State of South Carolina
Department of Mental Health

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Mark Binkley
Interim State Director

March 8, 2019

Mr. Jay West,
Subcommittee Chair
Legislative Oversight Committee
S. C. House of Representatives
P. O. Box 11867
Columbia, SC 29211

Re: Your letter of February 20, 2019

Dear Chairman West:

Thank you for your letter of February 20, 2019 transmitting a number of requests for information following the February 19, 2019 Subcommittee meeting.

Attached is the Department's response to those requests. Please let me know if you or other members have any questions about the information provided.

Department staff are also nearing completion of the response to the requests contained in your letter of February 7, 2019.

Sincerely,

Mark W. Binkley, JD
Interim State Director

Attachment

Cc: Carmen J. McCutcheon Simon

MWB:td

LEGISLATIVE OVERSIGHT COMMITTEE
Answers to Questions from 2-20-19

Inpatient Services Planning

- **Does the agency have a schedule by which policies related to inpatient services are reviewed and updated?**

  Per policy, the SCDMH Division of Inpatient Services policy and procedure directives are to be reviewed at least annually. Review does not necessarily mean the policy and procedure directive will be revised. Revision occurs as needed based on changes in law, standards, regulations, and/or practice.

- **What methods are used to estimate capacity needs?**

  SCDMH has acknowledged for some time that there are an insufficient number of adult inpatient psychiatric beds in different areas of the State to allow for the timely admission of all adults in need of psychiatric hospitalization. One manner in which this is evidenced is by the number of referrals of patients for admission to the Department's adult psychiatric hospitals who are placed on waiting lists. Another way the shortage is apparent is the number of adult patients reported by hospital emergency rooms who are awaiting transfer to a psychiatric hospital for inpatient mental health care.

  Like most states, the emergency departments in South Carolina's hospitals see a large, and increasing, number of patients in a behavioral health crisis. The crisis generally results from an untreated mental illness, from substance abuse or from some combination of the two. Because of a national shortage, many emergency departments in South Carolina do not have access to a psychiatrist or other mental health professional to assist in the evaluation of these patients. Additionally, due to the continuing shift towards community-based treatment in all areas of healthcare, including mental health care and substance abuse treatment, as well as for financial reasons, the number of available psychiatric hospital beds in community and State hospitals has declined nationally and in South Carolina. South Carolina has also experienced a large decline in community detoxification programs. In most communities in the State, a hospital emergency department is now the only option for an individual who is grossly intoxicated. Both nationally and in South Carolina, emergency departments have struggled with the issue of behavioral health patients waiting hours, or days, for a psychiatric assessment and an appropriate transfer or discharge plan to address their treatment needs. The issue is generally most serious at smaller, rural hospitals.

  The following is an excerpt from the 2018-2019 DHEC State Health Plan:

> ***Because the South Carolina Department of Mental Health (SCDMH) has had substantial decreases over the past several years in inpatient capacity, there are not enough adult inpatient beds available to meet the demand from referral sources for its beds. In a number of regions of the State, this has led to significant numbers of persons in a behavioral crisis waiting in hospital emergency rooms inordinate periods of time for an appropriate inpatient psychiatric bed to become available. These emergency room patients may not have a source of funding.***

Like all agencies of government, SCDMH has limited resources. But while funding limitations is one major reason why the agency has reduced the number of adult psychiatric beds, increased funding alone would not necessarily enable the Department to increase its inpatient capacity. Workforce shortages of nurses, psychiatrists, social workers and other direct care mental health staff plays a major role in how much bed capacity is available in SCDMH hospitals, even when there is available funding and the agency is seeking to fill positions. It is not uncommon at different points in time for a SCDMH hospital to temporarily reduce its ***functional*** bed capacity due to a loss of medical staff, and increase it when able to hire or contract with another physician.

The following is another excerpt from the 2018-2019 DHEC State Health Plan:

> ***SCDMH has attempted to alleviate this problem by means of its "Crisis Stabilization Program." Within available funding limits, the "Crisis Stabilization Program" is to provide short-term emergency stabilization of psychiatric patients in the local community, by use of both local hospital beds and non-hospital residential programs, such as community residential care facilities for those patients who do not require a hospital level of care. For patients needing stabilization in a hospital, subject to available funding the SCDMH contracts with one or more local hospitals willing to admit indigent patients assessed by the SCDMH mental health center as needing acute care in return for a daily rate for a defined period. These patients can be cared for in licensed general acute care beds or licensed psychiatric beds.***

As noted, SCDMH has initiated a number of measures aimed at addressing the shortage of adult psychiatric beds. Like public mental health agencies nationwide, SCDMH has expanded community mental health services even as it reduced hospital beds. Despite limited resources, SCDMH has formed partnerships with local hospitals and other organizations to address the inpatient bed shortage in effective and innovative ways.

