Accountability Report Transmittal Form

Agency Name: South Carolina Department of Mental Health

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South Carolina Department of Mental Health

Accountability Report

FY 2008

September 12, 2008

Section 1 – Executive Summary

1. Mission and Values

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

We are committed to eliminating stigma, promoting recovery, achieving our goals in collaboration with all stakeholders, and in assuring the highest quality of culturally competent services possible. Our values are respect for the individual, support for local care, commitment to quality, and dedication to improved public awareness and knowledge.

2. Major Achievements

In support of our mission, we began the new fiscal year with a major initiative to increase public awareness about mental health issues and to let taxpayers of South Carolina know they are getting a good return on their investment in the Department. The state director and other members of the leadership team made presentations to civic clubs and other audiences around the state, driving home the key messages about mental illnesses and how the Department strives to deliver quality services effectively and efficiently. Many of these public presentations were covered by local media, resulting in further dissemination of our key messages.

In addition, last year we continued to deliver services in public schools through our school-based mental health program. Our 282 school-based mental health counselors served about 13,000 children and adolescents in the program. We have mental health counselors in 457 schools or 42 percent of the schools in South Carolina.

Further, our services delivery capability grew through a unique, $1.2 million grant bestowed by the Blue Cross Blue Shield of South Carolina Foundation to ten school districts in rural South Carolina to hire mental health counselors, thus enabling us to have a presence in areas traditionally underserved.

We continued to help people with mental illnesses find jobs and places to live. For example, our supported employment program for adults with serious mental illnesses continued to produce good results and to garner national acclaim. Working with our partner, the South Carolina Vocational Rehabilitation Department, we now have over fifty percent of our clients in the program gainfully employed. The Charleston/Dorchester Community Mental Health Center, one of several with a supported employment program, recently received an award from health care giant Johnson & Johnson for demonstrating the best outcomes in getting people with psychiatric disabilities employment in the community. In addition, our housing and homeless program has now funded almost 1,600 housing units, including some for clients in the Towards Local Care (TLC) program.

As is true nationally, people with mental illnesses and substance abuse disorders continued to come to local hospital emergency rooms for treatment. The Department took steps to help alleviate this on-going problem in South Carolina. For example, funds were made available to open new beds in the community to get patients out of our psychiatric hospitals, thus making space to admit those waiting in emergency rooms. In addition, the Department 's mental health centers received funds for several projects geared

towards providing crisis and other services in the community, ranging from providing on-call staff after hours, to placing staff in local emergency rooms, to purchasing beds in local hospitals.

As another step towards solving the emergency room problem, the Department applied for and received from the Duke Endowment a $3.7 million grant to use telemedicine technology for psychiatric consultations. State-of-the-art video and voice equipment will be placed in all participating emergency rooms. This equipment will be directly linked to the Department, where psychiatrists will be available at all times (24/7) to conduct face-to-face consultations. Psychiatrists will be able to see and speak with the patient, family (when needed), and the emergency room staff.

Finally, by the end of the fiscal year, the Department had taken significant strides towards the eventual sale of the former downtown campus of the South Carolina State Hospital, now commonly referred to as the Bull Street property. The Columbia-based commercial real estate firm of NAI Avant was selected through the state's procurement process to provide marketing and brokerage services. We still have adult patients temporarily located at Byrnes Medical Center as well as children and adolescent patients at the William S. Hall Institute, both on the Bull Street campus, and it will be some time before we are able to relocate those programs. When the sale occurs, proceeds are to be reinvested in services for the Department's clients.

3. Key Goals

The key operational goals for the Department for FY 09 can be summarized as follows:
- Support the recovery of people with mental illnesses by:
  - Preparing them to them find meaningful jobs;
  - Funding safe, affordable places to live;
  - Continuing to help eliminate the stigma of mental illness.
- Maintain current levels of service as reflected in:
  - Contracts with the private sector;
  - Medical cost inflation;
  - Power and fuel cost inflation;
  - Computer licensing and maintenance;
  - Community housing through Toward Local Care (TLC);
  - Nutritional services.
- Continue forward progress on selling the Bull Street property by:
  - Developing and implementing a marketing plan;
  - Continuing relocation efforts for the services still on the Bull Street campus.
- Grow services in the community for children and adolescents by:
  - Increasing school-based services;
  - Placing Departmental staff in the offices of other human service state agencies;
  - Adding more intensive services programs;
  - Maintaining the number of children in out-of-home placements at less than one half of one percent of all children served by the Department.
- Alleviate the crisis in local emergency rooms by:
  - Implementing the grants for community crisis services awarded to community mental health centers;
  - Implementing the telemedicine psychiatric consultation services in emergency rooms around the state;
  - Transitioning patients into the community from beds in the Department's psychiatric hospitals.

- Continue to provide workforce development initiatives by:
  - Offering mentoring classes to selected staff;
  - Implementing an executive leadership development program;
  - Developing computer assisted training modules on core competencies.
- Grow revenue opportunities through financial grants by:
  - Establishing a grants management office;
  - Training staff in how to work effectively with grants;
  - Identifying grant opportunities and then applying for such.

4. Key Strategic Challenges

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

- **Managing Financial Resources Wisely**. Because of changes in Medicaid reimbursement rules for certain services delivered in our community mental health centers, our revenue from these centers declined about 35 percent last year. Further, our state appropriation for FY09/10 was reduced by over $8 million, but the needs for our services continued to grow.

- **Recruiting and Retaining Key Clinical Staff**. As reflected in our budget request for FY09, we believe that the Department needs almost $12 million over the next three years to hire the staff needed in our hospitals and our community mental health centers. A 2007 study by the South Carolina Budget and Control Board indicated that our clinical positions pay is 13-20 percent less than the market average for

such positions as registered nurses, licensed practical nurses, and mental health counselors. Our request for these funds was not granted.

- **Enhancing Our Services in the Community for Children and Adolescents**. We need to increase the number of our school-based mental health programs, especially in rural areas where mental health services are limited. Further, we need to improve accessibility to services by out-stationing our staff in social services offices and juvenile justice offices. Finally, we need to reduce the number of children in out-of-home placements and help them live in the least restrictive environments.

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

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

- **Strengthening Staff Competencies**. Because of our limited ability to hire new staff or to replace seasoned managers who have retired, we need to

implement an Executive Leadership Development Program to groom new leadership candidates as well as increase licensed clinical staff.

- **Providing Effective Treatment for Sexually Violent Predators**. By law, we are designated to provide treatment for those people deemed by the judicial system to be sexually violent predators. We must implement measures to maintain meaningful treatment opportunities despite an increasing census for that population.

- Offering more psychiatric **Crisis Services in the Community**. Still looming as a challenge for the Department is the continued presence in emergency rooms around the state of behavioral health care patients, about three-fourths of whom are unknown to us. As the census of the state grows, so does the number of people in the emergency room waiting for evaluation and treatment and perhaps an admission to one of the Department's inpatient programs. We will continue to face this challenge by offering more crisis services in the community (when funding is available), by opening more hospital beds for acute care patients, by working with our community partners who have a stake in finding a solution, and by using innovations like telemedicine technology to provide psychiatric consultations in emergency rooms.

- **Building New Hospitals and Centers and Providing Maintenance** on existing buildings. The Department has identified $187.8 million worth of capital projects that have some funding already or we have requested funding for. Some of these projects are new construction such as a new children's hospital, a new facility for sexually violent predators, or a new crisis services center for Pee Dee Mental Health Center.

- **Eliminating Stigma**. Many people with mental illnesses are reluctant or even ashamed to acknowledge their illness and seek treatment because of the stigma surrounding mental illness. Stigma results in discrimination. We are committed to eliminating stigma and to educating the public about mental illnesses.

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

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

1. Main Products and Services and Primary Delivery Mechanisms

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

2. Primary Client Segments and their Key requirements/ Expectations

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

3. Key Stakeholders

Groups that have a stake in the success of the Department of Mental Health include other state agencies, in particular the Departments of Alcohol and Other Drug Abuse Services, Disabilities and Special Needs, Health and Human Services, Vocational Rehabilitation, Social Services, Corrections, Juvenile Justice, and local school districts.

The legislative, executive, and judicial branches of government are also special stakeholders as they make decisions that impact individuals with persistent and serious mental illness.

Other key stakeholders are public health systems, especially hospital emergency staff, law enforcement, and jails as they work together with DMH to identify and support clients in crisis.

Nonprofit entities, which advocate for clients such as the National Alliance on Mental Illness, the Federation of Families, the Mental Health America of SC, Protection & Advocacy for People with Disabilities, and SHARE (Self-Help Association Regarding Emotions) are key stakeholders. SAMHSA (Substance Abuse and Mental Health Services Administration), the Veterans' Administration, and other federal funding sources are also stakeholders.

4. Key Suppliers and Partners

DMH contracts with several major vendors to provide services to our clients. The Campbell Veteran's Nursing Home in Anderson, SC and the Victory House Veterans Nursing Home in Walterboro, each a 220-bed facility, are operated through contract. DMH also contracts with Just Care, Inc. for significant segments of the agency's inpatient forensic services. Located on DMH property leased to this provider, DMH provides some of the professional treatment staff, while the vendor provides security, general nursing care, and room and board.

Our community mental health centers contract with a number of local providers such as general hospitals, private practioners, and other organizations for a variety of clinical and support services including local inpatient care, physician services, and several different types of supported residential options for agency clients.

Table 1	KEY CLIENT PERFORMANCE MEASURES		
Client	**Key Requirements**	**Key Measures**	**Results Cross-Reference**
Adults with Serious Mental Illnesses	Satisfaction	Client Perception of Care (MHSIP)	7.2-1
	Functional Improvement	Clinical Assessment (GAF)	7.1-2
	Symptom Reduction		
	Employment	Number/Percent Employed	7.1-3, & 7.1-4
	Housing	No. of Units	7.1-5
Alcohol & Drug Addiction Residents	Satisfaction	Client Perception of Care	7.2-4
	Abstinence	30 day Post-Treatment	7.1-9
Nursing Home Residents	Satisfaction	Resident & Family Survey	7.2-5
	Health & Safety	Life Expectancy Rate Reduced Pressure Sores Decrease Fall Rate	7.1-6 7.1-7 7.1-8
Children with Severe Emotional Disturbances	Functional Improvement	Clinical Assessment (CAFAS)	7.1-1
	Symptom Reduction		
	Parental Satisfaction	Parent's Survey (MHSIP)	7.2-3
	Youth Satisfaction	Youth Survey (MHSIP)	7.2-2
KEY MEASURES OF ORGANIZATIONAL EFFECTIVENESS AND EFFICIENCY			
Domain	**Measures**		**Results Category Chart**
Community Mental Health Centers	Number Served % of Clients with Major Mental Illness Hospital Admissions Rate Avg. Days Btw Hospital Discharge & Date Seen by CMHC Emergency Room: Decreasing Waits		7.5-6 7.5-2 & 7.5-4 7.5-7 7.5-14 7.5-10
Psychiatric Inpatient	30 Day Readmission Rate Seclusion Rate Restraint Rate Decreasing >90-Day Length of Stay Bed-Day Utilization		7.5-15 7.5-16 7.5-17 7.5-18 7.5-19
Administrative and Financial	Medicaid Revenue Billable Hours of Service Bed-Day Costs Regulatory Compliance and Audits		7.3-2 7.3-5 7.3-8 7.6-1

5. Location of Operations

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

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

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

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

6. Number of Employees

Our workforce includes 4,706 employees, 9% administrative, 49% in the community system, and 42% in our inpatient setting. Ninety-seven percent are in classified positions and 3% in unclassified or contractual positions. Forty-six percent of our employees are White, 52% are African-American, and 2% are of other ethnic nationalities.

7. Regulatory Environment

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

8. Performance Improvement Systems

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

Table 2	The DMH Performance Improvement System		
	Quality Improvement	**Performance Improvement**	**Quality Assurance**
Focus:	Current	Prospective	Retrospective
Initiated by:	Any Level	Upper Management	Management
Mechanisms:	Performance Improvement Teams	Performance Improvement Teams	Risk Management System
	Program Fidelity Monitoring	Key Performance Indicators	Facility Accreditation
		Outcomes Committee	Corporate Compliance
			Medicaid Audits
			Internal Audit
			Utilization Review

9. Organizational Structure

See Table 3

10. Expenditure/Appropriations Chart

See Table 4

11. Major Program Areas Chart

See Table 5

Table 3

SOUTH CAROLINA MENTAL HEALTH COMMISSION

State Director

- Division of Administrative Services
- Internal Audit
- Division of Inpatient Services
- General Counsel
- Public Safety
- Division of Community Mental Health Services
- Quality Management
- Medical Director

Division of Administrative Services
- Nutritional Services
- Information Technology Services
- Financial Services
- Physical Plant Services
- Human Resource Services
- Medicaid/Medicare
- Public Affairs
- Grants Administration

Institutions
- William S. Hall Psychiatric Institute
- Harris Psychiatric Hospital
- Bryan Psychiatric Hospital
- Just Care (Forensics)
- Sexually Violent Predator Program
- Morris Village Alcohol and Drug Addiction Center
- **Long Term Care:**
  - C.M. Tucker
  - Campbell Veterans Nursing Home
  - Victory House Veterans Nursing Home

Community Mental Health Centers

- **Region A** — Aiken-Barnwell, Columbia Area, Lexington, Orangeburg
- **Region B** — AOP, Beckman, Greenville, Piedmont, Spartanburg
- **Region C** — Catawba, Pee Dee, Santee-Wateree, Tri-County
- **Region D** — Berkeley, Charleston/Dorchester, Coastal, Waccamaw

Programs
- Employment/ACT
- Recovery/Family Inclusion
- Housing/Homeless
- Forensic Services
- TLC
- Continuity of Care
- Pharmacy Consultation
- Children and Family Services
- Deaf Services

- Administrative & Ancillary Services
- Clinical Grants and Waivers
- Evaluation, Training & Research
- Client Affairs
- Multi-Cultural Affairs

