.

11. DMH should collect management data that would help them ensure that private practice by DMH staff does not occur during normal working hours.

Dual Compensation

In addition to their regular salaries, DMH employees may receive additional compensation through dual employment to provide physician and professional staff coverage for inpatient facilities and mental health centers on nights, weekends, and holidays. (This excludes nurses and other staff who work shifts.) We reviewed the department's policies and practices concerning dual employment. We determined that some DMH doctors can earn as much as $50,000 in extra compensation annually by providing after-hours services at DMH hospitals.

24-Hour Physician Coverage at Inpatient Facilities

The eight inpatient facilities operated by the department (excluding nursing homes managed by private companies) provide 24-hour coverage by physicians and medical residents to the approximately 2,000 patients institutionalized. One doctor at each facility is the "officer of the day/ officer of the night" (OD/ON), and assumes responsibility for patient admissions, treatment, and any emergencies during evening hours, weekends, and holidays.

The OD/ON must remain on the premises for the duration of the on-call coverage. Arrangements for eating and sleeping are provided. For weekdays, OD/ON duty covers the hours of 5 p.m. to 8:30 a.m. On weekends and holidays, the doctors usually work 24-hour shifts, except at

Tucker/Dowdy-Gardner Nursing Care Center, where they work 12-hour shifts.

According to a survey conducted by DMH, Bryan Psychiatric Hospital and Harris Psychiatric Hospital report a high level of patient admissions and contacts with emergency rooms around the state during evenings and weekends. OD/ON doctors at these facilities make $45 an hour. The other facilities pay OD/ON doctors $35 an hour. At South Carolina State Hospital, for example, the majority of patient admissions occur during regular working hours. Round-the-clock physician coverage is required, however, to handle patient emergencies and to meet hospital accreditation standards.

In FY 94-95, DMH paid $2.2 million for OD/ON coverage by DMH employees. On average, the doctors providing these services earned $17,078 in extra compensation. Facility staff usually serve on a voluntary basis except at Hall Institute, which requires that all attending physicians (who make more than 51% of their salary from either Hall Institute or USC) and residents be assigned to the on-call roster. There are no limitations on how many hours a doctor can serve on OD/ON duty except that Hall Institute residents can earn up to the equivalent of 90% of their annual salary, and DMH-employed physicians can earn up to the equivalent of 50% of their annual salary. OD/ON compensation paid to individual doctors in FY 94-95 ranged from $72 to $52,530.

On-Call Coverage at the Mental Health Centers

Community mental health centers also provide dual compensation to doctors and other professional staff such as psychologists for on-call coverage, called "crisis intervention," for evenings, weekends, and holidays. Staff on crisis intervention duty do not have to remain on site, but they have to carry a pager and be available for consultation or face-to-face patient contact if needed.

In the Columbia Area Mental Health Center, which provides emergency assessment, crisis intervention counseling, and screening of patients for admission to DMH facilities, a mental health professional stays at the local hospital emergency room during evenings and weekends, with the physicians available for consultation. Some centers contract with local physicians and hospital staff to provide coverage after-hours and weekends. In FY 94-95, DMH spent $801,985 on crisis intervention for the mental health centers. (This does not include payments to independent doctors under contract with the department to provide coverage.) Clinical staff who are not medical

doctors are paid $50 a night for crisis intervention, $75 for a 24-hour period, and $200 for a full weekend. Doctors are paid $100 a night, $150 for a 24-hour period occurring on a state holiday, and $400 for a full weekend. In addition, if the clinician or doctor on call needs to make face-to-face patient contact, they earn an extra $30. (Only a onetime $30 payment is made whether they see one or several clients after-hours.)

Department of Mental Health Contracts

The Department of Mental Health has contracted with a variety of individuals and entities for goods and services. We found that management has not reviewed and approved all contracts before they became effective, and services were not always documented as required. In addition, contract monitoring could be improved.

Review and Approval of Contracts

DMH processes approximately 700 contracts annually. We reviewed a sample of 83 contracts, generally effective during FY 94-95, to determine if policies concerning the approval, review, and signature of contracts had been followed. DMH policies require that all contracts for professional services of $2,500 or more go through a review and approval process prior to the date they become effective. DMH's contracts section routes all contracts to appropriate departments for review and approval, including the legal department, clinical services, and financial services. Reviewing departments then return contracts to the contracting section with their approval or recommended changes. The contracts section is responsible for making any necessary changes and obtaining signatures from all parties. According to DMH's procurement policies and procedures, contracts should be submitted to the contracts section at least 30 days prior to the effective date of the contract. We found the following problems.

- The contracts section did not have all DMH contracts. Some revenue contracts were not on file with the contracts section.
- Twenty-six contracts were not approved by management until after they became effective.
- Nineteen contracts were signed by DMH or the contractors after they became effective. Some other contract signatures were not dated and we could not determine if they were signed in a timely manner.
- Two sole source justifications were either missing or signed after the contracts became effective.

Some problems with the above contracts overlapped. For example, two contracts with late or missing sole source justification were also approved late.

The following are examples of late approvals, contracts signed after their effective dates, and contracts lacking sole source justifications.

- A $15,000 contract for cross-cultural training, effective February 26, 1995, was not approved until March 1, 1995. The services were provided approximately four days before the contract was approved. The sole source justification for this contract was approved on March 2, 1995, after training had been provided.

- A contract for consulting services, effective July 13, 1994, was not approved until July 21, 1994. Services amounting to approximately $2,600 were provided before the contract was approved.

- A contract renewal for $48,829, effective on July 1, 1994, did not receive final approval until July 18, 1994, more than two weeks after the effective date.

- A contract between a mental health center and a physician was not approved or signed until after the doctor began billing for his services.

Documentation of Services Provided

We found insufficient documentation of services provided under three contracts.

We conducted an in-depth review of 46 of the 83 contracts sampled to determine if DMH received the services for which it paid. The review included an examination of payment vouchers, supporting documentation, and documentation of actual services received.

We found insufficient documentation of services provided under 3 of the 46 contracts.

- A contract for $35,000 required that 50 days of work be performed over a period of ten months. After reviewing DMH's files, we were only able to document 40 days of work provided by the contractor, and DMH paid for 41 days.

- One individual provided services under four contracts with DMH, and some contract dates overlapped. In one contract for consultation on issues relating to children, adolescents, and families, the services to be provided were vague. The contract required submission of a detailed invoice but the invoices only listed the number of days and stated "consultation re in school services." We were unable to document that DMH received services under this contract. In addition, we could not determine the total amount spent for these services because DMH cannot track the payments by contract when the same individual has more than

one contract. We examined all invoices from this contractor, and we attempted to match the invoices with contracts. We estimate the amount paid under this contract at $12,929.

- We were unable to determine whether DMH received services under a second contract with the same contractor. Invoices lacked supporting documentation or a summary of services performed. Quarterly reports required by the contract did not exist. We could not determine the amount spent on the second contract, and we estimate the amount spent at $7,473.

Contracts With Practice Plan

We reviewed three contracts between DMH and the USC School of Medicine's Clinical Faculty Practice Plan. Under these contracts, the practice plan receives payments and USC employees provide services. However, for two contracts, the practice plan has not fully reimbursed the university for salaries and expenses incurred when USC employees provided services to DMH.

Contract for Nursing Services

In 1995, DMH contracted with the USC School of Medicine's practice plan and the College of Nursing for $184,500 per year for nursing administrative services. Two full-time USC nurses as well as other USC employees provided the services; however, the payments went to USC's practice plan. The practice plan only reimbursed the university approximately $49,000. As a result, about $130,000 was channeled into the practice plan although USC-salaried employees provided the services. According to a college of nursing administrator, the $49,000 reimbursement was estimated based on that portion of the employees services that were unrelated to academic endeavors.

Contract For Psychologist

Since July 1994, DMH has paid $65,000 annually for consulting services provided by a psychologist who is a faculty member at the university. The contract for these services requires that payments be made to USC's practice plan, which funds a salary supplement to the psychologist with this revenue. While the psychologist is a full-time university employee whose salary is approximately $107,000, the practice plan has not reimbursed the university

for the portion of his USC salary paid while he was providing services for DMH.