EMERGENCY DEPARTMENT TELEPSYCHIATRY

SCDMH, in partnership with The Duke Endowment (TDE), the University of South Carolina School of Medicine, the South Carolina Hospital Association, and the South Carolina

Department of Health and Human Services, utilized a series of grants as well as State funding to create its award winning Emergency Department Telepsychiatry program. The program provides psychiatric evaluations through telemedicine in emergency departments (EDs) across South Carolina. There are currently 23 participating hospital EDs. These consultations began in March of 2009. South Carolina is the first state to successfully connect patients in hospital EDs statewide with consulting psychiatrists via a secure Internet connection meeting all privacy and confidentiality standards.

The patient in the ED sees the psychiatrist on a high definition flat screen monitor located on a wireless mobile cart in the privacy of the patient's room. The distant SCDMH psychiatrist, in real time, views the patient on a desktop system from their office. With the clarity of a high definition picture, cameras that the doctor can manipulate remotely, and clear audio, the psychiatrist conducts an assessment with the quality of a "face to face" encounter, just as in the doctor's office.

Emergency department medical professionals participate in the assessment process with the patient's approval. Prior to the tele-video assessment, the psychiatrist obtains and reviews available medical record information including laboratory results from the hospital. The assessment is concluded with written recommendations made to the patient's physician in the ED. Recommendations may range from psychiatric medication, individual and/or family counseling, discharge to a specific community provider for continuing treatment or transfer to a hospital psychiatric unit for inpatient treatment.

When the assessment is concluded, the psychiatrist completes an electronic medical record with treatment recommendations, affixes an electronic signature and sends a confidential copy to the ED for inclusion in the patient's medical record. A copy also goes to the nearest SCDMH mental health center for follow up care.

In addition to State appropriations and grant funding, these hospitals pay a modest user fee for the assessment/consultations, helping to offset its cost. The program provides approximately 700 evaluations in South Carolina EDs per month, and there have been over 46,000 evaluations since the program's inception. Patients have accepted the technology and readily participate in the assessments. Independent evaluations of the program's effectiveness have documented that for participating hospitals, the program has reduced patients' lengths of stay in EDs and increased the rate at which patients' follow-up with community aftercare. Participating hospitals report a high degree of satisfaction with the service.

To our knowledge, South Carolina remains the only state in the nation to design and implement a statewide comprehensive emergency department psychiatric evaluation program. This innovative program has received State and national recognition:

- (2011) The American Psychiatric Association awarded SCDMH and the Department of Neuropsychiatry and Behavioral Science of the USC School of Medicine the Psychiatric Services Achievement Award Silver Medal for the Telepsychiatry Consultation Program.
- (2012) DMH's Telepsychiatry Program received the SC Office of Rural Health's Annual Award.
- (2015) The Ash Center for Democratic Governance and Innovation at the John F. Kennedy School of Government of Harvard University recognized SCDMH's Program as part of its 2015 Bright Ideas program, honoring government programs at the forefront in innovative action.
- (2015) SCDMH's Telepsychiatry Consultation Program was recognized as a Statewide Telehealth Program of Excellence at the 4th Annual Telehealth Summit.

PLACEMENT OF MENTAL HEALTH PROFESSIONALS IN EMERGENCY DEPARTMENTS

SCDMH is one of only a few integrated public mental health systems in the 50 states and 8 U.S. territories, meaning that in addition to State hospitals, the agency also operates the State's community mental health centers. SCDMH community mental health centers have offered to partner with hospitals to share the cost of placing one of the Center's mental health clinicians in the hospital's ED to assist in the evaluation and disposition of psychiatric patients. Currently there are 10 participating hospitals. As with the Telepsychiatry Consultation Program, the hospitals which participate have seen that having a mental health professional in their ED has resulted in shorter lengths of stay for psychiatric patients, and improved linkage of those patients with community treatment services.