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Table 4	**Accountability Report Appropriations/Expenditures Chart**					
	Base Budget Expenditures and Appropriations					
	FY 06-07 Actual Expenditures		**FY 07-08 Actual Expenditures**		**FY 08-09 Appropriations Act**	
Major Budget Categories	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**	**Total Funds**	**General Funds**
Personal Service	$181,518,859	$118,989,812	$183,512,445	$131,190,379	$197,647,816	$129,935,765
Other Operating	$108,674,605	$ 39,050,288	$110,754,681	$ 38,380,106	$127,758,290	$ 33,544,309
Special Items	$ 688,000	$ 338,000	$ 598,000	$ 248,000	$ 300,000	$ -
Permanent Improvements	$ 20,304,443	$ 9,710,000	$ 12,034,806	$ -	$ -	$ -
Case Services	$ 9,751,221	$ 4,026,253	$ 12,981,208	$ 7,464,194	$ 21,814,731	$ 12,192,010
Distributions to Subdivisions	$ -	$ -	$ -	$ -	$ -	$ -
Fringe Benefits	$ 57,293,410	$ 37,502,379	$ 57,916,577	$ 41,081,798	$ 62,590,612	$ 42,220,282
Non-recurring	$ 9,800,000	$ 9,800,000	$ 4,863,500	$ 4,863,500	$ 5,358,317	$ 5,358,317
Total	$388,030,538	$ 219,416,732	$ 382,661,216	$ 223,227,978	$ 415,469,766	$ 223,250,683
		Sources of Funds	**FY 06-07 Actual Expenditures**	**FY 07-08 Actual Expenditures**		
		Supplemental Bills	$ 9,800,000	$ 4,863,500		
		Capital Reserve Funds	$ -	$ -		
		Bonds	$ -	$ -		

Table 5	**Major Program Areas**							
Program Number and Title	Major Program Area Purpose (Brief)	FY 06-07 Budget Expenditures			FY 07-08 Budget Expenditures			Financial Results References
II. A. Community Mental Health Centers	Services delivered from the 17 mental health centers that include: evaluation, assessment, and intake of consumers; short-term outpatient treatment; and continuing support services.	State:	62,810,446.41		State:	73,344,741.39		7.3- 5
		Federal:	7,661,641.43		Federal:	6,932,204.26		7.3- 6
		Other:	72,632,378.73		Other:	61,343,248.38		7.3- 7
		Total:	143,104,466.57		Total:	141,620,194.03		7.3- 10
		% of Total Budget:		42%	% of Total Budget:		42%	
II. B. Inpatient psych	Services delivered in a hospital setting for adult and child consumers whose conditions are severe enough that they are not able to be treated in the community.	State:	52,154,930.89		State:	54,693,709.71		7.3- 7
		Federal:	145,047.03		Federal:	196,042.04		7.3- 8
		Other:	30,379,129.34		Other:	32,532,054.27		7.3- 9
		Total:	82,679,107.26		Total:	87,421,806.02		
		% of Total Budget:		24%	% of Total Budget:		26%	
II. D. Tucker/Dowdy	Residential care for individuals with mental illness whose medical conditions are persistently fragile enough to require long-term nursing care.	State:	6,514,890.92		State:	5,986,371.99		7.3- 8
		Federal:	0.00		Federal:	0.00		
		Other:	13,940,263.98		Other:	14,576,989.32		
		Total:	20,455,154.90		Total:	20,563,361.31		
		% of Total Budget:		6%	% of Total Budget:		6%	
II. F. Support	Nutritional services for inpatient facilities, public safety, information technology, financial and human resources and other support services	State:	19,619,505.30		State:	19,755,059.65		
		Federal:	0.00		Federal:	0.00		
		Other:	1,836,020.09		Other:	1,741,535.52		
		Total:	21,455,525.39		Total:	21,496,595.17		
		% of Total Budget:		6%	% of Total Budget:		6%	
II. G. Veterans	Originally residential nursing care for veterans who also have a mental illness; role has now expanded beyond that so that any veteran is eligible who meets the admission criteria.	State:	14,506,635.91		State:	15,085,619.91		7.3- 8
		Federal:	0.00		Federal:	0.00		
		Other:	10,588,561.17		Other:	12,132,174.89		
		Total:	25,095,197.08		Total:	27,217,794.80		
		% of Total Budget:		7%	% of Total Budget:		8%	
II. H. Sexual Predator	Treatment for civilly-committed individuals found by the courts to be sexually violent predators. Mandated by the Sexually Violent Predator Act, Section 44-48-10 et al.	State:	2,974,405.12		State:	4,528,742.54		7.3- 8
		Federal:	0.00		Federal:	0.00		
		Other:	146,139.51		Other:	35,149.75		
		Total:	3,120,544.63		Total:	4,563,892.29		
		% of Total Budget:		1%	% of Total Budget:		1%	
III. Employer Contribution	Fringe benefits for all DMH employees	State:	37,502,378.78		State:	41,081,798.46		7.3- 4
		Federal:	1,270,323.26		Federal:	1,163,452.84		
		Other:	18,520,707.71		Other:	15,671,325.72		
		Total:	57,293,409.75		Total:	57,916,577.02		
		% of Total Budget:		17%	% of Total Budget:		17%	
Below: List any programs not included above and show the remainder of expenditures by source of funds.								
	Remainder of Expenditures: I. Administration	State:	3,733,538.44		State:	3,888,433.92		
		Federal:	802,975.18		Federal:	800,041.75		
		Other:	73,447.39		Other:	274,214.45		
		Total:	4,609,961.01		Total:	4,962,690.12		
		% of Total Budget:		1%	% of Total Budget:		1%	

1.1 Senior Leadership Direction

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

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

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

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

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

b) Performance expectations

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

c) Organizational values

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

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

- The Commission holds six of its twelve monthly meetings in a local mental heath center or inpatient facility. With two of the seven-person Commission members being a family member of a DMH client, there is a clear commitment to open discussion between stakeholders and the administration.
- Mental health clients, family members, advocates, and other stakeholders are

always, without exception, invited and encouraged to be part of policy discussion, priority-setting, and program development.

- Clients of mental health services are employed as Peer Support Specialists, serve on management teams of centers/hospitals, and participate on quality improvement teams. The mantra espoused by our client advocates – "Nothing about Us, Without Us" aptly represents the inclusive philosophy of DMH.

d) Ethical behavior

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

1.2 Focus on Clients

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

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

1.3 Impact on Public

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

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

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

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

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

- Individuals are rigorously assessed prior to their discharge from inpatient care;
- Clients found Not Competent to Stand Trial or Not Guilty by Reason of Insanity are treated in secure settings. Their

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gradual reintegration into the community is closely monitored by trained staff who are very knowledgeable of each client's treatment needs;

- An integrated system of community-based treatment with inpatient support to ensure the safety, continuity of care, and well-being of the citizens we serve.

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

The Department subscribes to a "press summaries" service and runs a volunteer "media watch," reviewing all newspaper articles/editorials in the state to maintain an awareness of public concerns and opinions. Periodic meetings are held with probate judges and the South Carolina Hospital Association across the state to address issues and concerns. The state director meets regularly with news media, editorial boards, members of the legislature, advocacy groups, and other community leaders to provide information about the Department and hear concerns and recommendations.

1.4 Maintaining Fiscal, Legal, and Regulatory Accountability

How do senior leaders maintain fiscal, legal, and regulatory accountability?
The director, senior leadership, and the Commission review data and written evaluations on fiscal, legal, and regulatory compliance regularly. The Internal Audit Division reviews formal litigation reports and the report findings of every six months. In FY 08 the Department established a Grants Management Office to provide increased regulatory oversight for all grants.

1.5 Key Performance Measures

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

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

1.6 Performance Review/Feedback

How do senior leaders use organizational performance review findings and employee feedback to improve their own leadership effectiveness and the effectiveness of management throughout the organization? How do their personal actions reflect a commitment to the organizational values?

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

1.7 Succession Planning

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

With an aging workforce and a large number of senior staff in the TERI Program, DMH responded proactively to ensure a smooth transition to a new cadre of agency leaders. Positions that could become vacant were flagged, and contingency plans were developed.

Additionally, an in-house Mentoring/

Succession Program was implemented. This is an eleven-month seminar that includes monthly classroom instruction lead by SCDMH senior leaders. Homework is supervised by mentors at the participants' home facility. Three participants have become our newest CMHC directors, and others have been promoted. This year, the department is beginning an Executive Leadership Development Program to groom a new generation of senior management.

1.8 Performance Improvement

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

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

1.9 Organizational and Workforce Learning Environment

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

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

1.10 Empowering and Communicating with Employees

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

1.11 Strengthening the Community

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

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

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

Category 2 – Strategic Planning

2.1 Strategic Planning Process

What is your Strategic Planning process, including KEY participants, and how does it address:
a. Organizational strengths, weaknesses, opportunities and threats
b. Financial, regulatory, societal and other potential risks
c. Shifts in technology or the regulatory environment
d. Workforce capabilities and needs
e. Organizational continuity in emergencies
f. Ability to execute the strategic plan

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

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

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

The DMH Executive Committee identified the draft goals in March as part of the FY 09 Budget Request Process and distributed them for public comment. They were posted on the web and distributed to advocacy groups,

CMHC/inpatient facility management and staff, and CMHC Boards. The State Planning Council (a 48-member group that includes 14 clients, 9 family members, 4 representatives of advocacy groups, 9 employees of DMH, and 12 employees from other human service agencies) reviewed the goals (late March through mid-May) and made recommendations to the Department in written and face-to-face interactions.

Figure 2.1-1 **FY 09 PLANNING PROCESS**	
Budget Development	
Nov-Dec '06	"Major Risks Assessment" (S.W.O.T) by senior leadership
Jan '07	FY09 & FY10 Budget Priorities Draft set by senior leadership
Feb '07	Full Stakeholder Survey of Budget & Program Priorities (Third Years)
Feb–Mar '07	Lead Program & Budget Office Staff Submit Draft Budgets
May '07	State Planning Council Submits Recommendations
Jun-July '07	Senior leadership and Commission Approve FY 09 Draft Budget
Aug '07	FY 09 Budget Submitted
Program Development	
Oct '07	Leadership sets strategic priorities other than budget request items
Dec '07	Key Deliverables and Timetable
Jan '08	Cost Figures Developed (if needed)
Feb 08	Leadership approves all priorities, timetable, and outcomes
Mar 08	Draft plan developed
Apr '08	30-Day (Web-Based) Public and Employee Review for comments
Apr–May '08	State Planning Council Critiques
Jun '08	Gen Assembly Passes FY 09 Appropriations
June-July '08	Senior leadership and Commission Approve State Plan
July 1, 2008	FY 09 Plan Implementation Begins

The strategic planning process calls for full stakeholder participation every three years. During these events, statewide input is obtained from the community mental health center local Boards, citizen advisory groups numbering approximately 270 people.

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

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

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

Disaster management planning for DMH is a separate process. Each Community Mental Health Center and hospital has free standing plans for internal emergencies, and each dove-tails with the DMH plan to provide for cross facility coverage and statewide emergencies. In FY 08, CMHCs and hospitals participated in a statewide disaster drill to evaluate their disaster plan.

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

2.2 Addressing Challenges through the Strategic Goals

With little prospects for new funding in FY 09 for clinical initiatives, the Department focused its programmatic planning on areas that were under its control, those areas that did not require new funding. Therefore, it is intentional that not all challenges (identified the Organizational Profile – Section I, Question 4) fully correspond to goals presented in Figure 2.1-4.

2.3 Developing and Tracking Action Plans

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

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

Senior leadership set aside over $6.4 million dollars of its FY 08 funding allocation in direct support of strategic objectives (Figure 2.1-2).

Figure 2.1-2	
Allocation	**Strategic Priority**
$4.9 Million	Crisis Stabilization & Inpatient Diversion
$1.1 Million	Housing Initiatives
$15.6 Million	TLC
$266 Thousand	Electronic Medical Record

Senior leadership assumes individual responsibility for statewide implementation and deployment of specific goals, and has a designated program staff member who assumes day-to-day oversight for the initiative. The State Planning Council, the

Commission, and senior leadership receive progress reports on the goals on a schedule dictated by nature of the goal.

2.4 Communication and Deployment

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

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

To communicate the plan to staff and stakeholders, the agency has a broad-based educational effort. Articles in the agency newsletter Images, discussions at Center/facility directors' meetings, presentations at Quarterly Stakeholder Meetings, and Internet and Intranet web postings are a few of the avenues that DMH leadership uses to keep all staff and management teams aware of activities and progress toward goals.

2.5 Measuring Progress

How do you measure progress on your action plans?

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

and in tracking progress at specific community mental health centers and facilities.

2.6 Evaluation of Planning Process

How do you evaluate and improve your strategic planning process?