Contract for Surgery Services

In 1994, DMH contracted with the USC practice plan to obtain surgery services for patients hospitalized at Byrnes Center. The contract, for $105,000, required the practice plan's surgeons to provide DMH with medicare, medicaid, and insurance billing information for patients who were treated, so that DMH could collect any reimbursements available. However, DMH records indicate that the surgeons did not provide DMH with the billing information and that the surgeons collected the reimbursements. During the course of our audit, DMH's legal department began a review of this matter.

Contracts With USC Neuropsychiatry Department

The USC School of Medicine's Department of Neuropsychiatry and Behavioral Sciences and Hall Institute are managed by two separate state agencies. As discussed in Chapter 2, the two agencies coordinate the training and education programs of the medical school's psychiatry residents. We examined a contract that Hall Institute and the USC Department of Neuropsychiatry and Behavioral Sciences entered into with another state agency. In addition, we reviewed a contract between USC's neuropsychiatry department and a mental health center.

Department of Juvenile Justice Contract

The Department of Juvenile Justice (DJJ) contracted with Hall Institute and the USC School of Medicine's neuropsychiatry department to obtain psychiatric services for juveniles for FY 94-95. The contract did not distinguish between the services to be provided by DMH psychiatrists and services to be provided by USC staff. Also, the contract did not indicate which agency would earn fees generated by providing services. In FY 94-95, DJJ paid the entire fee of $77,950 to USC for psychiatric services provided by Hall Institute staff.

Although DMH staff provided the services required by the contract, DMH did not receive any of the fees for providing the services. Instead, the $77,950 was deposited into a USC account and was spent for travel, honoraria, salaries for administrative staff, and other items. According to DMH

officials, this benefits both agencies. None of the revenue was used to reimburse DMH for salaries or other costs incurred in providing the services.

Community Mental Health Center Contract

In 1992, the Columbia Area Mental Health Center contracted with the USC School of Medicine's neuropsychiatry department for assistance in developing a research and training program. The contract required DMH to pay USC $100,000 in FY 92-93 for these services.

It is unclear why a community mental health center would initiate a research and training project. In addition, we question the need for a DMH community mental health center to contract with USC for these services since the mission of one of DMH's facilities, Hall Institute, is to provide these services. Section 44-11-10 (2) of the South Carolina Code of Laws states that, "The William S. Hall Psychiatric Institute at Columbia shall be maintained as a teaching hospital for the primary purposes of training mental health personnel and psychiatric research . . . ." In FY 92-93, Hall Institute had a budget of $20 million to carry out its mission.

DMH paid USC's neuropsychiatry department $100,000 in FY 92-93 for services which have not yet been completed.

In addition, while DMH paid USC's neuropsychiatry department $100,000 in FY 92-93 for these services, as of November 1995 the services had not been completed.

Other Contract Issues

During our sample of DMH contracts, some other specific problems were noted.

- A physician retired from DMH on June 30, 1994. Shortly before his retirement, he became the sole incorporator of a psychiatric association and on July 1, 1994, he contracted with a mental health center to furnish physician services at $75 per hour, not to exceed $135,000 annually. The contract, signed by the doctor, contains a clause affirming that he had not been a DMH employee within the past six months.

- A contract requires a one-year notice prior to cancellation and states that the contract will continue for an indefinite period of time. This contract was signed by the DMH director on April 6, 1993. However, services were not provided under this contract until July 1994. Other contracts

which we reviewed had a specified period in which they were effective and, generally, allowed for cancellation with 30 to 90 days notice.

- We found eight contracts that were inappropriately classified as exempt. Exempt contracts may be entered into without competitive procurement and include fee services such as those provided by physicians, dentists, and other professionals. According to the State Budget and Control Board's Division of Audit and Certification, which performs procurement audits of state agencies, exempted services must be those which only a licensed physician can provide. None of these eight contracts were for services requiring a licensed physician.

  For example, DMH hired a physician to provide consulting services which "will focus on the structure of SCDMH for delivering services in a changing healthcare marketplace, and Departmental operations in a managed care environment." DMH exempted this contract from competitive bidding because the contractor was a licensed physician, even though the consulting services do not require a licensed physician.

- A psychiatric practice group had contracts with two community mental health centers. During the contract period (FY 94-95), the two doctors in this practice became full-time DMH employees at one of the centers. The other mental health center was unaware that the doctors had become DMH employees and considered their contract to still be in effect. The doctors had not delivered any services to this center in FY 94-95 and, therefore, had not received any payments. However, this created a potential for paying the same doctors both as employees and as contractors.

In general, DMH contract monitoring could be improved. Some contracts required the contractors to provide detailed billings, and the contractors did not comply. In addition, according to a DMH official, DMH's accounting system has not tracked payments by contracts when contractors had multiple contracts.

Revised Procurement Policies and Procedures

In August 1995, DMH established policies and procedures dealing with professional service contracts in order to provide greater accountability and administrative supervision. For example, the procedures require that an administrative file be kept which includes copies of the contract, related correspondence, vouchers and supporting documentation, and documentation of services provided. The current procedures also provide for an evaluation and review process at the end of the contract term to determine if the contract should be renewed. Previous procedures did not contain provisions for monitoring contracts and documenting services.

Recommendations

12. DMH should follow its policies regarding the review, approval, and signature of all contracts. DMH should not allow contractors to provide services prior to the approval and signing of their contracts, and should not pay for services before they are provided.

13. DMH should ensure that all services are performed and documented, and DMH should not pay contractors unless detailed billing is submitted.

14. The University of South Carolina should require reimbursement from the practice plan for expenses associated with services provided by university employees through contracts with DMH.

15. DMH should ensure that when its employees provide services, fees generated by these employees are deposited into accounts of the Department of Mental Health.

16. When research and training services concerning psychiatry are needed, DMH staff should request the services from the William S. Hall Psychiatric Institute.

17. DMH should consider cancelling the research and training contract between the Columbia Area Mental Health Center and USC's School of Medicine and request a refund of funds which have not been expended.

18. DMH should competitively bid services provided by a physician when the services to be provided do not require a licensed physician.

19. DMH should consider not entering into contracts which require one year's notice prior to discontinuation and which have an indefinite term.

Transfer of Psychiatric Beds

On October 1, 1994, the Department of Mental Health entered into a memorandum of agreement with Richland Springs Psychiatric Hospital, which is the psychiatric unit of Richland Memorial Hospital. We found that this agreement does not adequately provide for the referral of indigent patients.

Background

Under the memorandum of agreement, Richland Springs agreed to admit annually a minimum of 595 patients, from Richland, Lexington, and Fairfield counties, who need acute psychiatric inpatient care. In return, DMH agreed to transfer to Richland Springs 23 local inpatient crisis stabilization beds from its allocation as identified in the South Carolina Health Plan.

The agreement between Richland Springs and DMH has helped reduce admissions to DMH psychiatric hospitals.

"Crisis stabilization" or acute psychiatric services are provided in an inpatient setting to those clients who need diagnosis and treatment for acute episodes of mental, emotional, or behavioral disorders. Such services may be provided in the psychiatric units of general hospitals or by psychiatric hospitals like DMH's Bryan Psychiatric Hospital. The length of stay is usually less than 30 days.

The South Carolina State Health Plan controls the number of beds available for inpatient psychiatric care through the Certificate of Need (CON) process. A specific number of psychiatric beds are allotted to the Department of Mental Health as well as other psychiatric facilities. Under the memorandum of agreement, therefore, DMH reduced its authorized allotment of psychiatric beds by 23; Richland Springs, with an existing capacity of 37 psychiatric beds and 10 substance abuse beds, was able to expand by 23, for a total of 70 beds. DMH also expected Columbia Area and Lexington mental health

centers (Columbia Area includes Richland and Fairfield counties) to reduce the number of their clients referred to Bryan Hospital.

The goal of the agreement was to reduce admissions from the three-county area to DMH inpatient facilities by 280 per year or a minimum of 3,080 bed days. Admissions for May through November 15, 1995, from the Columbia and Lexington mental health centers have declined 23% from the same period in 1994—a decrease of 208 admissions.