PREVENTION AND DIVERSION

Individuals with psychiatric treatment needs should be receiving their mental health treatment in a more appropriate setting than a hospital's ED. SCDMH through its community mental health centers, offers treatment services to help patients manage their psychiatric illness and avoid the need for emergency care. SCDMH has a total of 60 community mental center and clinic locations throughout South Carolina. Thanks to the support of the Governor and the General Assembly, the Department's appropriations have been increasing, and so have the delivery of community mental health services. Since Fiscal Year 2013, the number of new cases opened by community mental health centers has increased over 10%.

For persons in urgent need of mental health treatment, SCDMH mental health centers have crisis stabilization services to assist patients and avoid the need for them to utilize a hospital ED. Available crisis intervention measures include contracts between the mental health center and local hospitals which have psychiatric units. Under such contracts, the mental health center pays for the short term hospitalization of indigent patients who are referred by the center. In

Fiscal Year 2018, SCDMH mental health centers purchased over 4,200 local psychiatric hospital bed days for patients.

COMMUNITY CRISIS RESPONSE AND INTERVENTION PROGRAM (CCRI)

The CCRI program was built upon the successes of the Department's Charleston Dorchester Mental Health Center's 31 year old Mobile Crisis program. The CCRI Program began in May of 2018. Since that time it is now operational in 22 of South Carolina's 46 counties. When called by anyone, night or day, CCRI team members triage the situation, and if needed, may deploy anywhere in the community to provide an on-site assessment, and referrals to anyone in psychiatric distress. If the team does not need to physically deploy, its members can address psychiatric crises telephonically on a statewide crisis line and will soon have the capacity in some cases to respond using telehealth equipment. It is the Department's goal for CCRI to cover the entire state by June 30, 2019. The CCRI team has served over 900 distinct individuals through February 15, 2019, and has safely and successfully been able to divert over 51% of persons served from an emergency department.

CRISIS STABILIZATION UNITS/CENTERS

SCDMH, through its community mental health centers, is continuing to establish local partnerships with hospitals, law enforcement and other local officials to create crisis stabilization centers for individuals experiencing a mental health crisis who can be safely cared for in a non-hospital setting. The agency's Charleston-Dorchester Mental Health Center (CDMHC) opened the Tri-County Crisis Stabilization Center (TCSC) last year. With financial support from MUSC, Roper Hospital, the Charleston Center, and the Charleston County Sheriff's Department, the CDMHC opened a 10 bed residential program to provide short-term psychiatric assessment and treatment services to adults in psychiatric distress, who otherwise might end up in an emergency department, hospital inpatient unit, or jail. Through February 15, 2019, TCSC has served over 915 patients with over 907 of those being safely and successfully diverted from an inpatient unit. The Department's Spartanburg Mental Health Center opened its crisis stabilization unit, the Eubank Center, in partnership with Spartanburg Regional Hospital System, MHA, Spartanburg County, and the United Way, in October 2018. This unit is open from 1pm through 9 pm, Monday through Friday. Through February 15, 2019, the unit has served over 50 patients and has safely and successfully diverted 24 of those individuals from an inpatient unit. Several other mental health centers are working with community partners to plan additional crisis stabilization units around the state. The Anderson Oconee Pickens Mental Health Center and the Greenville Mental Health Center are fairly close to identifying an actual location and solid funding partners for their crisis stabilization units.

- **What are the methods by which the agency received public or patient feedback about inpatient services?**

  The agency at large has periodically obtained feedback by means of community forums hosted by the State Director held at each inpatient facility and mental health center, with invitations sent to local and State officials as well as being open to the general public.

  The Department's hospitals and nursing homes additionally receive feedback in several ways, including Patient and Family Satisfaction Surveys, Visitor Surveys, as well as via regular interactions with a variety of stakeholders, including probate judges, law enforcement, community mental health centers, private and community hospitals, substance abuse treatment facilities, mental health advocacy groups, and other state agencies (Department of Social Services, Department of Disabilities and Special Needs, etc).

  SCDMH hospitals and nursing homes are licensed and accredited, and consequently regularly the subject of external surveys by DHEC health licensing, DHEC certification, the Joint Commission and CARF. In the case of the Department's State Veteran Nursing Homes, the VA also conducts periodic surveys.

  The Department also has a robust patient advocacy system to both solicit and respond to complaints by patients or their families. Section 44-22-220 *S.C. Code of Laws*

  SCDMH Patient Advocacy maintains a database to capture all complaints in the Advocacy system. The data base categorizes complaints by date, patient and staff names, facility name, and type of complaint, with space for a short narrative. The database enables SCDMH to perform searches and run trend analyses. Reports are distributed each month to the Division of Inpatient Services (Quality Assurance, risk management, and facility directors). A redacted database is also provided monthly to an external advocacy organization, Protection and Advocacy for Persons with Disabilities, Inc. In addition, a monthly summary report is provided to the Mental Health Commission and agency leadership.