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

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

2.7 Strategic Plan Availability

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

FY 08 Strategic Goals and Accomplishments

Figure 2.1-3	FY 08 Strategic Planning Chart		
Program Number and Title	Supported Agency Strategic Planning Goal/Objective	Related FY 07-08 Key Agency Action Plan/Initiative(s)	Key Cross References for Performance Measures
Child & Adolescent Services	Improve Access to Care	Increase out-stationed DMH staff by 5 additional DSS offices (from 13 to 18 counties) in rural, currently underserved DSS county offices. Year-end report will show number of children served through DSS offices compared to previous year.	Outstationed staff in 18 DSS County Offices
		Increase out-stationed DMH staff by 2 additional DJJ offices (from 7 to 9 counties) in underserved DJJ county offices. Year-end report will show number of children served through DJJ offices compared to previous year	4 staff hired this year. Current total is 4 staff serving seven counties.
		Complete the staffing of at least 4 In-Home (family preservation) teams with the addition of 2 personnel	No funding received to pursue goal
		Increase the number of school-based programs by 10 with focus on rural area schools (from 171 to 181)	8 new rural area school-based programs begun
	Contain Out-of-Home C&A Placements	Maintain the percentage of children in out-of-home placement at an average yearly census that is less than .5% of number of children served in all DMH programs (N = 175)	Achieved. 162 children in out-of-home placement in FY 08: Figure 7.5-5
Community Placements (TLC Program)	Transition Long-Term Inpatients to Community Residential Care	Expand community residential and wrap-around clinical services to forty (40) additional persons (927 to 967 people) who are currently in long-term SCDMH psychiatric facilities or high-users of the inpatient system.	June 30, 2008 TLC capacity at 1,038: Figure 7.5-12
Housing	Increase Key Quality of Life Conditions for Severely Mentally Ill Patients	Develop 40 additional housing units	44 new units funded (cumulative total 1,596). 1:4 leveraging ratio of SCDMH funds to other state and federal funds: Figure 7.1-5
Employment		40% of all clients in IPS Programs Employed	53% Employment rate achieved: Figure 7.1-4
		Increase CMHC referrals to SC Vocational Rehabilitation Department (VRD) for non-IPS clients by 10%	Referrals increased 6% (from 1117 to 1186)
COSIG/Co-Occurring Programs	Develop Interagency Services for Persons with Mental Illness and Alcohol/Drug Addiction	Pilot sites (Waccamaw & Charleston) with DMH, VR, & DOADAS staff become operational, use common definition of co-occurring disorder, and use joint screening tool	Both pilot sites operational, using common definitions & joint screening tool
Electronic Medical Record	Migrate to EMR in all CMHCs and Hospitals	Continued roll-out of EMR to include at least 2 additional CMHCs (Total = 3)	5 CMHCs on-line with Electronic Medical Record

		Reduce, statewide, the total number of persons waiting in Emergency Departments by 10% (from 2,030 people annually in the Monday morning "snapshot count" to 1,827 people annually in FY 08)	No progress: 25% increase. Make a FY 09 goal: Figure 7.5-10
Crisis Services	Increase Hospital Emergency Department Diversions and Expand DMH Admissions Capabilities	Reduce, statewide, the number of persons in Emergency Departments waiting longer than 24 hours by 10% annually (from average of 34 people in the Monday morning "snapshot count" per week in FY 07 to 31 in FY 08)	No progress. 22% increase (projected). Make a FY 09 goal: Figure 7.5-10
		Initiate ten (10) new "ACT-Like" teams to target high users of MH services and services of other behavioral health care providers	12 new ACT-Like Teams established
Inpatient Services	Managing Financial Resources	Reduce pool and overtime costs, achieving a 5% reduction by end of FY 08, through increased recruitment and retention efforts	8% reduction in pool usage achieved. Costs decreased 6% from $8,861,626 to $8,321,200.
Employee Training	Recruitment & Retention	Begin Administrative Staff Training track	Completed
		Develop new and/or expand existing employee training for both Family/Child and Adult client populations	Completed
	Expand Revenue & Financial Growth Capabilities	Develop training for Primary Investigators of grants in project management and grant responsibilities	All PIs attended and Training Module available on-line
Annualiza-tions		Annualization: If funded, will provide for operational costs of the additional 35 bed capacity of BPH	22 of the 33 beds have been opened. Remaining beds will be open by July '08.
		Annualization: If funded, will provide for 220 bed operational costs of Walterboro VA Nursing Home	Census 201 on July 10, 2008. Full (95%) occupancy by Aug '08.
Capital Projects		Construction of 200-bed facility to house Sexually Violent Predator. FY 08 goal: Architectural plan and Solicitation of construction bids. Facility completion date: by end of FY 11	No funds received. Program has double bunks for up to 128 patients; 95 deemed the maximum for a safe environment.
		New Hall Psychiatric Institute (C&A: Finalize the hospital scope and budget and secure additional funding during FY 08 so design can progress.	No funds received
		Columbia Area MHC: Construction of Acute/Intensive Treatment Services (4^+$M) and Adult Treatment Services (5.6^+$M)	Final design drawings are at State Eng Office for review. Hope to bid in August/ September
		Construct McCormick Clinic: Purchase land and complete the preliminary design this FY	Architect selected. Preliminary design and land evaluations underway
		Faulty Construction Correction at BPH: Begin replacement of wood deterioration from fire retardant treatment.	First 4 lodges 50% complete. Phase II (4 lodges) in design. Phase III funds requested

Figure 2.1-4		**FY 09 and FY 10 Strategic Goals**	
Priority Areas	**Challenge**	**FY 09 Goals**	**FY 10 Goals**
General	Bull Street Property	Develop and implement marketing plan for sale of Bull Street property	Continue relocation efforts for remaining services on the Bull Street campus and implement marketing plan for the sale of the Bull Street property
Community C&A Services	Improve Access to Care	Increase the number of school-based programs by 10 with focus on rural area schools from 178 to 188	Increase the number of school-based programs by 10 over the FY09 accomplishments, with focus on rural area schools
		Increase out-stationed DMH staff by 3 DSS County Offices (from 18 counties to 21 counties)	Increase out-stationed DMH staff by 3 DSS County offices (from 21 counties to 24 counties)
		Sustain the current DJJ out-stationed staff in 9 counties	Increase out-stationed DMH staff by 1 DJJ County Offices (from 9 to 10 Counties) and sustain other nine positions
		Add one (1) new MST programs (Greenville) for total of 7, and add 1 IFS team in 1 rural county	Add one (1) new MST programs (Charleston) for total of 8, and add 1 IFS team in 1 rural county
	Out-of-Home Placements	Maintain the percentage of children in out-of-home placements at less than .5% of the children served in all DMH programs (N=175)	Maintain the percentage of children in out-of-home placements at an average yearly census that is less than .5% of the children served in all DMH programs (N=175)
Electronic Medical Record	Using Technology to Improve Services	Implement EMR in 2 New CMHCs (Total to equal 7)	Implement EMR in 2 Additional CMHCs (Total to equal 9)
Housing	Increase Key Quality of Life Conditions for Severely Mentally Ill Patients	Develop 40 additional housing units	Develop 40 additional housing units
		Maintain TLC statewide occupancy rate at 98% or 1,017	Expand TLC programs by 45 (1,038 to 1,083) residential and treatment options focusing on inpatients that are low functioning/behavioral challenging-like MR but not eligible for DDSN services. (Contingent upon funding)
Employ-ment		Expand Evidenced-Based Best Practice IPS programs in CMHCs without existing IPS programs (from 9 to 10 CMHCs)	Expand IPS programs by 2 CMHCs (10 to 12 Centers). Contingent upon funding
Staff Competence	Recruitment & Retention	Implement an Executive Leadership Development Program designed to groom at least 5 new senior DMH leaders	Continue the Executive Leadership Development Program to groom at least 5 additional new senior DMH leaders
		Implement elements of programs needed to increase licensed clinical staff (classwork, supervision, etc.)	Fifty (50) eligible to be licensed clinical staff will be engaged in clinical supervision to result in licensure
Grants Management	Managing Financial Resources	Establish an office of Grants Administration and provide fiscal oversight for all grants	Ensure fiscal oversight for all grants.
			Increase federal funds through new grants.

Sexually Violent Predators	Effective Treatment for SVP Program	Implement measures to maintain meaningful treatment opportunities for Sexually Violent Predator residents despite increasing census	Monitor and ensure meaningful treatment opportunities, as indicated
Hospital Emergency Department Diversions and Hospital Admissions	Crisis Services in the Community	Implement telepsychiatry between 25 community hospital Emergency departments (EDs) to divert patients from inpatient admission and reduce average length of stay (LOS) in EDs	Add 30 additional hospital EDs to network
			Explore other public/private consultative systems for telepsychiatry, e.g., substance abuse, stroke, etc.
		Reduce # of people waiting statewide in EDs who have a mental health &/or substance abuse issue from the FY 08 statewide weekly average of 59.4 to at least 53.46 (10% reduction)	Reduce # of people waiting statewide in EDs who have a mental health &/or substance abuse issue by 10% from the FY 09 statewide weekly average
		Reduce maximum # of hours people with a mental health or substance abuse issue wait for disposition in EDs from the FY 08 statewide weekly average of 132 hours to at least 118 (10% reduction)	Reduce # of hours waiting statewide in EDs who have a mental health &/or substance abuse issue by 10% from the FY 09 statewide weekly average
		Open Acute Care Beds at Harris and Bryan. Maintain current capacity at Morris Village, Hall, Wellspring	Review bed utilization and adjust for maximum appropriate census with existing resources.
Interagency Partner-ships		Compile listing of all MOAs between DMH (both state and local) and other agencies/ organizations to assess extent of formal collaborations, partnerships, and joint service provision	Review MOAS for needed changes and/or expansion, as indicted
Education of Public	Anti-Stigma Initiatives and Public Relations	Senior Leadership and Center Directors will educate citizens and constituent groups about mental health and addictions issues and how the agency provides taxpayers a good return on their investment	Continue to promote the Department's positive projects like the Duke Endowment, the BCBS of SC Foundation and school-based services, and community-based services to returning veterans and their families
		Conduct the "Art of Recovery Program" with public exhibitions of artwork by citizens with mental illness, promote positive media relations, and coordinate the Palmetto Media Watch Program	Sustain the "Art of Recovery Program"
Capital Projects	Building New Hospitals and Providing Maintenance	Hall Institute: Acquisition of funds to re-build. Resume design services.	Complete design. Advertise & start construction
		Construct Charleston MHC Children's Addition	Complete construction & occupy
		Award Construction Contract for Columbia Area MHC Phase II	Complete construction & occupy
		Columbia Area MHC master plan Phase III. Request funding through budget request	Start design and/or construction as funds are received

Capital Projects	Building New Hospitals and Providing Maintenance	Continue replacement of the fire retardant treated wood (FRTW) in the Bryan lodges and Support Buildings. Complete Phase I contract and award Phase II contract. Request funding for Phase III	Complete Phase II (remaining lodges). Continue with Support Buildings
		High priority deferred maintenance issues for both community and inpatient buildings. Request funding through budget request	Start design and/or construction as funds are received
		Construct McCormick Clinic. Request funding through budget request	Start design and/or construction as funds are received
		Pee Dee Crisis Center Construction. Request funding through budget request	Start design and/or construction as funds are received
		Sexually Violent Predator Facility. Request funding through budget request	Start design and/or construction as funds are received
		New water & electrical services for Tucker Ctr, Columbia Area MHC, & DMH Administration Building independent of the Bull St. campus systems. Complete electrical service for Tucker Center and Columbia Area. Request funding for Tucker water and Admin Bldg electrical through budget request	Start design and/or construction as funds are received
		Construct additional treatment facility for Bryan & Morris Village. Request funding through budget request	Start design and/or construction as funds are received
		Addition to the Holly Hill Clinic. Requests funding through budget request	Start design and/or construction as funds are received
		Construct Community Mental Health Centers for Santee-Wateree, A-O-P, and Catawba MHCs. Request funding through budget request	Start design and/or construction as funds are received
		Address Life Safety & Deferred Maintenance issues in Columbia Area MHC Carter Street apartments and adjoining support buildings. Request funding through budget request	Start design and/or construction as funds are received

Category 3 – Customer Focus

3.1 Determining Key Clients and their Requirements

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

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

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

The key client requirements for adults with severe mental illness have been defined by our clients through focus groups, needs assessments, and satisfaction surveys and are consistent with what is reported in the literature: regaining a sense of self-worth and dignity; having a hopeful outlook on life; achieving functional improvement; actively pursuing goals and aspirations in the areas of affordable housing, education, employment and social supports; and living a higher quality life.

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

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

Recovery and resiliency for children means increasing self-esteem, dignity, and school performance; remaining in their home; and working with the families to resolve issues and preserve the integrity of the family unit. These requirements are operationalized by SCDMH as: symptom reduction and functional improvement and parental/youth satisfaction.

3.2 Keeping Current with Changing Needs

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

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

Each CMHC has a Client Affairs Coordinator, a self-identified mental health client who participates in management meetings and decision-making to provide a voice for the client.

Each CMHC and inpatient facility also has an advisory board composed of clients of mental health services, and there is a statewide Client Advisory Committee operated by the Office of Client Affairs.

To gain a broader perspective on evolving health care service needs and directions, the agency participates in national forums, has representatives on health care measurement task forces, and has senior leaders who hold offices in national bodies that help set the direction of health care delivery systems.

A "Legislative Update" is published monthly during the legislative session to keep stakeholders, internal and external, aware of issues and events, and their feedback to the agency offers insight into current perspectives on health care trends. Additionally, many staff are surveyors for major accrediting bodies, bring innovative approaches back to South Carolina, and train other staff in new approaches to service delivery.

The Department has established a presence on the Internet and uses this medium to receive questions, concerns, and comments about the Department's services. The webmaster brings each of these to the attention of the director of the appropriate division head, as well as the state director.

3.3 Key Client Access Mechanisms

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

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

In addition, DMH is steadily expanding services into the natural environment of the child and their families. Staff is out-stationed in almost half of all South Carolina's public schools, in 18 county DSS offices and 4 county DJJ offices. Further, Assertive Community Treatment (ACT) Teams, Family Preservation and MultiSystemic Therapy Programs deliver case management and direct treatment in the client's home.

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

3.4 Measuring Satisfaction

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

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

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

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

3.5 Using Feedback Information

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

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

In addition to participation in all policy and program development committees and task forces, advocacy stakeholders are singled out for private meetings and discussions to address concerns and strategies for problem resolution. By including stakeholders in the fabric of the Department's operations, stakeholder satisfaction levels are assessed more diligently, than could be obtained simply through periodic surveys or questionnaires.

SCDMH is only the second state in the country to have peer-support services as a Medicaid billable service. A peer support person is a self-identified client of mental health with a diagnosed mental illness who delivers mental health services to other adult clients. In FY 08, 26 certified peer support specialists are working in community mental health centers.

3.6 Building Positive Relationships

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

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

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

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

Category 4 – Measurement, Analysis, and Knowledge Management

4.1 Determination of Measures

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

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

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

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

Accrediting bodies mandate many of our performance measures for our inpatient system. These measures, called ORYX, from the give us the ability to compare DMH inpatient facilities with other public mental health facilities nationally on key performance measures such as readmission rates and the use of seclusion and restraints. DMH leadership reviews this comparative data quarterly, and South Carolina has volunteered to be a pilot site for the development of national normative outcome data sets for an ORYX community mental health system.