The memorandum also provided that Richland Springs, in admitting the 595 patients, include "services to indigent patients"; that is, patients without private insurance, medicare, or medicaid and who are unable to pay for their care.

Indigent Patients Not Referred

According to staff at both Lexington and Columbia Area mental health centers, they were unaware that Richland Springs would take any indigent patients. Written referral criteria used by Columbia Area staff specified that clients sent to Richland Springs had to have a payment source such as private insurance, medicare or medicaid. If any indigent clients had been referred, they were referred with the understanding that they did have a payment source.

DMH has not monitored its agreement with RMH to ensure that RMH admits the number of patients required under the agreement.

Data provided by the Columbia Area Mental Health Center, which comprises the majority of client referrals, shows that from July 1994 through March 1995, 96% of center clients had a third-party payment source when they were admitted to Richland Springs. From April 1995 through September 1995, 94% had a payment source (see Table 3.1). (While the memorandum of agreement began in October 1994, the license for the 23 new beds was not issued until April 1995.)

Table 3.1: Columbia Area Mental Health Center Patients Admitted to Richland Springs

	Total Admitted	With Pay Source[a]	Self-Pay	Pay Source Not Shown
July 1994 – March 1995	264	255 (96.6%)	7 (2.66%)	2 (.76%)
April 1995 – September 1995	217	204 (94%)	8 (3.7%)	5 (2.3%)

a This includes private insurance, medicare, or medicaid.

Source: Local Inpatient Admissions Reports, DMH/CAMHC.

Lexington center staff reported that 32 patients from their area, none of whom are indigent, have been admitted to Richland Springs since April 1995.

Richland Springs is required to admit at least 595 clients needing acute psychiatric hospitalization annually under the terms of this agreement. Admissions since April 1995 have averaged 41.5 a month and at this rate will amount to only 498 a year. A clause in the agreement requires Richland Springs to relinquish the 23 crisis stabilization beds in the event they are not used in accordance with the agreed-upon terms.

Aspects of the Agreement Unclear

The actual number of indigent patients to be served by Richland Springs is not clear. The agreement with DMH states only that Richland Springs is to include "services to indigent patients in accord with the Richland Memorial Hospital Certificate of Need Application for Psychiatric Beds." The Certificate of Need application had to be filed with the Department of Health and Environmental Control before the 23 beds could be transferred.

The specific number of indigent patients that RMH should admit is unclear, and DMH had not referred indigents until November 1995.

Nowhere in the CON application or the memorandum of agreement does it show the actual number of indigent patients who should be admitted for treatment, the number of bed days, or the level of services to be provided. The CON application shows that Richland Springs expects to write off 5.7% of its gross revenues for "charity" patients.

According to DMH management, they are interpreting this to mean that Richland Springs should take as indigent patients about 6% of the 595 clients the centers will refer, or about 36 patients annually. However, there is not necessarily a relationship between the number of indigent patients referred and a 5.7% write-off of revenues.

The agreement does not clearly indicate how the terms of the agreement will be monitored. Also, current monthly reports on patient referrals do not specifically delineate patients who are indigent. Rather, as shown on Table 3.1, some clients are self-pay or have no specified payment source; whether these are indigent clients is unclear.

Using the CON Transfer as a Bargaining Tool

The CON for the 23 beds transferred to Richland Springs has a value, and Richland Springs projected its profits to increase after it expanded its operations. Net revenues for 1995 are projected to be approximately $1.3 million, an increase of 116% over 1994 net revenues of $586,450 (see Table 3.2).

Table 3.2: Projections of Net Revenues for Richland Springs Psychiatric Hospital

	Before Expansion	After Expansion		
	1994 (Actual)	1995 (Projected)	1996 (Projected)	1997 (Projected)
Excess of Revenues Over Expenses	$586,450	$1,267,785	$1,413,791	$1,634,404
Operating Margin (%)	9.6%	14.3%	14.2%	14.6%

Source: Richland Memorial Hospital Certificate of Need Application, August 17, 1994, as well as revised budget data.

There is no evidence that DMH used the potential value of these beds as a bargaining tool with Richland Springs to obtain increased benefits and services for indigent clients. For example, DMH could have required Richland Springs to provide a specified number of bed days and a specified level of services to indigent DMH clients. The current agreement does not clearly address this. DMH never established a market value for these beds because it did not negotiate with other service providers. According to DMH staff, other hospitals in the area either were not interested in expanding their operations or were not certified to participate in medicaid.

DMH did not establish a market value for the psychiatric beds or issue a request for proposals.

DMH might have obtained better terms in exchange for the transfer of the 23 psychiatric beds if it had negotiated with other hospitals. The department could have issued a formal "request for proposals" whereby hospitals could have submitted written proposals to serve DMH clients in exchange for the 23 beds. DMH has not documented that RMH's services to 36 indigent clients are a fair exchange for an increase in net revenues of approximately $1 million a year.

According to DMH management staff, they will study the results of the agreement after it has been in effect for a year or more.

DMH Officials Also Employed at Richland Springs

During the time this memorandum of agreement was negotiated, several DMH officials had dual roles and/or employment with both Richland Springs and DMH. The chairman of the DMH commission in 1994 was also medical director at Richland Springs.

Also, eight DMH psychiatrists employed at Columbia Area Mental Health Center, including the medical director of Columbia Area, were dually employed as on-call physicians at Richland Springs. The Columbia Area medical director and two other DMH doctors were also contract employees of Richland Memorial Hospital. There is no evidence these personnel actively participated in the negotiations; however, they stood to gain financially from increased DMH referrals to Richland Springs, especially referrals of paying patients. That is because DMH doctors treating clients in the hospital are able to bill for these services and collect such fees in addition to their state salaries. (This is discussed further on page 13).

The memorandum of agreement was not brought to the DMH commission, so there was no vote to approve the transfer of beds to Richland Springs. The executive director at CAMHC told us that she was not involved in the negotiations. The director of the Lexington Mental Health Center told us

that he was not aware of the final version of the memorandum until after it was signed. While DHEC's state health plan requires this agreement to be between the local mental health centers and the hospital, only the former director of DMH and the chief operating officer of the hospital signed it.

Diversion of Paying Patients

A DMH goal is to develop inpatient crisis intervention services in the community, so that clients needing short-term treatment do not have to travel to central state facilities such as Bryan Psychiatric Hospital in Columbia and Patrick Harris Psychiatric Hospital in Anderson. However, DMH has not developed a way to include indigent clients in this policy. As a result, paying patients are able to access local facilities such as Richland Springs, while indigent patients are sent to central DMH facilities. Therefore, DMH has less earned revenue that could be used to support increased services. Also, a "dual" system is created—one for those with insurance, and one for those without. We have determined that for FY 94-95, 70% of the Columbia Area Mental Health Center patients admitted to Bryan Psychiatric Hospital have no health insurance (see p. 17).

Recommendations

20. If Richland Springs Psychiatric Hospital does not serve sufficient numbers of indigent patients (at least 5.7% per year) or if other terms of memorandum of agreement are not met, then the Department of Mental Health should consider terminating the agreement.

21. If the agreement is not terminated, then DMH should re-negotiate with Richland Springs and/or other interested providers when the initial term ends October 1, 1999. This should include establishing specific services and a specific number of bed days for serving indigent clients.

22. The department should issue a "request for proposals" when seeking private sector services for clients.

Hiring of Local Mental Health Board Member's Spouse

The Columbia Area chairman's wife served the center as a consultant and was later hired as a full-time employee.

In October 1992 the then-executive director of the Columbia Area Mental Health Center (CAMHC) contracted with a consultant for the center's thrift store operations. At this time, the husband of the consultant was the chairman of the CAMHC Board of Directors.

The contract, at $50 an hour up to a total of $499, was to help the center improve the business management of its thrift store. Because the total cost of the contract was under $500, the center did not have to seek competitive bidding. In April 1993, after the contract ended, the consultant was hired as a full-time CAMHC employee. The CAMHC Board of Directors was not informed of the hiring until after the employment had begun.

