

**PIEDMONT CENTER FOR MENTAL
HEALTH SERVICES**

PERFORMANCE IMPROVEMENT

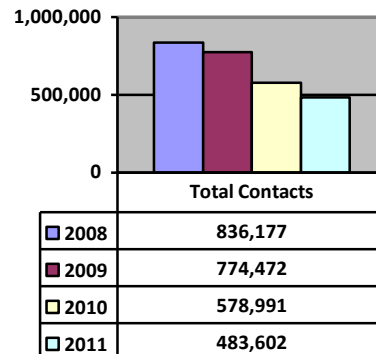
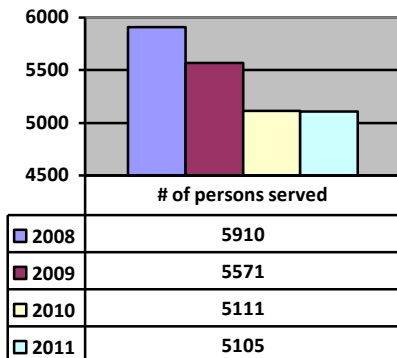
FY 2011-2012



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ANNUAL PLAN

This is the third-consecutive year that we have experienced a decline in the total number of contacts and total number of persons served.



The PCMHS has 125 full-time employees, and 8 contract employees. The number of full-time employees has increased from FY10-11. This is the result of our decision to hire additional frontline personnel to staff our residential programs. In the past we relied heavily on pool employees from temporary staffing agencies.

Serving adults and children with serious mental illness and/or emotional disturbance continues to be the top priority of the PCMHS. To serve these populations we have developed a variety of clinical programs at locations that offer easy access to services. Our service programs include:

- Community Housing
- Crisis Diversion
- Crisis Intervention
- Intensive Case Management (TLC)
- Mental Health Court
- Out Patient Treatment
- Psychosocial Rehabilitation
- Residential Treatment
- School Based Services

- Strategic Initiatives

The following Performance Improvement Plan incorporates recommended changes from FY10-11 performance outcomes to address access to care, efficiency and effectiveness. Consumer satisfaction will require the transition from a state monitored system of measuring satisfaction with services to a local initiative that will provide data that are more meaningful.

ACCESS

In prior years, we have monitored the amount of time it takes to access afterhours crisis services. After several years of meeting our goal, we decided to explore a new objective that both increases access and reduces stigma. Most of our clients enter our system of care through one of our two mental health clinics. In recent years, we have expanded our access points to include schools, and community housing programs. The FY11-12 Access objective is designed to move the organization toward community integration of behavior health services by increasing the number of persons who enter our system of care through non-clinic based programs.

BUSINESS PRACTICES

This objective, carried over from previous years, is always a challenge to the organization. As our traditional resources of revenue, (state funds and Medicaid) have diminished over the years it has become increasingly important for us monitor revenue vs. expenditures on an on-going basis in order to make mid-year adjustments as needed.

EFFICIENCY

The SCDMH Division of Performance Improvement established a statewide goal of 90% conformance to performance standards. PCMHS has consistently met that goal for several years. A review of SCDMH P/I audits reveals that PCMHS consistently scores low in many of the same areas over time. We are challenging ourselves to reach a 95% conformance to performance standards in an effort to improve in areas where we have been underperforming.

EFFECTIVENESS

This year we will have two effectiveness objectives. In previous years, our objective has been for persons served to maintain or improve functioning following an episode of care. We have found that most (52%) of our clients maintain their functioning level following an episode of care, but only 37% demonstrate improved functioning. We use the GAF score to measure functioning. In order to reduce subjectivity in assigning GAF scores, all clinical staff members are required annually to complete training on how to assign accurate and consistent GAF scores.

Because our perception of progress may be different from that of our clients, we will also ask a sample of at least 10% of former clients if the maintained gains made in treatment post-discharge.

SATISFACTION

In previous years, the SCDMH has provided us with detailed satisfaction data specific to our organization. Utilizing the Mental Health Statistics Improvement Project consumer surveys, they administered the surveys and analyzed the data annually. Due to budget cuts the SCDMH Division of Evaluation, Training and Research no longer provides this data broken down to the Center level. As a result, we will need to develop and administer our own client satisfaction survey in order to obtain data that is specific to PCMHS.

Domain	Objective	Performance Indicator	Sample	Time Frames	Extenuating Factors
Access	Increase the number of cases opened in non-clinic based programs by 5%	Baseline = 315 5% increase=331	All cases opened at locations other than the Greer and Simpsonville Clinics	Data for FY11-12 collected monthly and reported annually	None
Business Practices	To end the fiscal year with no more than a 3% variance	End of year allocation and expenditure comparison	FY11-12 Budget	Data monthly	Possible mid-year budget adjustments
Efficiency	To receive a score of 95% or above on our FY11-12 SCDMH Quality Management Audit	As scored by SCDMHQM following their annual audit.	Based on a stratified sample of open and closed medical records	Quarterly peer audits will be used to gage our progress toward this objective	None
Effectiveness	70% of consumers will report that gains made in treatment remain 90 days post-discharge	Monthly post-discharge telephone interviews	A sample of at least 10% of all discharged consumers	Post-discharge data collected monthly	Difficulty in locating/contacting clients post-discharge

Effectiveness	50% of persons served will demonstrate improvement in overall functioning following an episode of care	GAF scores assigned at admission, every 90 days while in treatment and at discharge	All clients discharged during FY11-12	Data provided quarterly by the SCDMH Division of Evaluation, Training and Research.	None
Consumer Satisfaction	80% of persons served will report satisfaction with services received	Annual center wide consumer satisfaction survey	All current clients willing to participate in the survey during a designated period of time	Consumer satisfaction survey competed annually at each location/program	None