Figure 4.1-1
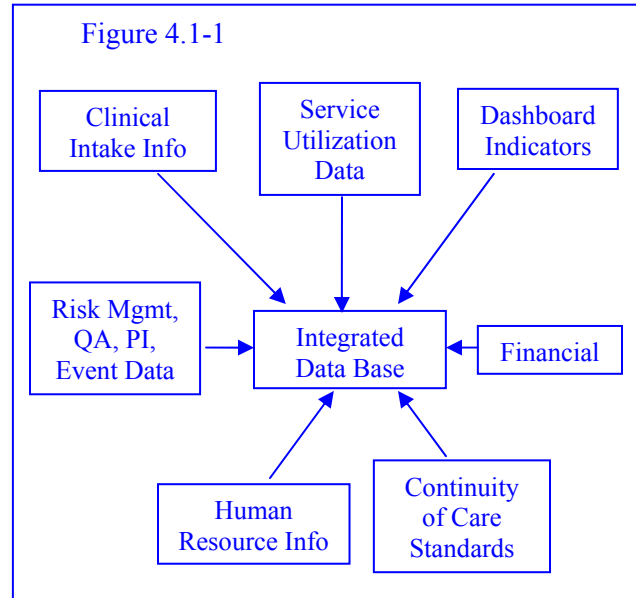
4.2 Using Data and Information in Decision Making

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

Centralized data is compiled on a weekly, monthly, quarterly, and/or yearly basis, and disseminated on the Department's internal (Intranet) website and through various publications. The objective is to provide the right information to the right people at the right time to improve client care and organizational performance.

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

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Management staff in CMHCs, hospitals, and the administration also produces reports of their choosing from a large selection of "canned" programs on financial, human resource, and clinical performance of the agency.

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

4.3 Key Measures

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

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

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

4.4 Comparative Data Use

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

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

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

4.5 Data Quality, Reliability, Availability

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

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

All organizational component sites have T-1 communication circuits, providing improved performance support for SAP and web-based applications such as SAP Imaging, Report2Web, pharmacology on-line, and telepsychiatry.

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

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

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

contact. SCDMH has fully implemented HIPAA requirements.

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

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

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

4.6 Priorities for Improvement

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

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

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

4.7 Management of Organizational Knowledge/Best Practices

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

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

- The Key Performance Indicator Report is sent to senior leadership, CMHC board chairs, the Commission, center and facility directors, and other DMH management. It is discussed at various meetings including senior leadership, the Commission meeting, center board meetings, etc.

- In FY 04, the DMH senior leadership implemented an in-house Mentoring/ Succession Program. This eleven-month program includes monthly classroom instruction lead by DMH senior leaders and homework supervised by mentors at their home facility.

- An Executive Leadership development Program begins this year to prepare a new generation of senior leaders.

- The DMH Risk Manager has made presentations to the center directors and the Commission on key findings, recommendations, and system-wide actions.

- Progress reports on clinical and administrative initiatives are made at quarterly CMHC/Inpatient Directors' meetings.

- Reports are available on the Intranet for key indicators, hospital data, service data, center data, etc

- Best practice programs are featured in *Images*, the DMH newsletter published quarterly

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Category 5 – Human Resources

5.1 Organization of Work Systems

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

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

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

5.2 Knowledge Transfer

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

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

5.3 Recruitment and Retention

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

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

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

5.4 Workforce Capability and Capacity Assessment

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

The Division of Evaluation, Training and Research (ETR) is responsible for meeting

the training needs for strategic priorities of SCDMH and training needs of employees that exceed the expertise/capabilities of individual units . While the strategic plan and accrediting body standards drive the agency's training plan, ETR also has a Training Council for policy/priority setting. At the individual level, training and development needs are an integral part of annual employee evaluations and planning stages for the next year.

Each year ETR sends out a Needs Assessment Survey throughout the agency. Since SCDMH is a health care agency, many of the staff are clinicians. Therefore, one survey is sent out to physicians and another is sent out to non-physician clinical staff. This year a survey was also designed for and sent to the administrative staff. The results of the survey are used to develop the training calendar for the next year. In addition to the written needs assessment, nursing staff complete annual competency verification in a lab setting. Other staff competency is verified by their supervisor and documented in their annual performance evaluation.

5.5 EPMS Supports High Performance

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

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

Employees and their supervisors meet at least once during the rating period to discuss the employee's performance and to identify

problems that may be impeding optimum performance. Supervisors are encouraged to use this time to coach their employees and to discuss the potential they see for their employees to achieve professional goals.

5.6 Leadership Development

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

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

In February 2004, SCDMH designed, developed, and implemented a Mentoring Program, discussed elsewhere in this report, to prepare staff to assume positions of leadership to replace those senior staff leaving though the TERI plan. The program, now in its fifth year, is an eleven-month seminar that includes monthly classroom instruction lead by SCDMH senior leaders and homework supervised by mentors at the participants' home facility. Three participants have become our newest CMHC directors, and several others have been promoted.

In 2008, SCDMH developed an Executive Leadership Development Program to prepare a cadre of qualified individuals to assume Executive Leadership positions within the agency. This program is aimed at improving the effectiveness of both the individual and SCDMH as a whole. The program is 11 weeks long, and has a written assignment and program evaluation process built into it. A program guide focuses on developing the knowledge of the organization among participants. The guide includes discussion of ethical practices and issues and strategic goals and challenges facing SCDMH.

Participants are required to complete a written project and oral presentation on a

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

5.7 Key Developmental and Training Needs Identification

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

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

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

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

classes to be held, enrollment, and completed training.

The Department also utilizes traditional approaches to staff education and training – classroom instruction. In FY 07 ETR began using the SCDMH videoconferencing system to provide live trainings. This**,** also, has reduced the need for travel and has resulted in significant cost savings for the mental health centers. In addition, the agency offers specific training for employees to prepare them for professional license exams and license renewal.

5.8 Transferring Training to the Job

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

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

5.9 Training Directed Toward Goals

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

At the end of each fiscal year, the agency sets its priorities for the coming year. The training calendar is developed using the results of the needs assessment and strategic goals. All training is two-pronged in that it is designed to meet the needs of the staff and the mission and strategic plan of the agency. Throughout the year ETR assesses where they are in meeting those priorities and makes changes in their direction as needed.

5.10 Evaluating Training Effectiveness

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

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

5.11 Employee Motivation to Achieve Potential

How do you motivate your employees to develop and utilize their full potential?

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

We continue to identify and promote best practices in treatment modalities and train teams in best practice concepts to ensure that our employees are well informed and competent to deliver services.

Our tuition assistance program, available to all employees, allows employees to be reimbursed for classes that are beneficial to the employee's current job or to prepare the employee for other positions in the Department.

Our mentoring program for employees who are a Band 5 or greater identifies employees with potential and grooms them as future leaders to fill critical positions within the Department by matching them to the work

that needs to be done. This year-long program provides exposure to areas such as Finance, HR, Procurement, Inpatient Services, Legislative Issues, Strategic Planning, Information Management, Accreditation and Community Services.

5.12 Employee Well-Being and Satisfaction Measures

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

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

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

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

The Exit Interview serves as a valuable tool in providing feedback regarding why employees leave our system. This information is provided to appropriate center/facility directors or division deputy directors for use in improving

communication and tackling issues that may not be readily evident.

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

5.13 Promoting Career Progression

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

Career progression and succession planning is integral to the agency. The Mentoring/ Succession program prepares middle management staff for positions of increased responsibility. This year, a Mini-Supervisory Series has been added to address the needs of new supervisors. The Executive Leadership Development Program has been added to prepare individuals to assume executive leadership positions in the agency. Participants are selected in collaboration with the leadership at the center or hospital from which the participants are chosen.

5.14 Maintaining Safe and Healthy Work Environment

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

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

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

Supplementing our own inspections, the Department takes full advantage of the health and safety inspections provided by the numerous accrediting bodies who survey each of our community mental health centers and our hospitals. The Department has received no violations in any recent survey.

Other examples of our own initiatives in this area include:

- the development of a "Violence in the Workplace" directive;
- pre-employment tuberculosis testing;
- annual employee health screenings;
- annual employee health clinic free flu shots;
- annual wellness related activities;
- a program to treat injured employees with the goal of providing them with immediate quality care and returning the employee to work as quickly as possible;
- air quality and hazardous chemical inspections of buildings;
- inspections by quality assurance teams, Internal Audit, and Public Safety;
- ongoing monitoring of community residential care facilities that provide residences for clients in local communities;

- specialized safety training conducted by safety experts from the State Accident Fund;
- preferred provider agreements with healthcare practitioners to assist employees with job related injuries;
- safety inspections of all Department facilities by fire and safety officers;
- Fire/Safety committees composed of employees and fire/safety officers; and
- Employee clinic that, in addition to caring for and tracking work related injuries, provides immunizations, vaccines, and blood pressure readings.

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

All staff in treatment areas receive annual, competency-based training in de-escalation techniques and therapeutic physical intervention skills to manage potentially violent situations. Clinical staff in the children's programs receive specialized self-defense and intervention training appropriate to the population they serve, as do employees working with the geriatric and the forensic populations. Maintenance and ancillary staff also receive training specialized to meet their need.

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

Category 6 – Process Management

6.1 Core Competencies

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

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

The core competencies are identified as:

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

2. **Citizen and Stakeholder Involvement**
   Embedded into the fabric of SCDMH, at the administrative and operational level, is a philosophy of inclusiveness. This includes:
   - Governance by a Commission of appointed citizens
   - Local mental health center Boards appointed by the legislature
   - State Planning Council dominantly composed of clients, family members, advocates, and sister-agency service providers
   - Stakeholder participation in all major policy and program development decisions

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

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

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

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

   DMH hires self-identified mental health clients as Peer Support Specialists because we believe they can offer unique services, provide hope and inspiration to other clients, strengthen our learnings about our own system, and because it is the right thing to do.

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

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

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

6.2 Key Processes

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

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

Value is created by designing services to meet need, as defined by the client, the family, and our partners, and client perceived value is ensured by:
– including clients in their treatment planning and goal-setting process;
– continually monitoring client satisfaction and program outcomes;
– having Client Advocates in Centers and hospitals to assist clients and resolve issues;
– including all stakeholders in Departmental policy and program activities;
– focusing on client Recovery; and
– monitoring of processes through QA audits, peer review, utilization review, and Medicaid audits.

6.3 Incorporating Efficiency and Effectiveness Measures into Processes

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

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

The Department constructs programs based upon the reported results from research studies in the mental health field, making the agency's design process a science-to-practice methodology (Figure 6.1-1).

Figure 6.1-1
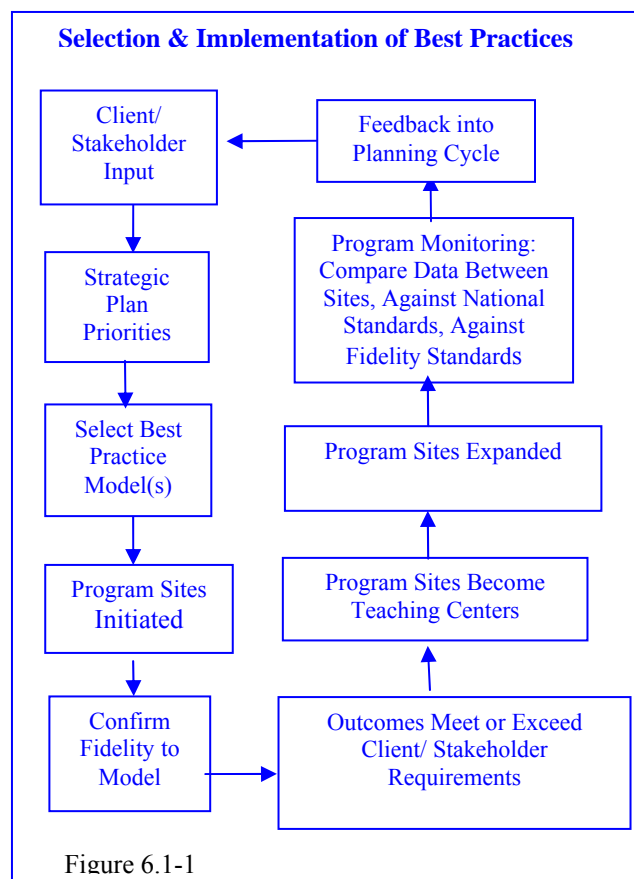
The Department's telepsychiatry and video conferencing system has produced substantial cost-savings and has proven to be an effective means of communicating. Each DMH hospital and mental health center has the necessary equipment performing at 384 kbpm, permitting proper visual and verbal communication.

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

In FY 08 the Department received a $3.7M grant from Duke Endowment that will significantly expand our use of telepsychiatry. Our goal is to link DMH to all Emergency Departments in the state, using state-of-the-art video and voice equipment. DMH psychiatrists will be available 24/7 to provide face-to-face consultations to emergency room staff.

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

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

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

6.4 Daily Operations: Meeting Key Performance Requirements

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

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

The elements of accreditation standards are made operational through policy documents, the Continuity of Care Standards Manual, the CMHC Operating Standards Manual, case record reviews, Quality Assurance (QA), local and state office level audits, corporate compliance audits, risk management system, and utilization review. Our standards are frequently higher than those set by accrediting bodies, and never lower.

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

6.5 Process Evaluation and Improvement

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

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

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

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

The event investigations are tracked, and a determination is made whether to initiate a Quality of Care Review Board (QCRB). These boards, composed of DMH professionals and advocacy representatives, assess the root cause of the occurrence and make recommendations for corrective actions.

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

6.6 Key Support Processes

What are your key support processes, and how do you improve and update these processes to achieve better performance?
Key support processes include:
- Finance
- Human Resources
- Information Technology
- Nutritional Services
- Physical Plant
- Vehicle Management

The deputy director of administrative services, a member of senior leadership and chair of the Business Committee, manages support/business processes.

All process improvements for this area are coordinated though monthly meetings of the Business Committee. Findings and opportunities for improvement are disseminated to the entire Department through this committee and the center/facility administrators' committee.