The former director of CAMHC had requested advice from the DMH legal office regarding any prohibition against hiring the spouse of a board member; the legal office reported that this was not illegal. State ethics laws (§8-3-50) state that "no public official, public member or public employee may cause the employment . . . of a family member to a state or local office or position in which the public official . . . supervises or manages."

Previous opinions by the State Ethics Commission on similar situations at state government agencies have held that the current ethics law allows the employment of a board member's or agency official's relatives, as long as there is no direct supervisory relationship. Section 44-15-70 authorizes the CAMHC board to employ staff, and the employees report to the executive director who reports to the board. Therefore, the board chairman has only indirect authority over CAMHC employees.

Recommendation

23. The General Assembly may wish to consider amending §8-13-750 to restrict state agencies from hiring the immediate family of their boards, commissions, and top management staff.

Patient Discharges and Facility and Community Resources

In this chapter, we examine DMH's practice of "flagging" patient records to determine whether certain patients were retained inappropriately. We also sample files of patients who were discharged from short-term psychiatric hospitals. In addition, we examine expenditure and patient population changes from FY 89-90 through FY 94-95.

Flagged Files for Patients in Long-Term Psychiatric Care

Crafts-Farrow State Hospital (CFSH) and South Carolina State Hospital (SCSH) are DMH's long-term psychiatric care institutions for the mentally ill. The majority of patients in these hospitals are there involuntarily, committed by the courts until such time as treatment is no longer needed. According to FY 93-94 statistical reports, the average length of stay is almost two years for State Hospital and six months for Crafts-Farrow. Some patients had been institutionalized for 20 years or more. (During this review the department was in the process of consolidating the two facilities, and by January 1996 was beginning to close down portions of Crafts-Farrow.)

We reviewed the department's policies and practices for releasing patients committed to state facilities. DMH's policy is to discharge as many clients as possible back into the community. From FY 85-86 to September 1995, the populations of CFSH and SCSH have declined 69%.

One of our objectives was to determine whether any patients currently committed to State Hospital or Crafts-Farrow had been retained or prevented from being discharged due to inappropriate political or legislative interference. We excluded from this review a case, currently under litigation, that involves a former DMH patient. We reviewed the department's system for flagging patients' records, interviewed staff, and examined medical records for a sample of clients. We found no evidence that patients currently are being retained inappropriately.

Flagging of Medical Records

The Department of Mental Health places flags on selected patient files to alert staff to special notifications or conditions. Some of these flags require that the approval of the facility director be obtained or that law enforcement be notified before a patient is discharged. The written policy for the placement of flags on medical records states:

> The Facility Director, or his designee(s), may determine or be advised that some special condition or circumstances exist in a patient's case that warrants the records of that patient be documented to provide some special informational or review function on the patient's case. In addition, S.C. Code of Laws [44-22-70(B)] requires that notice of discharge be given prior to discharge to anyone who had made a written request to this effect. Special flags on the medical records will assist staff to fulfill these obligations.

DMH flags patient records so that staff will be aware of certain information.

We concentrated our review of patient records on these flagged files in order to ensure that the flags did not have a chilling effect on a patient's potential to be discharged. We also examined patient records to determine if there was adequate justification for each flag. As of September 1995, a total of 511 patients were housed at the South Carolina State Hospital and Crafts-Farrow State Hospital. We found that DMH had placed flags on the medical records of 151 patients (30%). This excludes flags placed in records solely to alert staff that a patient has allergies or has medicare or medicaid.

Types of Flags

We determined that the majority of the flags were used to notify hospital staff that a patient posed a great risk for "eloping" (leaving without permission) from the facility. The following table describes the types of flags placed on patient records.

Table 4.1: Types of Flags Placed on Patient Files

Flag Type	Description	Total[a]
Elopement From Facility: "EFF Risk" stamp	If a patient has ever escaped from a DMH facility, an EFF stamp is placed on the patient's file to notify staff of this occurrence.	103
Criminal Charges: Red flag indicating "extreme caution"	Requires that solicitors, sheriffs, other law enforcement officials, and sometimes victims, be notified when the patient is discharged. This includes patients with charges nolle prossed, criminal charges pending, judicially committed court cases, those not guilty by reason of insanity, and those adjudicated incompetent. This category also includes temporary flags placed when a patient has requested a judicial hearing.	46
Administrative: Green flag	Used by the facility director in cases where a patient cannot be discharged or released for weekend pass without director's approval.	15
Protection & Advocacy (P&A): Yellow flag	A flag, as well as a yellow sticker, placed on the outside of a patient's file to alert staff to notify P&A officials of any changes in a patient's treatment plan or discharge planning.	13
Compact Resident	Patient is allowed to be transferred across state lines.	3
Name Alert	Used to alert staff that there are multiple patients with the same name.	2
Total		**182**

a Totals are different due to multiple flags for some patients. Also, this does not include records which were flagged to notify staff about medicare/medicaid patients or those who have allergies.

Source: DMH Patient Records.

Results of Review of Flagged Files

We examined 93 patients' records (18% of the total population) which included all patients who had criminal, administrative, and/or protection and advocacy flags placed on their records.

We found no evidence that flagging these records had prevented the discharge of the patients or was indicative of inappropriate political interference. Most of the patients with flagged files had a history of violent or criminal behavior, and the files documented the reason for the flag in the

form of letters or memos from law enforcement, copies of judicial orders, and/or caseworkers' and physicians' notes. For every file reviewed, we tried to determine if medical staff had recommended discharge for a patient; if any person outside the state hospital system had opposed that discharge; and if alternatives to institutional care were available.

Some patients were no longer benefiting from inpatient hospitalization. However, appropriate community placements have not been available.

Community and Legal Pressure

In six cases, we found documentation that law enforcement, judges, state officials, and/or family members opposed the return of patients back to their homes and communities because of past violent or dangerous behavior. Five of the six patients had already been discharged and readmitted to State Hospital many times, and still displayed active psychotic symptoms or aggressive behavior. Progress notes by medical staff indicated that two of these six patients no longer needed hospitalization but still needed intensive supervision in a high-risk, high-management residential facility, which was not available.

Therapeutic Benefits Maximized

In three other cases, clinical notes in the file indicated that the patients were medically stabilized and probably had reached maximum therapeutic benefit from institutional care. Two of these patients had charges "nolle prossed" (dropped) for murder and one had charges nolle prossed for strong arm robbery. They had not been discharged because suitable community placements were not available.

Hospital Dependent Patients

In at least two cases, clinical staff recommended that the patients be discharged; neither patient had a criminal history. However, the patients had been institutionalized for so long that they were "hospital-dependent" and had refused placement in the community.

We also interviewed several social workers at SCSH and reviewed legislative correspondence to determine whether any patient discharges had been inappropriately hindered. We found no documentation that patients were being kept in the hospital because of inappropriate legislative or political interference.

Supporting Documentation

DMH policy requires that staff provide written justification for placing flags in patient files. Staff should explicitly state the circumstances for the flag, and identify who is to be contacted and when. This documentation should become a permanent part of the patient's medical record. Of the 93 records reviewed, we identified 2 files which lacked sufficient documentation regarding the flag. One patient had a flag for "possible charges pending"; however, the file did not specify whom DMH is to notify when the patient is discharged. The other file contained only a record of a telephone conversation to document charges against a patient. The file did not show evidence that the charges were verified in writing.

Additionally, we found four cases where DMH did not place or remove a flag as directed by the supporting documentation in the patient's file. For example, we found evidence that one patient had five previous escapes from a DMH facility, but there was no EFF risk stamp on the patient's file. In another example, two files had memos from the director of legal processing for a flag to notify staff that the patient had filed a petition and a hearing was scheduled. However, we did not see a flag on either patient's file or find documentation that the flags should be removed.

Recommendations

24. The Department of Mental Health should continue to ensure that each patient's record contains adequate documentation for all flags, and that all flags are placed as directed.

25. The Department of Mental Health should continue to seek alternatives to institutional placement whenever possible.

Community Follow-up Care

DMH could improve follow-up care for patients after they are discharged from psychiatric hospitals by contacting patients who missed their follow-up appointments. Follow-up is important to help ensure continued care between inpatient facilities and community centers.