  The data is also available and used by advocacy, legal, leadership, quality assurance, and risk management to analyze trends by center, facility, or to research complaint history by individual patients and/or staff. The data is also available, when needed, in decision making by the SCDMH centralized credentialing committee.

  Finally, there are external advocacy organizations that regularly and routinely visit patients and residents of the agency's inpatient facilities, and will provide feedback, recommendations or critiques concerning inpatient services to management. The two primary external advocacy organizations are Protection and Advocacy for Persons with Disabilities, Inc., mentioned above, which regularly has staff attorneys present in all SCDMH hospitals, and the State's Long Term Care Ombudsman's staff, who regularly visit SCDMH nursing care facilities.

Inpatient Services Human Resources

- **How did the agency correlate the staffing pilot with reduced turnover and increased employee morale?**

  The Lodge F staffing pilot increased the utilization of 24/7 non-nursing clinical staff and increased available active treatment hours for patients, especially on the weekends. Human Recourses distributed anonymous pre-pilot evaluation surveys. Additional surveys were given to staff and patients at days 30 and 90 of the pilot. Positive feedback was received from the 30 day evaluations. This feedback described improved morale on the unit as well as increased active treatment and reduction of behavior incidents. Since implementation, overtime has decreased and there has been less staff turnover.

- **What are the onboarding and continuous training strategies for front line employees in inpatient services? How does the agency measure the effectiveness of these strategies?**

  The Evaluation, Training and Research (ETR) department, in the SCDMH Division of Medical Affairs, provides orientation and job-related training for all new front line employees in inpatient services. This orientation includes review of relevant SCDMH and Division of Inpatient Services policies and procedures. It includes Behavior Emergency Stabilization Training (BEST), which addresses how staff are to respond to various patient behaviors posing an emergency safety situation which might occur in the inpatient facilities. All staff also receive a BEST Update from ETR annually. ETR also provides Cardio Pulmonary Resuscitation (CPR) training for all of the front line staff during orientation and annually thereafter.

  Before the front line staff begin work on their assigned units, they must be assessed by ETR and demonstrate that they are competent to perform the duties for which they were hired. In addition, they must complete and pass, with a score of 80 % or better, a number of on line training modules which include, but are not limited to, Privacy and Security, Work Place Harassment, Corporate Compliance, Infection Control and Fire Safety.

  Annually the front line staff are assessed by ETR to verify their continued competency to perform the duties outlined in their Performance Evaluation. They must take and pass a written test with a score of 80% or better and demonstrate competency in identified skills. On an annual basis they must also complete on line training modules that address the information needed for them to have the knowledge, skills and ability to continue to perform their required duties in a competent and professional manner.

  ETR also provides training for the front line staff upon request or based on identified needs.

Patient Discharge Practices

- **What is the daily cost of services for people that are being prepared to return to the community in the pilot program at G. Werber Bryan Psychiatric Hospital?**

  The preliminary daily cost of services for the pilot program that focuses on patient discharge for two lodges is $533.00 per patient per day. The estimated cost per patient per day for psychiatric/medical healthcare is $518.00. Therefore, the additional estimated cost per patient per day for the Learning Lab is $15.00. These figures are estimates for the initial year of the pilot program. **Please note**, patient participation in the pilot program is not a pre-condition to discharge of a patient who is otherwise ready for discharge.

- **Does DMH ever transfer a person to a local hospital with a psychiatric ward to provide continuing services?**

  DMH has had a few cases in the past where a patient was transferred to a local hospital with a psychiatric unit for a medical reason that required the patient to be on a med-psych floor for inpatient Electroconvulsive Therapy (ECT) treatment. The transfer of patients to a local hospital with a psychiatric unit has not occurred in the last several years.

- **How many Not Guilty by Reason of Insanity (NGRI) patients are there? How many have been admitted in the last three fiscal years?**

  There are 49 NGRI patients currently in the hospital. There are 148 NGRI patients currently in the community being monitored by the NGRI Outreach Clinic. From January 2016 to date, there have been 49 new NGRI patients admitted to the hospital.