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

Category 7 – Results

7.1 Mission Accomplishment Results

The DMH measures for mission accomplishment may be grouped, as follows:
a) *Child & Adolescent Clinical Outcomes*
b) *Adult Clinical Outcomes*
c) *Client Quality Of Life Outcomes*
d) *Nursing Home Clinical Outcomes*
e) *Alcohol and Drug Addiction Outcomes*

a) *Clinical Outcomes: Child and Adolescent Services*

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

Our child clinical instrument is the CAFAS, and assessments are conducted at admission, six-month intervals, and discharge. CAFAS scores are classified into four categorical levels (Minimal, Mild, Moderate and Severe). The Moderate and Severely Impaired individuals meet the DMH definition as a priority population: severely emotionally disturbed.
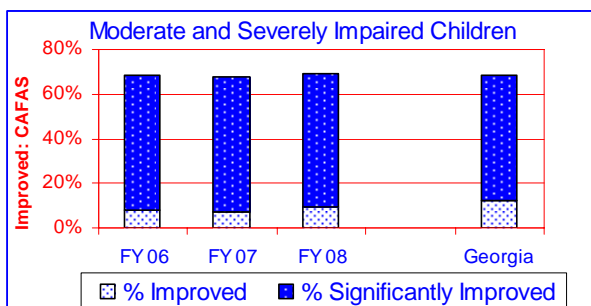
Figure 7.1-1 (Higher is Better)

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

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

b) *Clinical Outcomes: Adults Services.*

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

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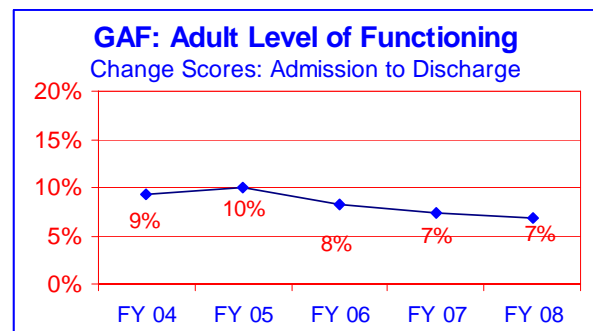
Figure 7.1-2 (Higher is Better)

DMH is still exploring the utility of this measure and how to configure the data. By using paired scores, the figure includes discharge scores that may skew the results. Many of our clients, those with the severest illness, are not discharged; they remain in continued treatment. Limiting the data to clients who are discharged probably includes those persons with less severe illnesses and whose change score would be the smallest.

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c) Client Quality of Life Outcomes

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

In FY 08, DMH again exceeded the national average in employment rate for all mentally ill clients it serves (Figure 7.1-3).

DMH Patients
Percent Employed
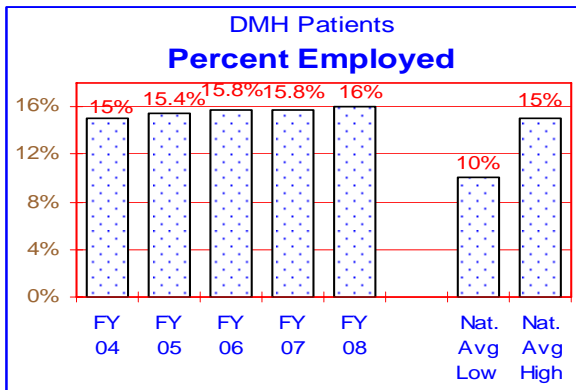
Figure 7.1-3 (Higher is Better)

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

The IPS Employment Programs produce an employment rate three times that of traditional employment programs (Figure 7.1-4) and the SCDMH rate approaches the national best-in-class program.

IPS Employment Program
Consumers Employed Competitively
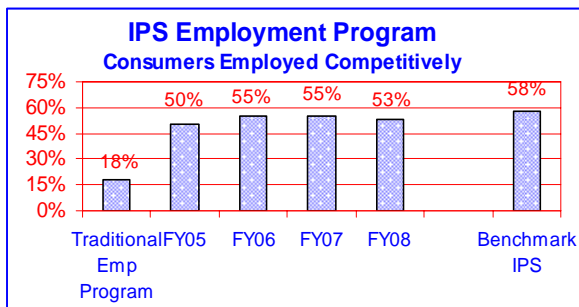
Figure 7.1-4 (Higher is Better)

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

Housing for Consumers
Number of Housing Units
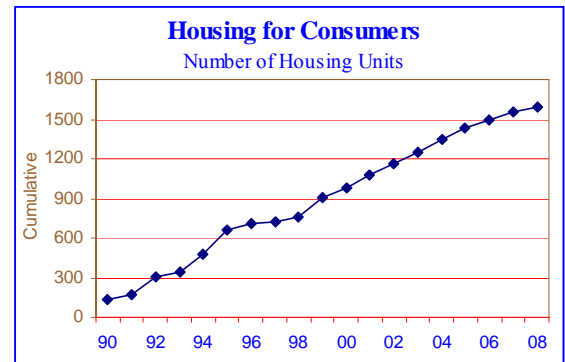
Figure 7.1-5 (Higher is Better)

While not all clients require assistance with housing or employment, for those that do these factors can be key determinates in their ability to live in the community.

The Housing Program funded 44 new units of housing in the community this year. When combined with the TLC Program units, 111 new units were made available for severely mentally ill individuals this year.

d) Clinical Outcomes: Nursing Home Residents.

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

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Nursing Home Life Expectancy
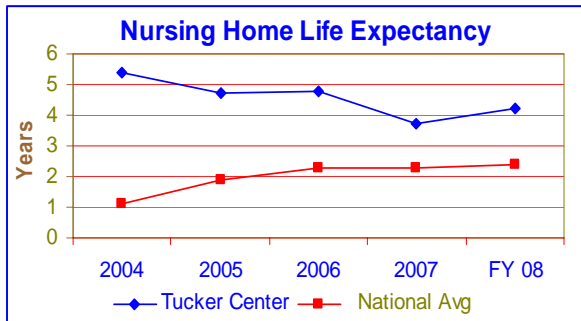
Figure 7.1-6 (Higher is Better)

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

Tucker Center residents acquire fewer decubidi ulcers (bedsores) than the state average. In FY 07 Tucker Center lowered its standard for reporting bedsores, below the state criteria. Even so, occurrences remain below state norms.

Pressure Sore Occurances
Percent of Residents
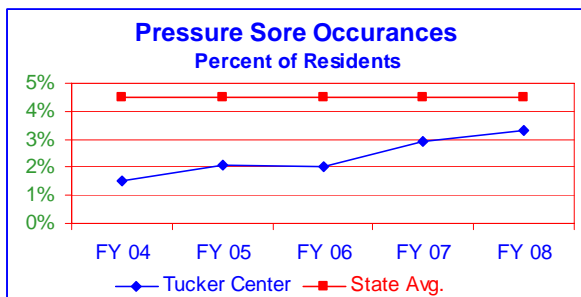
Figure 7.1-7 (Lower is Better)

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

Injury Rate from Falls
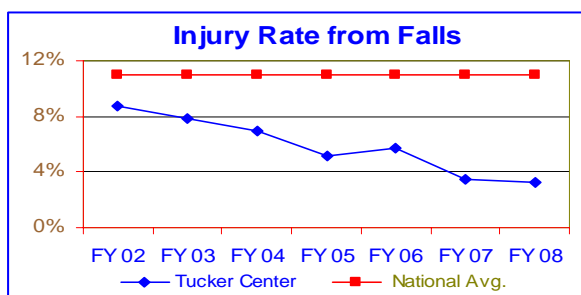
Figure 7.1-8 (Lower is Better)

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

The key measure for effectiveness with A&D clients is abstinence following treatment (Figure 7.1-9). Eighty-four percent (84%) of Morris Village residents were abstinent at 30-day follow-up in FY 08, and the trend line continues to reflect a gradual increase.

Abstinence Rates for MV A&D Consumers
30 Days Post-Treatment
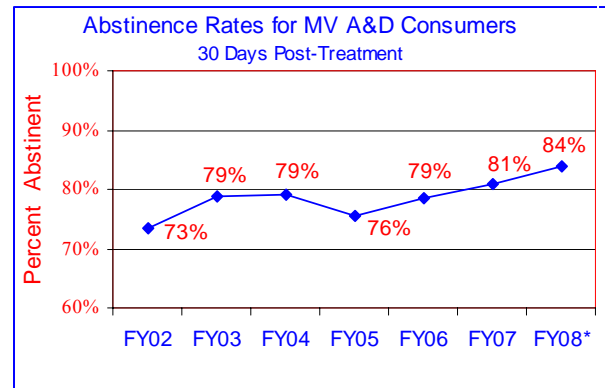
Figure 7.1-9 (Higher is Better)   * 1st Quarter Only

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

7.2 Client Satisfaction Results

DMH measures client satisfaction through:
a) Adult "Perception of Care;"
b) Youth and Family "Perception of Care;"
c) Nursing Home Resident and Family Satisfaction; and
d) Morris Village (Alcohol and Drug Services) Resident Satisfaction.

a) Adult Client Perception of Care:
Client perception of care is assessed with the MHSIP Client Satisfaction Survey, and DMH is rated by clients at a level equal to the national average (Figure 7.2-1). Changes in survey collection methodology resulted in no data being collected in FY 07.

Client Satisfaction
MHSIP Survey Results
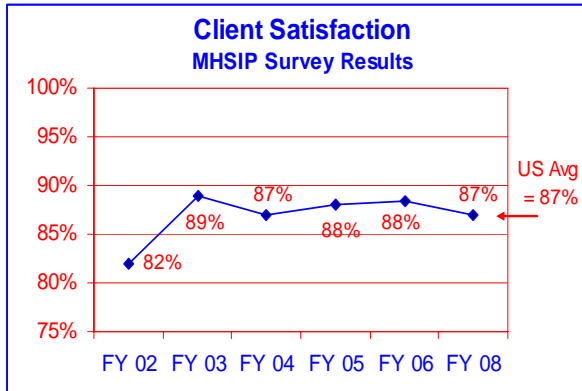
Figure 7.2-1 (Higher is Better)

b) Youth and Family Perception of Care:

The MHSIP Youth Services Survey and the Family Satisfaction Survey were recently introduced. The DMH Youth Survey (Figure 7.2-2) satisfaction level was 86%; National Youth MHSIP comparison data has not yet been released.

Youth Satisfaction
MHSIP Survey Results
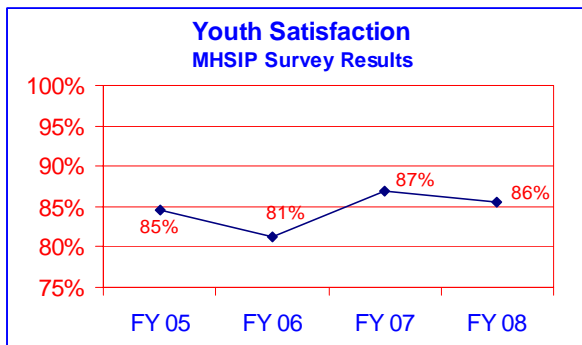
Figure 7.2-2 (Higher is Better)

The Youth Family Satisfaction score was 89%, slightly less than last year but still well above the national average (Figure 7.2-3).

Family of Youth Satisfaction
MHSIP Survey Results
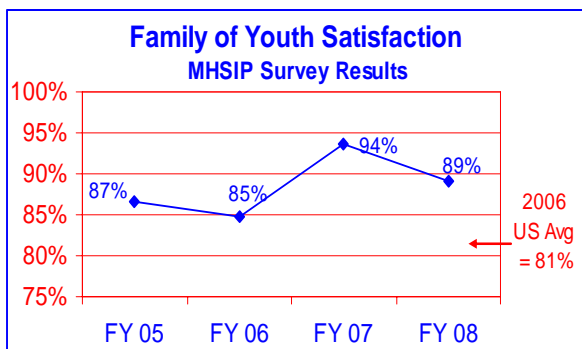
Figure 7.2-3 (Higher is Better)

c) Nursing Home Resident and Family Satisfaction

Both residents and their family members are assessed at Tucker Nursing Care Center for level of satisfaction. Results ("Usually Satisfied" or "Exceptionally Satisfied") continue an upward trend (Figure 7.2-4).

Tucker Center Satisfaction Survey:
Resident & Family
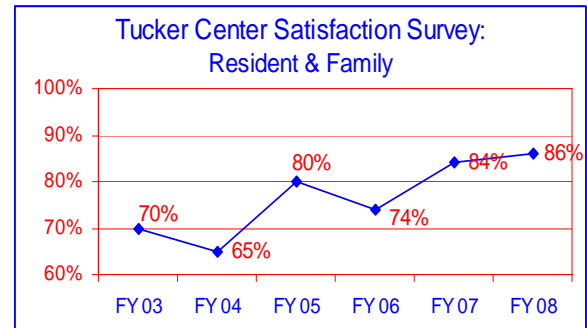
Figure 7.2-4 (Higher is Better)

d) Alcohol and Drug Addiction Inpatient Services:

Morris Village residents, 65% of whom are involuntarily committed to treatment, report satisfaction with the services they receive at 88% (Figure 7.2-5).

Satisfaction with MV A&D Services
30 Days Post Treatment
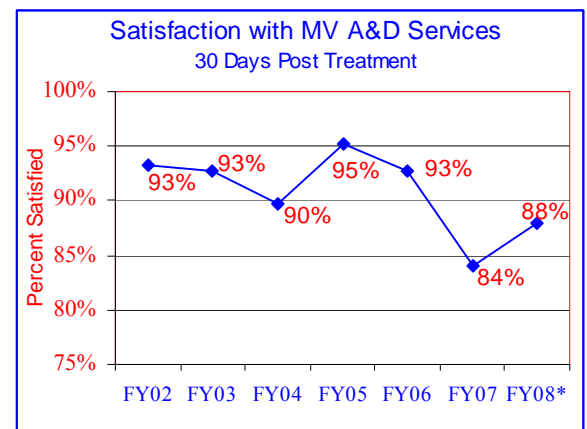
Figure 7.2-5 (Higher is Better)   * 1st Quarter Only

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7.3 Financial Performance Results

The Department's operating revenue (all fund sources) shows significant fluctuation from FY 01 through FY 08 (Figure 7.3-1). Even with these fluctuations, DMH has operated within its budget and has never run a deficit.