When a patient is discharged from a DMH psychiatric hospital, the hospital is responsible for making an aftercare or follow-up appointment for that patient with the local community mental health center (CMHC). DMH procedures also require the hospital to send certain discharge information to the CMHC immediately and mail more detailed information within a certain time frame.

Centers maintain a file on each patient to ensure proper follow-up care. If the patient does not keep the appointment, DMH policy requires the CMHC to contact the patient. This contact includes telephone calls, letters, and/or a home visit. If the patient still refuses services or cannot be located, a clinical review will be held to make recommendations regarding what additional efforts should be made by the CMHC.

Follow-Up Appointments

According to DMH records for FY 94-95, 886 patients were discharged with appointments from Bryan Psychiatric Hospital to community mental health centers in Richland or Lexington counties. Of the 886, 342 (39%) appointments were not kept. For patients discharged with appointments from Harris Psychiatric Hospital to community mental health centers in the Piedmont and Spartanburg regions, 248 (36%) of 690 appointments were not kept.

We reviewed a sample of files for patients discharged four or more times from Bryan Hospital to Richland and Lexington counties' centers and from Harris Hospital to the Piedmont and Spartanburg centers during FY 94-95. We found that both hospitals are regularly forwarding the required patient information to the CMHCs.

The centers, however, varied in their efforts to contact patients who missed scheduled appointments. We found that patients discharged from Bryan Hospital missed 42 of 68 (62%) of their scheduled appointments. Files from the local CMHCs had documentation of 12 (29%) attempts to contact patients after missed appointments.

In our sample of patients discharged from Harris, we found that seven of nine patients kept either all or most of the scheduled appointments after each discharge. For these 9 patients, 6 (15%) of 39 appointments were missed. The files of three of the patients had evidence of attempted contact. It was difficult to determine what attempts were made to contact patients who missed their appointments; therefore, these figures should be considered approximate. None of the files we examined had a uniform tracking form indicating the date of an appointment, whether the appointment was met, or whether an appointment was rescheduled.

Alcohol and Drug Abuse Patients

In our sample of patients discharged from Bryan Hospital, 10 of 20 were referred to the local alcohol and drug abuse commission office for aftercare for at least one-half of their appointments. There is no documented follow-up between Bryan Hospital and the alcohol and drug offices to ensure that patients kept scheduled appointments, and no statistics are maintained on this type of follow-up appointment.

In April 1991, DMH and the South Carolina Commission on Alcohol and Drug Abuse entered into a memorandum of agreement. One of the objectives is for the two entities to ensure continuity of care between DMH-operated programs and local alcohol and drug programs by sharing information. According to a DMH official, it is unclear how many counties are implementing this agreement.

Harris Hospital has a alcohol/drug inpatient treatment program while Bryan Hospital does not. According to Harris Hospital officials, Harris samples a small number of patients referred to local alcohol and drug offices as well as local CMHCs and reports a compliance rate of between 60% and 65%.

Recommendations

26. DMH community mental health centers should maintain a uniform tracking form indicating date of scheduled appointment, if appointment was kept, rescheduled, or missed, and what efforts were made to reschedule missed appointments.

27. DMH should continue efforts to ensure the continuity of care and the sharing of information between DMH and the alcohol and drug commission offices.

DMH Expenditures and Population by Facility

One of our objectives was to determine if DMH is reallocating funds from inpatient facilities and administrative offices in Columbia to community mental health centers. The department's goal has been to deinstitutionalize patients whenever possible by providing care through community mental health centers. We reviewed DMH expenditures in FY 89-90 and compared them to expenditures in FY 94-95.

Agency records show that expenditures for community mental health programs have increased by 81% over the five-year period, while the number of patient services provided by these centers increased by 92%.

Overall, funding for community mental health centers has increased by 81% from FY 89-90 to FY 94-95.

Expenditures for most programs in Columbia have increased also, but at a lower rate. For example, expenditures for Bryan Psychiatric Hospital, an acute care facility, increased by 45%. The average daily census increased by 9.4%. Expenditures for the Byrnes Center for Geriatric Medicine, Education and Research (formerly Byrnes Medical Center) increased by 7.4%, while the average daily census decreased from 93 to 37 (60%). State Hospital's expenditures decreased by $2.7 million (10%), and the average daily census decreased by 45%. DMH's central administrative expenditures increased by 23%, from $9.4 million to $11.6 million.

Table 4.2 provides expenditure data for DMH inpatient facilities, administration, and for community mental health centers. Table 4.3 provides an analysis of the patient census at DMH facilities in FY 89-90 and FY 94-95.

DMH management's goal is to provide as much care as possible in the communities in order to decrease the population in DMH facilities.

Table 4.2: Comparison of DMH Expenditures in FY 89-90 and FY 94-95

	FY 89-90	% of Total	FY 94-95	% of Total	Change From FY89-90 to FY94-95
Central Administration					
Administration	$9,381,924	4.2%	$11,568,239	3.9%	23.30%
Public Safety	$3,316,462	1.5%	$2,842,218	1.0%	(14.30)%
Consolidated Support	$17,067,818	7.6%	$18,407,636	6.3%	7.85%
Extended Care					
State Hospital	$26,832,275	11.9%	$24,095,378	8.2%	(10.20)%
Crafts-Farrow	$20,085,535	8.9%	$20,727,885	7.1%	3.20%
ICF/MR[a]	$2,077,655	0.9%	$2,835,902	1.0%	36.50%
Acute Care					
Bryan Hospital	$12,707,299	5.6%	$18,420,201	6.3%	44.96%
Harris Hospital	$10,617,266	4.7%	$13,628,655	4.7%	28.36%
Other Inpatient					
Byrnes Medical Center	$11,100,016	4.9%	$11,921,681	4.1%	7.40%
Hall Institute	$18,754,142	8.3%	$22,032,334	7.5%	17.48%
Morris Village	$5,791,903	2.6%	$7,255,940	2.5%	25.28%
Nursing Care					
Dowdy-Gardner/Tucker	$22,673,840	10.1%	$21,419,861	7.3%	(5.53)%
Dowdy-Gardner/ Rock Hill	$7,151,777	3.2%	$7,342,794	2.5%	2.67%
Campbell VA	$69,161	0.0%	$6,509,525	2.2%	b
Community Mental Health					
CMHCS (all 17 centers) and special items[c]	$57,301,729	25.5%	$103,926,683	35.5%	81.37%
Total	**$224,928,802**	100.0%	**$292,934,932**	**100.0%**	30.23%

a Includes clients receiving intermediate level nursing care.
b Statistic not meaningful.
c Included $1.7 million for special items.

Source: DMH Office of Planning.

Table 4.3: Average Daily Census for DMH Facilities

Inpatient Psychiatric Facilities	FY 89-90	FY 94-95	Difference	% Change
State Hospital	588	323	(265)	(45.07)%
Crafts-Farrow	470	348	(122)	(25.96)%
ICF/MR[a]	28	45	17	60.71%
Bryan Hospital	191	209	18	9.42%
Harris Hospital	152	149	(3)	(1.97)%
Hall Institute	173	150	(23)	(13.29)%
Morris Village	166	132	(34)	(20.48)%
Dowdy-Gardner/Tucker	1,032	679	(353)	(34.21)%
Campbell Nursing Home	0	211	211	
Total	2800	2246	(554)	(19.79)%
Byrnes Center (non-psychiatric medical facility)	93	37	(56)	(60.22)%
Community Mental Health Patient Contacts	749,282	1,441,226	691,944	92.35%

a Includes clients receiving intermediate level nursing care.

Source: DMH Office of Planning.

Staffing and Certification Findings

One of our objectives was to determine if DMH inpatient facilities had adequate numbers of registered nurses (RNs) and other medical staff. To this end we reviewed surveys conducted by the Department of Health and Environmental Control (DHEC) for the U.S. Health Care Financing Administration (HCFA). Two facilities, Bryan Psychiatric Hospital and Crafts-Farrow State Hospital, were cited for deficiencies in meeting the staffing criteria. Failure to remedy these deficiencies could lead to a loss of federal medicare and medicaid funds. However, both have taken remedial actions and now meet applicable federal standards.