- **What percentage of NGRI patients are returned to the community unmonitored by the Outreach Clinic? What percentage require ongoing monitoring?**

  NGRI patients are monitored by the SCDMH NGRI Outreach Clinic when discharged from the Bryan Psychiatric Hospital's Forensic component. Section 17-24-50, *SC Code Ann*. Provides as follows:

  > **SECTION 17-24-50. Length of confinement or supervision of defendant found not guilty by reason of insanity.**
  > In no case shall a defendant found not guilty by reason of insanity be confined or be under supervision longer than the maximum sentence for the crime with which he was charged without full civil commitment proceedings being held.

Unless released from supervision by an Order from the Chief Administrative Judge of General Sessions, all discharged NGRI patients remain in active monitoring by the NGRI Outreach Clinic for as long as the maximum sentence they could have received had they been convicted.

Joint Commission Accreditation Process

- **What is the cost of the Joint Commission accreditation process?**

  Annual cost of accreditation fees is $21,660.00 combined for both inpatient Psychiatric hospitals. Additional costs of $17,317.00 were incurred from surveys for overall total of $38,977.00.

- **Are there other accreditation services that might be more cost effective?**

  Other accreditation organizations were researched to determine cost associated with the accreditation services. However, specific costs were difficult to obtain due to multiple variables including the type of accreditation, number of practice settings, number of surveyors and number of days for survey.

- **How was the Joint Commission, a private non-profit organization, selected as the accrediting entity?**

  The decision pre-dates current leadership by almost 50 years. The South Carolina State Hospital sought and received full Joint Commission accreditation in 1964, making it the first State hospital in the Southeastern United States to receive Joint Commission accreditation. When the Department developed the William S. Hall Psychiatric Institute, Bryan Psychiatric Hospital and Harris Psychiatric Hospital, it sought to have them accredited by the Joint Commission as well. It has also been the case for many years that accreditation by the Joint Commission, CARF or the Council on Accreditation (COA) – has enabled hospitals, including SCDMH hospitals, to have "deemed" status for purposes of certifying that the hospital meets all Centers for Medicare and Medicaid Services (CMS [previously HCFA]) standards necessary for a hospital's participation in the State's Medicaid program.

- **Does certification by the Centers for Medicare and Medicaid Services (CMS) or the Department of Health and Environmental Control (DHEC) serve the same purpose as Joint Commission accreditation?**

  CMS and DHEC have different missions and visions than the Joint Commission. Joint Commission accreditation not only offers deemed status with CMS, but allows for improved collaboration with other Joint Commission accredited facilities that provide services to the patients we serve in our hospitals. In addition, the Joint Commission is collaborative and

educational in their survey approach and encourages facilities to excel in providing safe and effective care of the highest quality and value.

As important, the Department believes having accredited facilities is a significant benefit to the agency in recruiting and retaining professional staff. Accreditation serves as a well-recognized indicator that the facility maintains high standards of care, safety and staff governance. It also enables the hospitals to serve as clinical training sites for many affiliated college and university clinical training programs, which the Department believes also increases its ability to recruit needed clinical staff by familiarizing students about the agency's programs.

Sexually Violent Predator Treatment Program (SVPTP)

- **Since anyone qualifying for the SVPTP is in prison for a qualifying sexual offense, at what point during the person's prison sentence does the Department of Corrections begin to offer treatment options?**

  SCDMH is aware that the Department of Corrections does have treatment services for sex offenders. SCDMH is unable to speak to the extent of those services or when and how inmates are selected to receive those services.

- **Once a person is adjudicated into the program, is there a prediction made on the likelihood of the treatment reducing the person's risk to society enough for him to reenter society?**

  During SVP commitment proceedings, the person receives a sexual violence risk assessment by at least one psychologist or psychiatrist to determine if their risk to reoffend sexually is of such a degree "as to pose a menace to the health and safety of others" … "if not confined in a secure facility for long term control, care, and treatment." A jury or judge determines if the individual meets this legal threshold. There currently are no predictive tools that can specifically predict the likelihood that the person's risk will be reduced through treatment. However, once committed to the program, treatment program staff determine what treatment track is best suited for the resident's level of intellectual functioning and to some degree, treatment amenability. Each resident is evaluated annually by a SCDMH psychologist or psychiatrist to determine if they continue to be "likely" to commit acts of sexual violence and whether they continue to meet the definition of a sexually violent predator. Overall, research results show benefits of sex offender treatment in reducing sexual recidivism and newer tools are continuing to be developed to measure changes in risk over time through treatment.