Total Operating Revenue
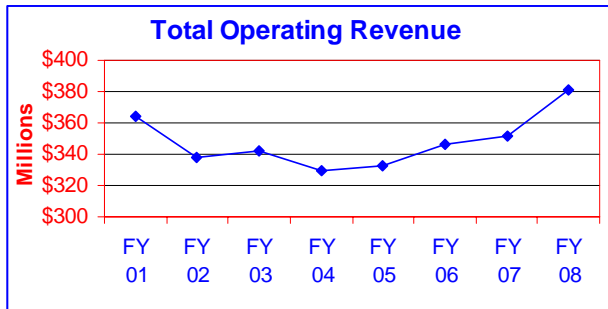
Figure 7.3-1 (Higher is Better)

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

Revenue Source Trends
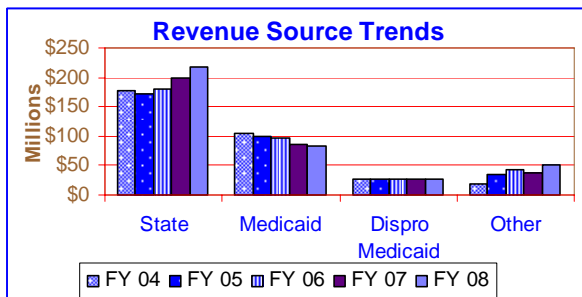
Figure 7.3-2 (Higher is Better)

In FY 08, DMH was awarded over $8.8 million new grant dollars (Figure 7.3-3), a major accomplishment in a time of diminishing resources, federal as well as state.

Total Grant Dollars Received
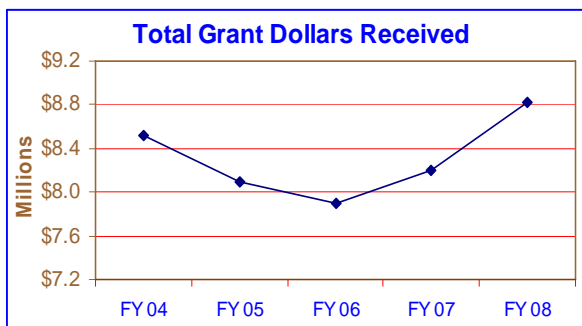
Figure 7.3-3 (Higher is Better)

State Accident Fund Premiums have risen dramatically in the past nine years. While the number of claims is down 40% since FY 2000, the increases in medical costs have continued to push the premiums upward 200% during this same period (Figure 7.3-4).

Workmans Compensation Premiums and Claims
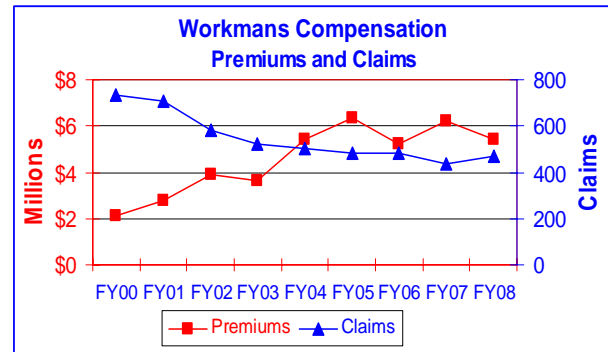
Figure 7.3-4 (Lower is Better)

DMH tracks the number of services it provides that qualify as HHS billable hours. Figure 7.3-5 shows that DMH has maintained its focus through very difficult budget years, providing billable hours of service to its priority populations: severely mentally ill adults and children. In FY 08, however, the total billable hours decreased by 37% for adults and 10% for children.

Billable Hours of Service to Clients with Major Mental Illness
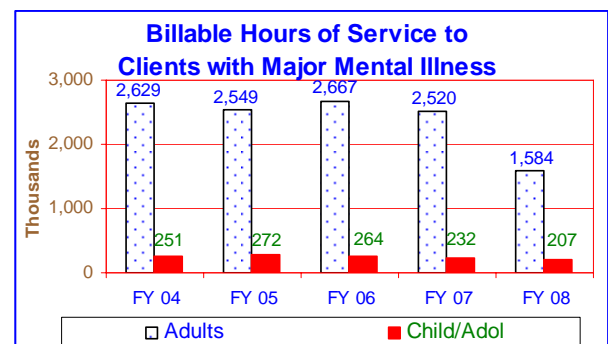
Figure 7.3-5 (Higher is Better)

Expanding community programs and reducing inpatient use not only conforms to stakeholder expectations, but also is also more cost effective. For example, approximately 55% of the patients admitted to community crisis units are Medicaid-eligible. While inpatient psychiatric care

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cannot be billed to Medicaid, community crisis stabilization units can.

Further, the average cost of an admission to a psychiatric hospital is $3,052 versus $975 for the cost of admission to a local crisis stabilization unit.

The TLC program, begun in 1991, is designed to return long-term psychiatric inpatient clients to live in the community through intensive support from CMHCs. To date, 2,000 clients with serious and persistent mental illness, 1,561 from an institutional setting, have participated in the program.

Figure 7.3-6 compares the average one-year cost of maintaining a client in the hospital with the cost associated with TLC community enrollment.
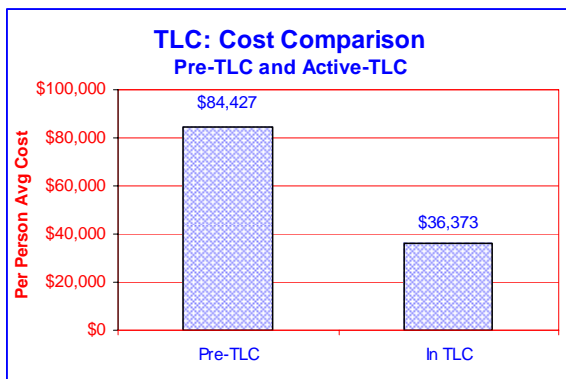
Figure 7.3-6 (Lower is Better)

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

Not only is community-based treatment the right thing to do, it is also financially a much more efficient use of fiscal resources. It is for these reasons that the Department aggressively promotes crisis programs in the community to prevent unnecessary hospitalizations and promotes community preparation programs in

the inpatient facilities to assist clients in learning the life skills they need to succeed in their community transition.

Community expansion has not been achieved at the expense of inpatient programs, but through new dollars, Medicaid revenue, and re-direction of cost-savings (Figure 7.3-7).
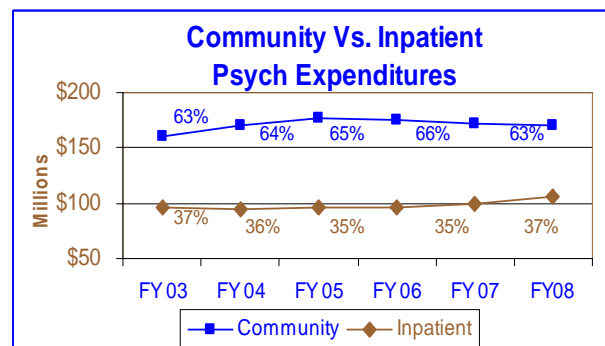
Figure 7.3-7 (Higher is Better for Community; Lower is Better for Inpatient)

The Department actively seeks to contain the costs associated with inpatient care. Bed-Day costs (Figure 7.3-8) reflect the expenses of providing inpatient care within the specialized facilities. FY 08 data is not yet available.
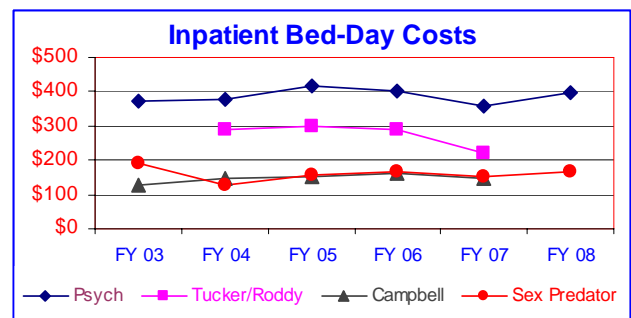

Figure 7.3-8 (Lower is Better)

DMH has done well to hold down the rising cost of expensive inpatient care. Figure 7.3-9 shows the per day cost of DMH acute care facilities compared to the average cost DMH pays through contract to private psychiatric facilities.

While the costs are about equal, DMH has promoted the expansion of local inpatient capacity because it is the preference of stakeholders, and it is in keeping with the

Department's commitment to local care alternatives for crisis stabilization and diversion programming.

Inpatient Psychiatric Per Day Costs
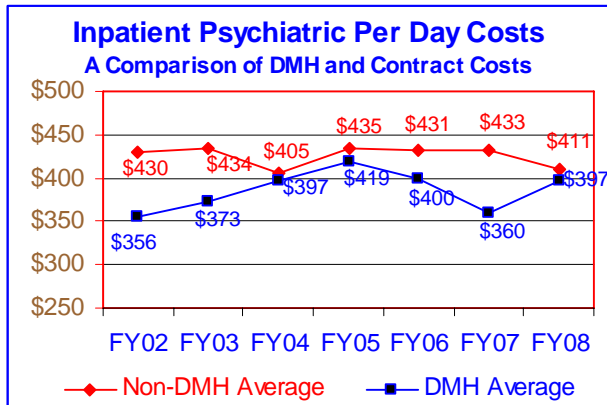**A Comparison of DMH and Contract Costs**

Figure 7.3-9 (Lower is Better)

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

The commitment to a community system has spurred DMH to enter into housing development, partnering with housing authorities and non-profit organizations to create single and multi-family residences for clients who, otherwise, may have no alternative outside of institutional life. DMH has achieved

a 4:1 leveraging of its housing funds, a rate not exceeded by any other state.

Finally, the commitment to community care means decreasing the number of children who are placed in out-of-home care and the dollars associated with this level of care. The 54% reduction in the number of children placed in out-of-home care (Figure 7.5-5) has resulted in a 72% reduction in the overall costs (Figure 7.3-10), allowing CMHCs to redirect over $8M into more appropriate child treatment programs.

Out-of-Home C&A Placement Costs
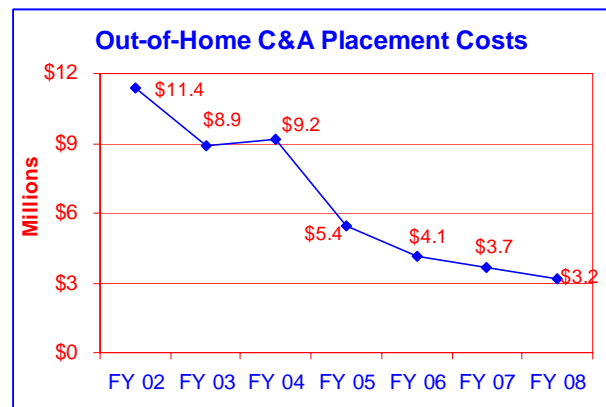
Figure 7.3-10 (Lower is Better)

7.4 Workforce Results

SCDMH conducts a formal assessment of workforce issues through a satisfaction survey on a two-year cycle.

In the area of overall employee satisfaction (Figure 7.4-1), 60% of employees reported that they were satisfied or very satisfied with their job, a 10% decrease from the previous survey, but equal to the FY 04 employee survey.
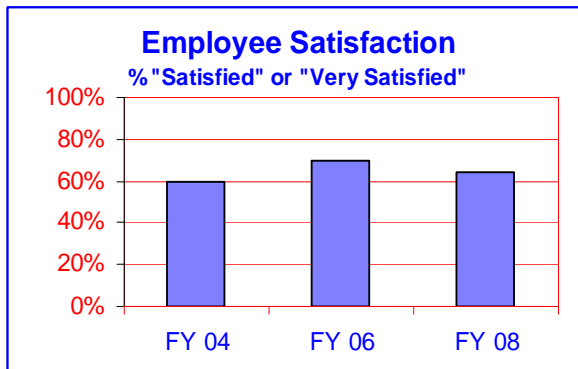
Employee Satisfaction
% "Satisfied" or "Very Satisfied"

Figure 7.4-1 (Higher is Better)

Eighty percent of employees surveyed agreed or strongly agreed that they perceive their work as contributing to the mission of the agency, a proxy measure indicating employee perception of their "involvement" in DMH (Figure 7.4-2). .

Employee Involvement
% "Agree" or "Strongly Agree"
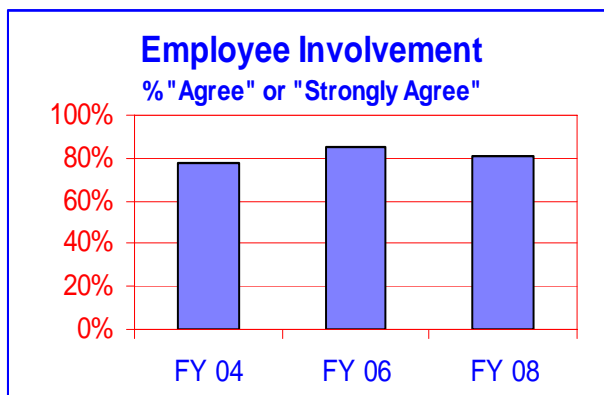
Figure 7.4-2 (Higher is Better)

In the area of staff development, 52% of employees responded that they received adequate training to perform their job

(Figure 7.4-3), an 8% decrease from the FY 06 survey.
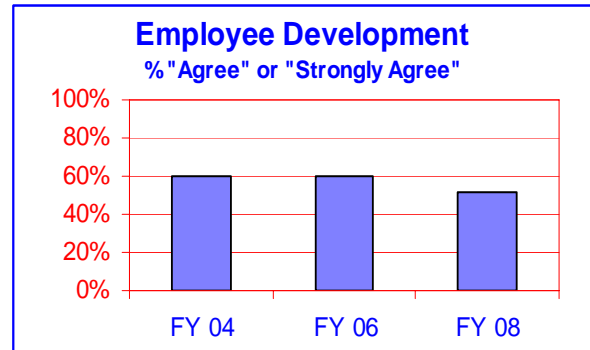
Employee Development
% "Agree" or "Strongly Agree"

Figure 7.4-3 (Higher is Better)

DMH provided 20,656 hours of employee training in FY 08 with 102,025 participants. Included in those numbers were 185 hours of training conducted via videoconferencing with 1,124 participants.

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

Similarly, the SCDMH Computer Learning Modules (CLM) include 37 on-line courses available to staff. If the modules were not available, staff would have 37 hours of in-classroom training to take, not including travel time. For the clinical staff, this would have a negative impact on their productivity and billable hours. The estimated man-hour cost savings to SCDMH for the on-line learning modules for FY07/08 is $3,494,724 (based on 5,100 employees at an average hourly wage of $18.52).

DMH provided 2,133 hours of employee training directly related to meeting the goals of the strategic plan in FY 08 (Figure 7.4-4), a 300% increase since FY 04.