- Bryan Hospital is certified by HCFA to participate in medicare. In its annual survey in March 1995, HCFA found that Bryan did not meet standards requiring that registered professional nurses be available 24 hours each day. Bryan Hospital had 16.8 vacancies in its registered nursing positions and had 14 fewer direct care RNs than the previous year. According to the HCFA report, ". . . the total number of RNs for direct care was not adequate to provide active treatment measures in an acute admissions hospital." The HCFA survey also found that Bryan relied on outside agency nurses to cover staff shortages and that, during the two-week period chosen for review, two night shifts had no RNs on duty. In May 1995 Bryan took remedial actions including hiring more nurses, closing one lodge, and de-certifying two other lodges to accept patients needing less than acute care.

- Crafts-Farrow State Hospital is certified by HCFA to participate in medicare/medicaid programs. Its HCFA evaluation conducted in FY 94-95 also found that the hospital did not meet nursing staff standards. Crafts-Farrow did not have enough registered nurses to provide direct care on all shifts, and also used temporary nurses. In addition, Crafts-Farrow was deficient in documenting the credentials and training of physicians on staff to show that they were qualified, nor was there evidence in the files of supervision by a certified psychiatrist. HCFA also found that Crafts-Farrow did not meet special medical records requirements; as a result, the report noted ". . . Major deficiencies in treatment plans and a lack of active psychiatric treatment . . . ."

Remedial actions taken by Crafts-Farrow include: reducing the number of HCFA-certified beds by transferring patients who no longer needed active psychiatric care; hiring more nursing staff; and providing increased training to selected staff. As of October 1995, Crafts-Farrow had 14 doctors on staff, including 2 certified psychiatrists.

As shown in the HCFA evaluations, Bryan and Crafts-Farrow hospitals rely on temporary nursing agencies to cover staff shortages. In FY 94-95, DMH data show that Bryan spent $779,744 on temporary nurses and Crafts-Farrow spent $999,056. Based on mid-year projections for FY 95-96, DMH expects to decrease its expenditures for temporary nursing at the two hospitals by approximately $1.3 million.

We also reviewed a HCFA survey for Tucker/Dowdy-Gardner Nursing Care Center conducted July 1995. The center was cited for several deficiencies, but these did not involve staffing issues. As a result of this evaluation, DMH had to pay a $67,000 fine.

All DMH inpatient facilities except for Crafts-Farrow also have accreditation from organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); JCAHO accreditation is voluntary.

Recommendation

28. The Department of Mental Health should continue to monitor nursing staff levels to ensure adequate coverage and should continue to decrease reliance on temporary nursing agencies.

Issues for Further Study

During our review, we identified two concerns which warrant further review by DMH management.

Byrnes Center for Geriatric Medicine, Education and Research

Expenditures for the Byrnes Center for Geriatric Medicine, Education and Research should be reviewed to determine if it would be more advantageous to spend these resources for community programs and to obtain medical care for patients from non-DMH hospitals. Byrnes Center provides laboratory, outpatient, inpatient, and other medical services (which are non-psychiatric) to DMH patients. It also provides medical care to tuberculosis patients referred by the Department of Health and Environmental Control. Byrnes Center also has operated a detoxification program for voluntary and involuntary admissions since 1987. However, the number of patients receiving care at the Byrnes Center is decreasing. While the Byrnes Center has 166 beds, the average daily census declined by 60% from 93 in FY 89-90 to 37 in FY 94-95. In FY 94-95, the Byrnes Center spent approximately $12 million.

Because DMH's goal is to channel patients from inpatient facilities in Columbia to communities, and because the Department of Corrections no longer contracts with the Byrnes Center for inpatient medical services, the number of patients hospitalized at the Byrnes Center is declining.

In addition, the Byrnes Center entered into an agreement in 1992 "to affiliate with the University of South Carolina School of Medicine for the purposes of education and training." However, the need for this affiliation should be reviewed. Section 44-11-10 states that Hall Psychiatric Institute shall serve as the research and training facility for the Department of Mental Health. DMH's Tucker/Dowdy-Gardner Nursing Care Center has served as a teaching geriatric center, providing undergraduate and graduate students at the University of South Carolina the opportunity to obtain experience related to various disciplines. In addition, students at USC's School of Medicine provide various services at Tucker/Dowdy-Gardner. Designating Byrnes as a center for geriatric education and research could duplicate the training and research mission of Hall Institute.

Commission Input

During our review, we noted that several major policy issues were not brought to the DMH commission for review. DMH management stated that while there are no guidelines outlining what issues are to be reviewed by the commission, they attempt to bring major decisions to the commission for approval. Commission input could be helpful when deciding whether to change major agency programs, especially when these changes impact department revenues.

For example, we could find no evidence that the DMH commission approved the following actions.

- In 1994, DMH staff negotiated an agreement with Richland Memorial Hospital (RMH) to transfer a Certificate of Need for 23 psychiatric beds from DMH to Richland Memorial Hospital's psychiatric unit. This arrangement allowed RMH to increase the size of its psychiatric facility and its revenues, and required DMH to refer patients to RMH.

- In 1987, DMH staff created a private pay, "deluxe accommodation" facility at Hall Institute. This facility, Shearouse Pavilion, has incurred significant financial losses, and it competes with private sector psychiatric hospitals.

Recommendations

29. The Department of Mental Health should review expenditures for medical care provided at Byrnes Center and expenditures at other facilities to determine if resources could be saved by contracting with private hospitals for medical and other services for DMH clients.

30. The DMH commission should participate in decisions that involve major changes in DMH programs or operations.

Agency Comments

DMH South Carolina Department of Mental Health

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John A. Morris, Jr., M.S.W.
Interim Director of Mental Health

MISSION STATEMENT
The men and women of the S. C. Department of Mental Health, in partnership with consumers, families and their diverse communities, will assist citizens with mental disorders to improve the quality of their lives.

February 28, 1996

Mr. George L. Schroeder, Director
400 Gervais Street
Columbia, SC 29201

Dear George:

I am pleased to submit to you the official DMH response to the LAC report entitled "A Review of the South Carolina Department of Mental Health." We understand that it will be printed along with your report.

Again, I wish to commend your staff for their unfailing courtesy in dealing with our department. As is natural, we disagree with the report in some substantive areas. However, on the whole, we believe the report reflects favorably on DMH and its staff, especially in the critical area of patient care.

Sincerely yours,

John A. Morris, MSW
Interim State Director

EXECUTIVE SUMMARY OF DEPARTMENT OF MENTAL HEALTH RESPONSE

The Department of Mental Health welcomes the release of this LAC report, and we encourage the readers of the report to pay close attention to the actual **findings** of the report. We approached this audit confidently, and have cooperated fully with the audit staff, whom we commend for their courtesy and patience. As with all audits, this one finds areas that should be and, in some cases already are being, improved. We agree with all or parts of 19 of the audit's 26 recommendations that involve DMH--many of which read that DMH "should continue" existing practices, an endorsement of our commitment to continuous improvement.

We are most pleased with the review of patient care activity. One of the main allegations that prompted this LAC review was the implication of political interference in the clinical care of patients in our hospitals; this was a serious moral and legal challenge to DMH. We draw the reader's attention to Chapter 4 of the report, which found **"no evidence...indicative of inappropriate political interference"** (p.39). In that same chapter, the LAC reviews outpatient follow-up; we share the LAC's concerns about continuity of care and have made significant strides in improving the monitoring of services.

While we agree with much of this report, we regret that some issues are portrayed inaccurately. At the same time that the LAC recognizes the important move that DMH has made in transferring so many clients to their home communities, they fail to acknowledge that this move would not have been possible without mental health center physicians who also work in community hospitals. The report suggests that there is the **potential** for these doctors to refer to their own practices inappropriately, but provides no evidence that they have done so. DMH policies prohibit this practice.

