

LAC

A Review of the South Carolina Department of Mental Health

March 1996

Members of the General Assembly asked that we review the South Carolina Department of Mental Health (DMH) and focus our audit on several objectives.

- ❑ The relationship between DMH and the University of South Carolina School of Medicine Clinical Faculty Practice Plan.
- ❑ Ways in which DMH physicians can earn extra income, including private practice and dual compensation.

- ❑ How DMH contracts are procured and managed.
- ❑ Whether any patients in state mental hospitals have been prevented from being discharged due to inappropriate interference by outside interests.
- ❑ If DMH ensures proper follow-up once a patient is discharged from a state hospital.
- ❑ If DMH allocates funds in accordance with changes in where clients are treated.

Clinical Faculty Practice Plan



Some physicians and other employees at the William S. Hall Psychiatric Institute function in a dual role as both DMH staff and faculty at the USC School of Medicine. These doctors are paid by DMH as full-time staff and also are paid salary supplements from the medical school's clinical faculty practice plan.

The practice plan is funded by patient billings; Hall Institute physicians are allowed to bill patients for their professional fees and then deposit the money into the practice plan. Thus, even though the doctors see these patients during normal working hours, none of the fees generated go to DMH to offset overhead expenses. For example, the practice plan does not reimburse DMH for the doctors' medical malpractice insurance.

Appropriation act provisos do not specifically authorize DMH physicians to participate in the USC School of Medicine practice plan. We also found that only 2 out of the 48 DMH staff who received salary supplements in 1994 reported the supplements as they are required to do by state law.

We also examined the operations of Shearouse Pavilion—a facility operated by Hall Institute for private paying patients. Shearouse provides “deluxe” accommodations and is supposed to be self-supporting through patient billings. However, we found that the facility had only 50% occupancy in FY 94-95 and ran a \$600,000 deficit from FY 90-91 through FY 94-95. We recommended that DMH discontinue using state funds to subsidize Shearouse Pavilion.

Hall Institute management made an agreement with an insurance company to allow policyholders of that company to be served at Shearouse Pavilion at below-cost rates, contributing to Shearouse's deficit. DMH central administration learned of the agreement after it became effective and wrote off more than \$37,000 in charges.

Agency comments to the audit begin on page 71.



Private Practice by Community Mental Health Physicians

DMH policies allow DMH physicians to have a private practice as long as it is conducted during off-duty hours and doctors do not self-refer DMH clients to their own practice. However, some community mental health doctors have private practices at local hospitals, where they can treat DMH clients on a private paying basis. DMH has experienced problems in the past with compliance to these policies, and in response has instituted more internal controls.

In general, we found that it is difficult to ensure that doctors and other professional staff conduct only state business on state time, and that DMH patients who can pay for private care are not being channeled into the doctors' own practices.

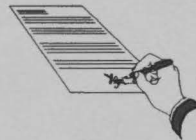


Patient Discharges

We reviewed 93 patient files to determine if inappropriate political or legislative interference had hindered the discharge of patients committed to state long-term psychiatric hospitals. Each of these 93 patient records was "flagged" by DMH to alert staff to certain conditions, such as that law enforcement, solicitors, or the hospital director were to be notified before a patient could be discharged. We found no evidence that flagging these records had prevented the discharge of a patient or was indicative of inappropriate political interference. (We excluded from this review a case, currently under litigation, that involves a former DMH patient.) Most of the patients with flagged files had a history of criminal or violent behavior.

Also, we determined that DMH could strengthen its efforts to ensure that discharged patients kept appointments at community mental health centers. Care at the community level helps keep patients out of more costly inpatient facilities.

Copies of all LAC audits are available to the public at no charge. If you have additional questions, please contact George L. Schroeder, Director.



DMH Contracts

We reviewed a sample of 83 DMH contracts, mostly for professional services, and found several problems.

- Twenty-six contracts became effective before they were approved by management.
- DMH contracted with USC medical school surgeons for services; the surgeons were required to provide billing information so that DMH could collect medicaid, medicare, and private insurance for the patients they treated. The surgeons did not provide the billing information and have themselves collected the reimbursements owed DMH.
- USC and DMH jointly contracted with a state agency to provide psychiatric services. DMH salaried psychiatrists provided the services, but payment for these services was deposited in a USC School of Medicine account.
- A community mental health center contracted with, and then hired, the wife of its board chairman. Current ethics laws allow this.

We also reviewed a memorandum of agreement between DMH and Richland Springs Psychiatric Hospital (a unit of Richland Memorial Hospital). In this agreement DMH transferred its authorization for 23 psychiatric acute-care beds to Richland Springs; Richland Springs was to provide care to 595 DMH clients annually, including indigent clients. However, DMH did not monitor the agreement to ensure that indigent clients were referred to the hospital, and very few indigent DMH clients were served.



DMH Expenditures Versus Patient Populations

DMH expenditures for community mental health centers have increased by 81% from FY 89-90 through FY 94-95. Patient contacts at these centers increased 92% during this time. Expenditures also have increased at most DMH hospital facilities even though institutional patient populations have generally decreased.