Strategic Priorities Training
Hours of Training

2,500	
2,000	2,133
1,500	1,863
1,000	1,234
500	
0	126 336 496

FY 03 FY 04 FY 05 FY 06 FY 07 FY 08

Figure 7.4-4 (Higher is Better)

DMH's actions to improve the working environment are reflected in reduced workers' compensation claims. Figure 7.4-5 shows a 34% reduction in the number of claims since FY 01.
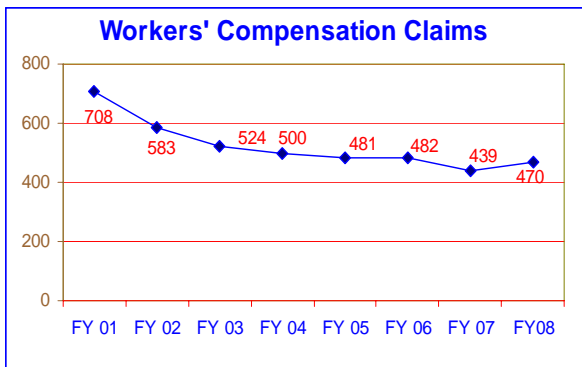
Workers' Compensation Claims

800	
600	708 583 524 500 481 482 439 470
400	
200	
0	

FY 01 FY 02 FY 03 FY 04 FY 05 FY 06 FY 07 FY08

Figure 7.4-5 (Lower is Better)

Employee turn-over rate is 17.2% for FY 08 (Figure 7.4-6), slightly down from last year and below other, comparable, state agencies.

Employee Turnover Rates

25%	22.50%
20%	18.3% 18.78%
15%	15.0% 17.2%
10%	
5%	
0%	

FY05 FY06 FY07 FY08 Comparable Agencies
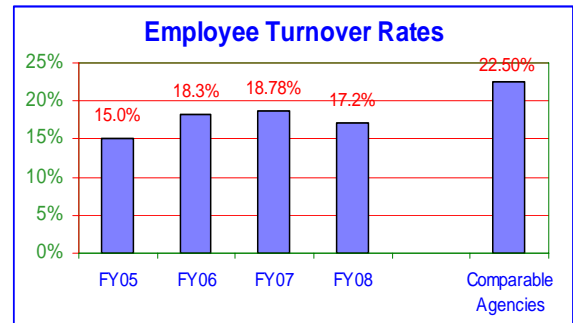
Figure 7.4-6 (Lower is Better)

In affirmative action, DMH ranks 12th among large state agencies for percentage of goals met. Figure 7.4-7 shows the percent of affirmative action goals met by the agency each year since FY 04.
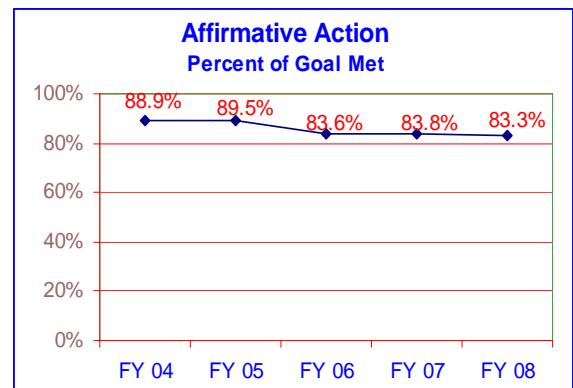
Affirmative Action
Percent of Goal Met

100%	
80%	88.9% 89.5% 83.6% 83.8% 83.3%
60%	
40%	
20%	
0%	

FY 04 FY 05 FY 06 FY 07 FY 08

Figure 7.4-7 (Higher is Better)

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7.5 Organizational Effectiveness and Efficiency Results

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

a) Community Services to Priority Populations
b) CMH Services Clinical Effectiveness
c) Inpatient Services Clinical Effectiveness
d) Support Processes Outcomes

a) Community Services to Priority Populations:

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

DMH has, for the past three years, hovered at slightly less than the national average in the number of adults served per 10,000 population (Figure 7.5-1).

Penetration Rate - Adults Served
Community Mental Health Services
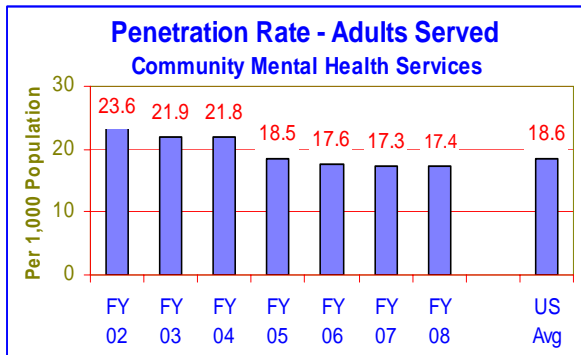
Figure 7.5-1 (Higher is Better)

The gradual decrease in the adult penetration rate most likely reflects the Department's focused reduction in treating persons who are not severely mentally ill and intensifying services to those who meet the criteria for severely mentally ill (SMI) and seriously and persistently mentally ill (SPMI).

Eighty-eight percent of all DMH adult clients meet the definition of SMI, and 85%

of all FY 08 adult client contacts are with SMI clients (Figure 7.5-2).

Adult Contacts with Major Mental Illness
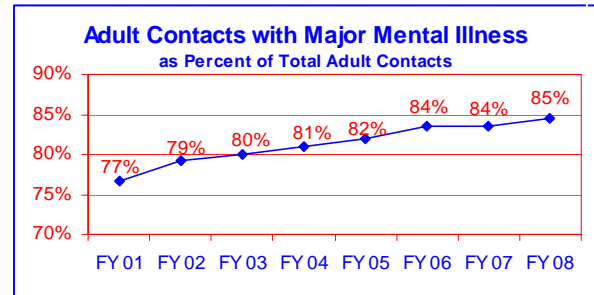as Percent of Total Adult Contacts

Figure 7.5-2 (Higher is Better)

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

Penetration Rate - Ages 0-17 Served
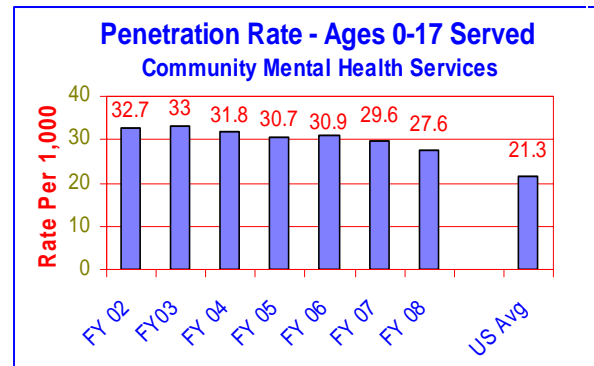Community Mental Health Services

Figure 7.5-3 (Higher is Better)

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

C&A Contacts with Major Mental Illness
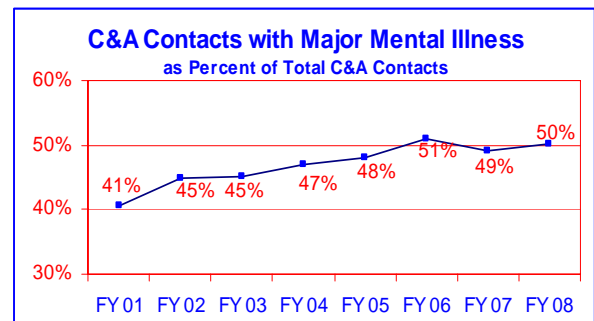as Percent of Total C&A Contacts

Figure 7.5-4 (Higher is Better)

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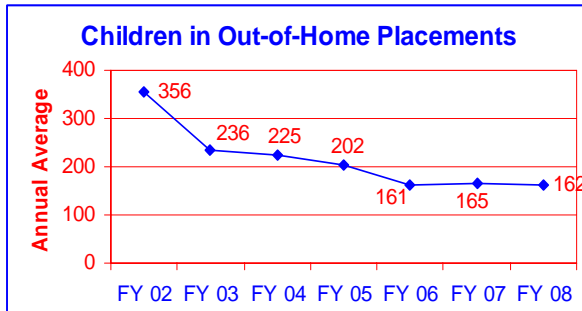
Children in Out-of-Home Placements

FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
356	236	225	202	161	165	162

Figure 7.5-5 (Lower is Better)

The actual number of persons, all ages, served through the community centers from FY 03 - FY 08 is shown in Figure 7.5-6.

Number of People Served in CMHCs
Unduplicated Count

FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
88,630	89,381	90,733	89,480	87,641	87,762
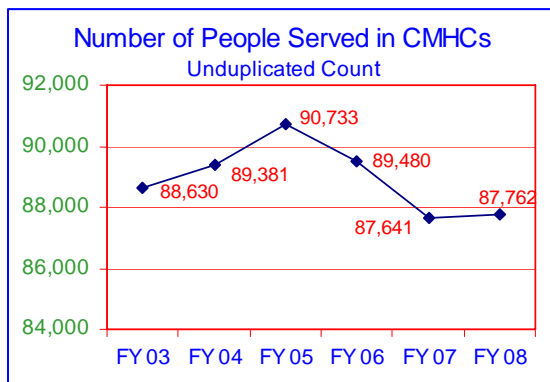
Figure 7.5-6 (Higher is Better)

b) CMHC Services: Clinical Effectiveness

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

Adult Psychiatric Hospital Admissions

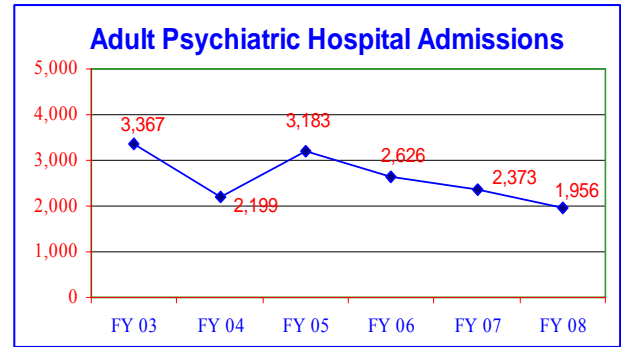| FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
3,367	2,199	3,183	2,626	2,373	1,956

Figure 7.5-7 (Lower is Better)

In fact, there are probably multiple reasons for the 42% decrease in psychiatric hospital admissions in the past five years, some desirable and some not so desirable:

– Improved crisis stabilization and crisis diversion programs in the community;

– The purchasing of acute care beds in local communities; and

– The increase in the percentage of patients who stay in the hospital longer than 90 days, resulting in a decrease in acute care beds available to admit short- term patients.

South Carolina has paralleled the country with a phenomenal growth in Emergency Department (ED) use by persons in crisis, both behavioral health and all other categories. As can be seen in Figure 7.5-8, 45,961 people with a primary diagnosis of alcohol/drug (AD) or mental illness (MI) made 37,719 visits to South Carolina EDs in 2006, and the number continues to climb by about 1,000 per year.
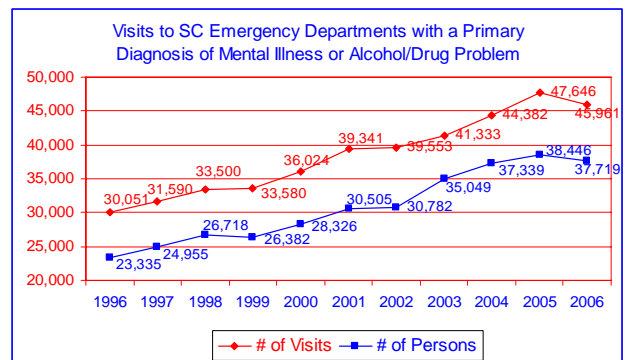
Visits to SC Emergency Departments with a Primary Diagnosis of Mental Illness or Alcohol/Drug Problem

Year	# of Visits	# of Persons
1996	30,051	23,335
1997	31,590	24,955
1998	33,500	26,718
1999	33,580	26,382
2000	36,024	28,326
2001	39,341	30,505
2002	39,553	30,782
2003	41,333	35,049
2004	44,382	37,339
2005	47,646	38,446
2006	45,961	37,719

Figure 7.5-8 (Lower is Better)

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This increase in emergency room use has had a major impact on the public healthcare system and the Department of Mental Health.

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

In FY 08 DMH funded special initiatives totaling $4.9M to reduce the burden placed on these hospitals and community crisis centers. To quality for the additional funding, CMHCs submitted competitive bids. The proposals included some combination of multiple interventions, including placing physicians (8 centers) or other mental health professional (5 centers) in the ED, establishing crisis teams (3 centers), and/or contracting for additional bed days in local hospitals (9 centers)

Contracting for short-term use of beds in non-DMH hospitals not only reduces the need for DMH inpatient beds, it also provides crisis care near the patient's home and enhances local, community-based options. Figure 7.5-9 shows the growing trend in this treatment option.
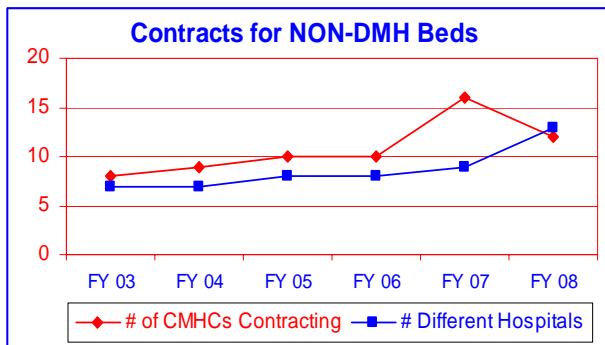
Figure 7.5-9 (Lower is Better)

Even with these efforts, the number of persons waiting in the ED longer than 24-hours has continued to average about 37, according to our Monday morning snap-shot count (Figure 7.5-10).
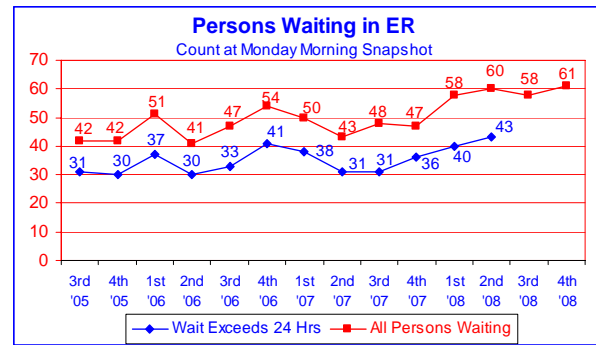

Figure 7.5-10 (Lower is Better)

Particularly challenging to DMH is that a significant number of the persons who present themselves in the EDs with a primary diagnosis of mental illness and/or alcohol/drug are unknown to DMH (72%). They have no history with our agency, at least not within the past three years (Figure 7.5-11).
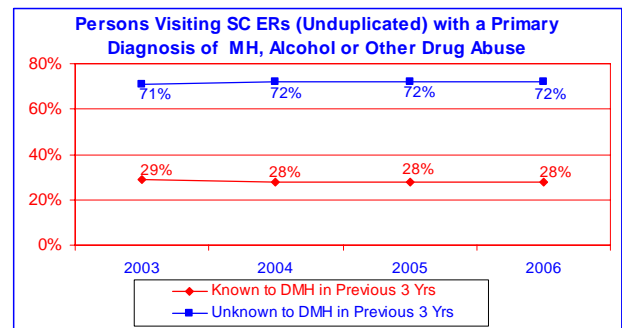

Figure 7.5-11

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

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

Following specialized preparation by hospital staff, patients selected for the TLC Program receive intensive support through the community mental health centers, helping them adjust to community life and

secure daily living skills. Figure 7.5-12 shows the growth in the TLC program.