The report suggests that the Director of Shearouse Pavilion engaged in improper behavior in contract negotiations with an insurance provider. Our review indicates that the Director was not

involved in fee negotiations and that he had informed DMH legal staff of his affiliation with the insurance company--information that we provided to the LAC prior to the completion of their report.

The report criticizes DMH for its relationship with Richland Memorial Hospital for diversion of emergency admissions. A major goal for DMH in recent years--endorsed by the General Assembly--has been our move toward local care. A key element in that strategy has been to decrease admissions to state facilities and increase utilization of local hospitals which can bill for Medicaid. The DHEC state plan allows DMH to allocate diversion beds in support of this policy. Richland Memorial is the only Columbia area hospital to demonstrate a willingness to use the beds. The arrangement has accomplished its goals and greatly benefitted DMH and the patients we serve. The LAC seems to have missed the major intent **and actual outcomes** of the agreement.

The LAC reviewed a small, judgmental sample of our contracts. They identified some problems with technical contract management practices, many of which we have already corrected. There is an implication in this section that DMH is paying for services we are not receiving, and yet the LAC found no evidence that services were not provided. In more than 95% of the contracts reviewed, the LAC had no problem with the adequacy of the documentation of services.

The report implies that DMH does not receive value for its affiliation with the USC School of Medicine. One vignette may serve to counter that implication:

> **In the mid-1980s, the children's unit of the SC State Hospital suffered from chronic understaffing and severe over-crowding; the hospital was the object of a Justice Department complaint that focused on staffing and patient care issues; and access to fully trained child psychiatrists was a major problem. In late 1986, the unit was transferred to the Hall Institute. Today the child and adolescent service consists of several specialty programs which are fully staffed with qualified clinicians, and the hospital is accredited by the Joint Commission on the Accreditation of Healthcare Organizations and certified by the Health Care Financing Administration. The Institute staff now includes 10 board certified child psychiatrists.**

This illustration is just one of the many examples of the benefits to the state of DMH's affiliation with the School of Medicine. When the USC School of Medicine was established, the General Assembly structured it as a **community based medical school.** It does not have its own hospital but rather by design creates partnerships with local institutions, such as the VA Hospital, Greenville Hospital System, Richland Memorial, and the Department of Mental Health. DMH believes that the state receives benefits from this arrangement between USC and DMH that exceed the sum of the two parts. The LAC report takes a much-too-narrow view of this affiliation.

In spite of some strenuous disagreements with portions of the report, on the whole we believe the LAC report is helpful to DMH. Our mission is patient care, and the report is reassuring in that regard. We are also stewards of the public's resources, and the LAC offers suggestions that we will find useful in our continuing efforts to improve efficiency and accountability. We assure the Governor, members of the General Assembly and the citizens of the state that we will move assertively to ensure that DMH continues to operate in a responsible, businesslike manner as we seek to continuously improve the quality of our patient care.

DETAILED RESPONSES TO THE REPORT

Following is a more detailed response to the LAC report, including disputations of fact and additional clarification. Headings and page numbers correspond with the LAC report.

CHAPTER 2 - PHYSICIAN COMPENSATION

DMH Participation in Practice Plan (p 7-8) The Department of Mental Health supports the intent of the LAC's recommendation that the General Assembly clarify the participation of DMH employees in the USC School of Medicine's practice plan. However, any clarification should not jeopardize the benefits that accrue to the department's patients as a result of these relationships. We believe that the LAC has approached the issue of the USC practice plan in too simplistic a fashion by focusing only on the issue of compensation.

Medical schools traditionally create practice plans to augment faculty salaries so that they can attract the best practitioners possible. In addition, fees earned belong to the School of Medicine, not the faculty member, and are used not only for faculty supports but also to fund joint projects of the School of Medicine and DMH. We need to emphasize that the Practice Plan is a part of the USC School of Medicine which, as a state university, has its own reporting mechanisms, including reports to the State Auditor and the USC Board of Trustees.

The proviso's language relating to salary supplements makes reporting an individual, not an agency, responsibility. Nonetheless, we have taken steps to ensure that physicians will be made aware of the requirement by annually notifying them of this requirement. As the LAC found, there is no deadline specified for reporting supplements, and we would welcome added clarification of this proviso.

Lease Arrangement (p 8-9) This issue is now moot. The lease with the USC School of Medicine's Practice Plan has been terminated, and the practice plan vacated the Hall Institute premises in January 1996. The lease arrangement pertaining to practice plan space was not renegotiated in September 1995 because we were in the process of converting the Hall Institute outpatient billing system from the practice plan to a new billing system used by the DMH Community Mental Health Centers. We did not wish to disrupt this system and risk delay of billing, given that the practice plan was leaving in January.

Shearouse Pavilion (p 10-13) We strongly dispute the LAC's contention that the director of Shearouse Pavilion inappropriately used his position to obtain a discounted rate for a private insurance company for which he also provided contract services. Our review of this matter shows that the director of Shearouse Pavilion was not involved in the fee negotiations. Furthermore, review of other Shearouse contracts similar to the LAC-cited contract show that there were no cost advantages gained for that insurance company. In light of these facts, we are concerned that these allegations have been made in a public document. We have struggled with the self-supporting status of Shearouse--which is projecting a positive balance sheet for this fiscal year--and will continue to review this program periodically.

Private Practice by Community Mental Health Physicians (p 13 - 19) With regard to DMH doctors conducting their private practices, the Audit Council indicated that ..."DMH has taken steps to control when

and how..." this occurs. As the LAC reports, the department had in place prior to this audit the following controls on private practice:

- Private practice is limited to off-duty hours;
- Support personnel and supplies may not be used for any private practice;
- Employees must notify their facility or center in writing of their intent to engage in private practice;
- Center physicians are explicitly prohibited from referring a patient to their private practices.

The LAC found no evidence during their 1995 review to indicate that any DMH physicians were seeing private practice patients during their regular state working hours or that there were any abuses of other aspects of this policy. The department takes exception to the LAC's inference that the Department's goal of treating patients in the community allows a center doctor to send a DMH client to his private practice group. The DMH directive and guidelines do not allow for self referral. The LAC notes that DMH's internal auditors review compliance with all private practice policies. The Internal Audit Division reports directly to the Mental Health Commission, and if any problems or violations arise in internal audit reports, the Commission requires corrective action by management.

CHAPTER 3 - DEPARTMENT OF MENTAL HEALTH CONTRACTS

The Department processes over 700 contracts annually and has a clearly defined approval process by program, financial and legal staff. The LAC reviewed 86 contracts from two, or possibly three, years -- a time period in which DMH would have processed no fewer than 1,400, and potentially as many as 2,100, contracts. With regard to sample methodology, we believe that the Council's contract sample was largely generated from 1995 media reports and is a judgmental sample rather than a random sample.

Documentation of Services (P. 24-25.) While we concur with the LAC that all contractual services need to be documented, we believe that we are already doing an effective job in this area and note that the LAC in their review found that 95% of the contract files had adequate documentation. There is no indication that services were not provided in the other 5%, and in fact the department takes the position that the services in question were provided.

Prior to the LAC audit DMH instituted an additional contract monitoring process which ensures that the department does not pay for services that have not been provided. Contracts are required to have clear, precise and quantifiable performance indicators and goals so that both the department and the contractor are clear on what is expected. At the completion of the contract term and before payment, DMH assesses whether the requested product was delivered. Written documentation by the contractor and the Department of these "deliverables" has been, and will continue to be, included in each contract file.

Community Mental Health Center Contract (p.27) We disagree with the LAC criticism of a Columbia Area Mental Health Center contract for research with the USC School of Medicine's Department of Neuropsychiatry rather than with DMH's Hall Institute. While Hall Institute is the Department of Mental Health research and training facility, it has limited resources. The major part of the Institute budget is for direct patient care, including all inpatient children's programs, the Forensic unit, the Allan Project (for persons found not guilty by reason of insanity), and several specialty outpatient clinics. Less than 10% of the Hall budget is allocated for research and training.