TLC: Funded Community Placements
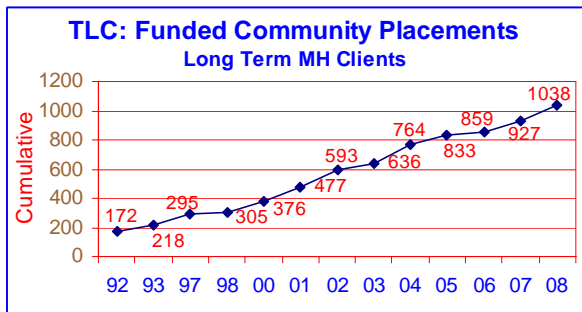**Long Term MH Clients**

Figure 7.5-12 (Higher is Better)

As TLC funding for community placement has grown over the past twelve years, returning over a thousand long-term, severely mentally ill clients to the community, the program's growth parallels the shrinking census of hospitalized, long-term psychiatric patients (Figure 7.5-13).
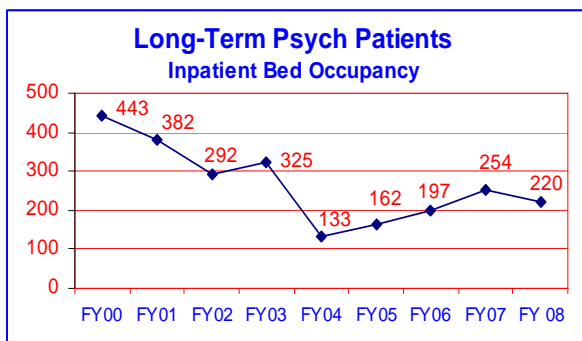
Long-Term Psych Patients
Inpatient Bed Occupancy

Figure 7.5-13 (Lower is Better)

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

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

Senior management and the Commission review data quarterly on the number of days between inpatient discharge and the date of their first appointment at a local community

mental health center (Figure 7.5-14).

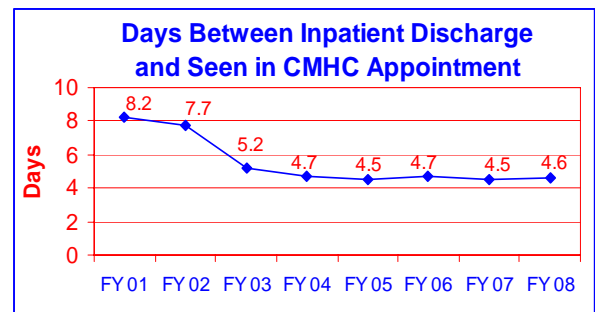**Days Between Inpatient Discharge and Seen in CMHC Appointment**

Figure 7.5-14 (Lower is Better)

SCDMH average of 4.5 days has a range of 4.0 to 5.3 days, well under our seven-day standard. One state, Oklahoma, publishes its data on this measure and has a 6.2 day average, with a range of 1.3 to 8.8 days.

c) Inpatient Services: Clinical Effectiveness

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

A low 30-day psychiatric re-admission rate reflects adequacy of inpatient treatment, as well as solid follow-up and maintenance in the community following discharge. Figure 7.5-15 shows that DMH remains below the national average.
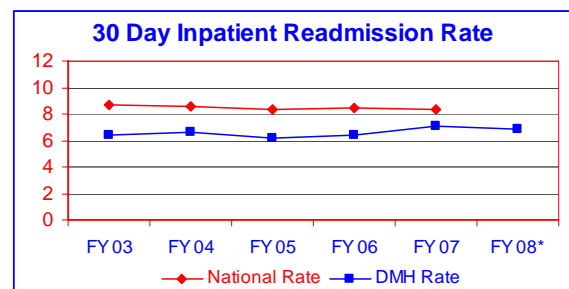
30 Day Inpatient Readmission Rate

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

Other key ORYX measures for inpatient facilities include the use of restraint and seclusion, defined as the number of hours clients spent in restraint or seclusion for every 1,000 inpatient patient hours (Figures

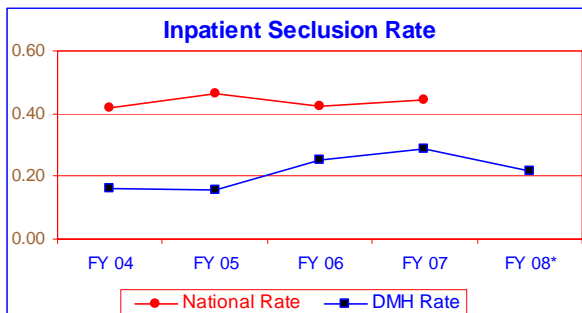7.5-16 and 17). DMH consistently scores below the national average on both of these measures.

Inpatient Seclusion Rate

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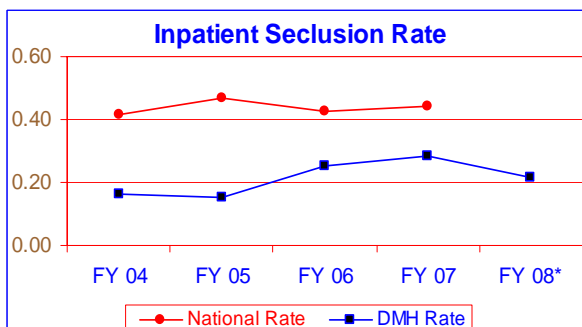
Inpatient Seclusion Rate

Figure 7.5-17 (Lower is Better)   * 10 Months data

Senior leadership also monitors inpatient bed availability weekly. The impact of long-term patients in short-term beds erodes DMH's capacity to admit new patients, creates problems for EDs, and raises the costs of inpatient services (Figure 7.5-18). This number has been rising for eight years.

Psych Inpatient:
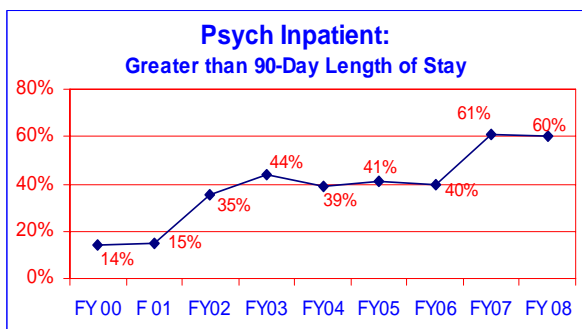**Greater than 90-Day Length of Stay**

Figure 7.5-18 (Lower is Better)

Psychiatric inpatient admission rates, length of stay, and longer-term patients in short-term beds also directly impacts total "bed-days" (Figure 7.5-19).

DMH Inpatient Utilization
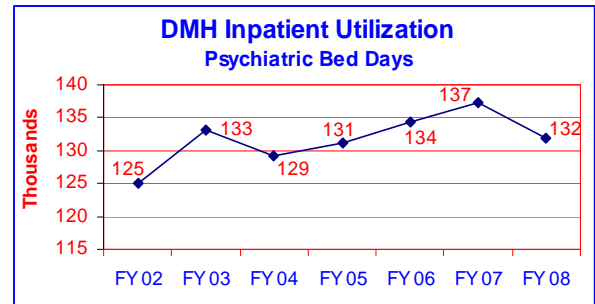**Psychiatric Bed Days**

Figure 7.5-19 (Lower is Better)

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

After a marked rise in the number of persons needing admission and the increased length of their wait, the Department responded with several initiatives. The result has been a dramatic reduction in the average wait for both the Psychosocial Rehabilitation Program and the Pre-Trial Unit, with the exception of one anomaly in the 3rd quarter of 2008. (Figure 7.5-20).
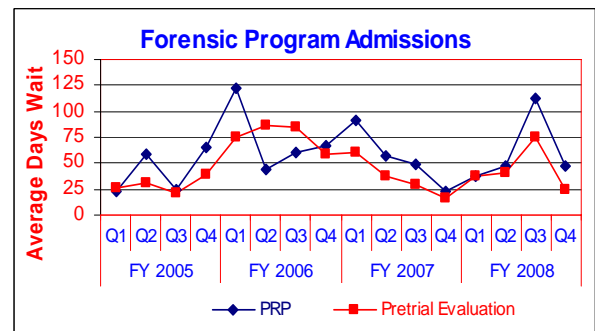
Forensic Program Admissions

Figure 7.5-20 (Lower is Better)

d) Support Processes Outcomes
Figure 7.5-21 identifies the Department's key support/business processes and the performance level of each.

Figure 7.5-21	**Key Business and Support Processes**	
Process	**Key Requirements**	**Status**
DOAS (as a whole)	The Division of Administrative Services (DOAS) will not overspend its budget.	FY 08 Goal met.
Finance	No significant audit findings by State Auditors	No significant findings in most recent SFY audit.
	Invoices paid with 3 business days	Goal met.
	Limit of 5 payroll errors per pay period	Goal met.
	Composite bank account reconciliation's are performed within 30 days after receipt of the bank statement.	Goal met.
	Process procurement request up to $10k within 5 working days; $10k and $25k within 15 working days; and above $25k within 28 working days	Goals being met when necessary purchasing information is furnished by the requestor.
Information Technology	Database applications will be backed up sufficient to recover any database up to the most recent log file.	No significant data losses reported.
	Protect user data from virus infection using real-time virus protection software.	100% of infected files are cleaned, quarantined or deleted.
	Archive vital medical and financial records.	Goal met.
	User satisfaction	Most categories of users in the 2006 survey show improvement over 2004 survey. Overall satisfaction is 89%
Nutritional Services	Provide nutritious, appetizing and satisfying meals for all of DMH clients within annual budget.	Goal met
	Provide up-to date, culturally sensitive patient/ family nutrition opportunities and materials per Joint Commission standards.	Goal met
	Complete nutrient analysis of current menus and assure that therapeutic menus are consistent with SC Dietetic Association diet manual.	Goal met
	Maximize sales (revenue) for department through, providing/selling meal service to other state agencies / private sector organization.	Goal met
Physical Plant	Insure that all capital projects are completed within approved budgets.	Goal met: 8 Projects were closed in FY08 with $33,095 remaining balance.
	Provide living environments in compliance with all regulatory requirements and standards.	There were no JOINT COMMISSION surveys during this time frame. Results of DHEC surveys were satisfactory.
	Provide efficient, cost effective building and grounds maintenance.	Building maintenance costs per square foot were 8.5% less than the national average. Grounds maintenance & custodial costs were significantly less than industry average due to the use of inmate labor
Vehicle Management	Ensure that all vehicles and equipment repairs are conducted in the most cost efficient manner.	The Vehicle Maintenance Shop passed State Fleet certification for 2008 with no issues
Human Resources	See Category 7.4 for HR discussion	See Category 7.4 for HR results.

7.6 Regulatory/Legal Compliance and Community Support Results

DMH is subject to review/audit/survey by a wide variety of bodies. Figure 7.6-1 provides an overview of many of these entities, their function, and the status of our most recent review.

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

Figure 7.6-1	**Legal and Regulatory Compliance**	
AGENCY OR ENTITY	**FUNCTION**	**Current Status**
CARF/Joint Commission	National Accreditation	All CMHCs & Inpatient accredited
VA	National Accreditation of Veterans' Nursing Homes	In compliance
HHS Program Integrity Audit	Medicaid Division of Corporate Compliance	In compliance
HHS Program Field Review	Review of programs and documentation to identify training and compliance issues.	In compliance
DMH Quality Assurance Team	Review of client care practices and medical records documentation for quality of care, accreditation and corporate compliance issues.	In compliance or action plan to achieve compliance
DMH Internal Audit	Review of administrative practices, policies and procedures for compliance with DoFS, Human Resources, and other regulations.	In compliance or action plan to achieve compliance
DMH Corporate Compliance	Regular review by DMH for conformance with DMH Corporate Compliance Plan	In compliance
DHEC	Inspection of CRCFs operated by Centers for conformance with regulations.	In compliance
DHEC	Inspection of day programs preparing food for conformance with sanitation regulations.	In compliance
DHEC	Inspections of inpatient facilities for compliance with regulations.	In compliance
Fire Marshal	Inspection of facilities for fire safety	In compliance
Medicare Professional Review Organization	Review of medical records to determine appropriateness of Medicare reimbursement—contract organization of SC Blue Cross Blue Shield	In compliance
ADA	Regulation of access for disabled	In compliance

Glossary of Terms and Abbreviations

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

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

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

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

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

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

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

CME – Continuing Medical Education, physician continuing education credits.

CMHC – Community Mental Health Center.

CRCF – Community Care Residential Facility

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

Client – person with mental illness served by the DMH.

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

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

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

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

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

DMH – South Carolina Department of Mental Health.

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

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

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

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

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

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

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

MHSIP – Mental Health Statistical Improvement Project, a multi-state project to design satisfaction surveys for mental health clients, youth, and family members.

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

Pathlore – a computerized employee training registration and documentation system.

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

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

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

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

SAP – computerized financial management system.

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

SHARE – Self-Help Association Regarding Emotion, a client advocacy and self-help organization.

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

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

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

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

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