Other Contract Issues (p.27-28) The Department takes issue with several conclusions made in this section by the Audit Council. With regard to the physician signing a contract the day after leaving state employment, the LAC infers that the physician knowingly made a false statement to mislead DMH. This is not the case. Contract documentation indicates that DMH was aware of the physician's employment and retirement, and that the contract was approved only after the physician had incorporated, obtained a federal identification number and been covered by private professional liability insurance. The purpose of the "prior employment" clause in the contract is to assist in identifying physicians with prior employment status so that proper steps can be taken before a contract is finalized. This case shows that the clause accomplished its purpose.

We want to clarify the Council's finding regarding a contract with a one year cancellation period and an indefinite term, when other contracts had a specified time period and generally allowed for cancellation with 30-90 days notice. The agreement in question is an amendment to DMH's affiliation agreement with the USC School Of Medicine and contains the same term and cancellation provisions as the umbrella affiliation agreement. This agreement provides for coordination of efforts in education and training, medical staff

recruitment and academic appointments. This agreement facilitates a long-term cooperative relationship between the parties and as a result has no specific ending date. This is not a contract for delivery of machine parts which can be cancelled with 30 days notice; it reflects a continuing relationship for the training of mental health professionals and the conduct of services research.

We are also somewhat puzzled by the lack of materiality of the LAC "finding" on two doctors who had contracts with two community mental health centers and became employees of one of the centers. The LAC states the potential existed for paying the doctors both as employees and contractors. However, no services were delivered under this contract after employment and no problems resulted. Furthermore, the DMH model contract for physicians includes a clause that terminates the contract automatically if the physician becomes an employee. There are many "potentialities" in any system, but they should not be treated as audit findings.

Transfer of Psychiatric Beds (p 30-35) The Department of Mental Health strongly disagrees with much of the Audit Council's review of this area. We believe the LAC report misses the point of the transfer of beds to Richland Memorial Hospital. The stated goal of the agreement, to reduce admissions to DMH facilities from the Richland-Lexington-Fairfield county area, has clearly been met. The LAC concedes this point in their report but severely understates its importance. The agreement has succeeded in diverting from state facilities many patients whose care would have been funded totally by state dollars. The department in the period May to September 1995 has decreased admissions by 23% to state facilities, compared with the same period in 1994. The LAC focus on the indigent care issue is misleading. The anticipated amount of indigent care is a minimal amount of the total care being sought from this contract. Since the fall of 1995 a protocol has been used by the mental health centers to ensure that indigent patients will be referred and admitted to RMH in numbers sufficient to exceed the minimum specified in the CON application.

The LAC report criticizes the Department for not negotiating with other service providers in order to obtain market value for the 23 beds transferred to Richland Memorial Hospital and to obtain "better terms" in exchange. This is an unfair criticism. The Department has documentation which indicates that a concerted statewide effort was made to interest hospitals in accessing all crisis stabilization beds identified by the DHEC Medical Facilities Plan. Furthermore, DMH discussed obtaining diversion services from at least two other hospitals in the Columbia area. No negotiation took place between DMH and these two facilities

because one was not interested and the other could not accept medicaid patients, which was part of DMH's criteria for the transfer of any crisis stabilization beds. Fifty-three (53) of the 76 beds available in the Columbia area are still available today. Sending out a "Request for Proposals" for these beds when clearly there was no interest would have been a waste of state time and resources.

Finally, the Department objects to the implications in the review of "DMH Officials Also Employed at Richland Springs." The LAC provides no evidence that any of the referenced DMH physicians, some of whom treat patients at Richland Memorial, were involved in the contract negotiations, and we are confident that there was no such involvement.

CHAPTER 4 - PATIENT DISCHARGES AND FACILITY AND COMMUNITY RESOURCES

Flagged Files (p. 37-41) DMH's mission is to serve clients; therefore, the most important issue LAC reviewed was the allegation that patients were not being discharged because of political influence. The Audit Council found **no evidence that clients were being retained inappropriately in inpatient facilities** or that "political" and "outside" interference prevented the discharge of patients. Furthermore, we are pleased the LAC found neither serious nor material weaknesses in documentation relating to the placement or removal of flags in patient files.

Follow-up Appointments (p.42-43) We concur with the Audit Council that follow-up care for patients discharged from our psychiatric facilities is vitally important. The Department has dramatically increased its effectiveness in this area, and we are continually striving to ensure that our community centers and our facilities work in concert to maintain effective continuity of care for clients. The Department closely reviewed the statistics that the LAC provided on follow-up of patients with four or more discharges from Bryan Hospital to Richland and Lexington community mental health centers. We conducted our own review and we dispute the follow-up figure of 29% (p.42) for the CMHCs in Richland and Lexington counties; our review indicates that the LAC dramatically under-reported follow-up documentation by the CMHCs. Much of this discrepancy is due to the sample methodology used by the LAC which counted clients referred to other state agency systems who have the primary responsibility to ensure that follow-up appointments are made. Within the DMH system we link our

CMHCs and hospitals by computers and in other ways; we do not yet have these linkages with other systems.

Many of our clients suffer from substance abuse as well as a psychiatric illness. It is estimated that as many as 60% have this dual diagnosis. The Department of Mental Health and the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) continue to work cooperatively to maintain continuity of care for this population. Governor Beasley has sought to emphasize interagency cooperation and, as a result, the Department of Mental Health is strengthening communication between the two agencies so that seamless care can be provided. Cooperation between the local offices of our two agencies is improving.

.DMH Expenditures and Population by Facility (p.44-46) The LAC reported that the Department has reduced the populations at our long term facilities, South Carolina and Crafts Farrow State Hospitals, by 69% since FY 1986. Expenditures for community mental health have increased by over 81% since FY 1990, while the number of patient services provided by these centers increased by 92%. This is one of the real success stories of the Department as treatment in a community setting is not only more cost effective, but also more therapeutic for our clients who are provided services near their homes, their families and other support services. The LAC examined DMH expenditures from FY 1990-FY 1995 to determine if DMH is reallocating funds from inpatient facilities and administrative offices to community programs. Large fixed costs remain constant until facilities consolidate and close. The LAC's comparison of daily census with percentage of decrease/increase in expenditures implies that there should be a proportional correlation. This is an inappropriate implication because of these unavoidable fixed costs, inflation and the expenditures necessary to ensure continued facility certification and licensure.

The LAC states that "...expenditures for Bryan Psychiatric Hospital, an acute care facility, increased by 45%. " This percentage reflects total dollar growth for the FY 1990-1995 period. However, we believe that a more accurate comparison is to look at the facility's expenditures during the period as a percentage of DMH's total budget. In this way, inflation and mandatory pay raises are taken into account. Therefore, as a percent of total DMH dollars, Bryan's growth has been less than one percent in the period. State Hospital declined from 11.9% of budget share to 8.2%, and Crafts-Farrow State Hospital declined from 8.9% budget share to 7.1%. These are significant reductions. Similarly, the Department's

central administrative expenditures, as a percentage of total budget, have actually decreased from 4.2% to 3.9%.

Issues For Further Study (p.49) While the census at the Byrnes Center has been declining, Byrnes provides more than inpatient services. For example, in FY1994, Byrnes also provided the following amounts of outpatient services to DMH clients: 1,945 emergency room visits; 9,808 outpatient clinic visits; 908 onsite consultations by Byrnes' physicians at other facilities and centers; 842,878 lab tests; 8,771 x-ray procedures; 3,203 EEG's; and 180,000 pharmacy transactions. While this information was provided to the LAC, they chose not to include it. For purposes of accuracy, we feel that it is important to make this significant outpatient role known. Lastly, we have reviewed costs for providing inpatient services at Byrnes as opposed to outsourcing, and our most current review indicated that use of Byrnes was the most cost effective alternative. We will continue to evaluate this regularly.

SUMMARY & CONCLUSIONS

We will work closely with the follow-up Legislative compliance review process to ensure that we implement the changes with which we concur. Our track record of compliance with the recommendations of the prior LAC audit of 1989 is excellent.

The members of the Mental Health Commission and the leadership of DMH take very seriously our legislative mandate to provide the best quality care for citizens of South Carolina who suffer from mental illnesses. We operate with an open door and invite scrutiny of our services and management practices, which we believe reflect our commitment to continuous quality improvement.

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