

**AN ANALYSIS OF AN  
EMPLOYEE TIME AND  
MOTION  
QUESTIONNAIRE**

**FINDINGS**

**Time and Motion Subcommittee  
Of Cumberland County Mental Health  
Center**

**October 2002**

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## **DATA COLLECTION INSTRUMENT**

## SECTION I

### *Introduction*

The Time and Motion Subcommittee of Cumberland County Mental Health was initially established on 8 May 01 as directed by the Center's Clinical Redesign Committee (see appendix A). The specific mission rendered was to review operational procedures and identify functional impediments. The primary basis for this request evolved from the perceived need for an independent review of the Center's "systems" and its efficacy in meeting the myriad of demands placed on the area authority from both a clinical delivery and an administrative operations perspective. From the mission statement, the Time and Motion Subcommittee outlined a three-pronged approach in this evaluative process which consisted of an employee questionnaire, a static records review, and a time efficiency monitoring process. This study specifically analyzes the data obtained from the employee questionnaire administered to all agency personnel during the time frame of September to October 2001. This questionnaire was deemed by the Time and Motion Subcommittee as an efficient means to gauge employee sentiment concerning clinical and operational issues and obtain critical feedback concerning their perceptions about "what worked" and "what didn't" as a starting point while the Area Authority evolves to meet the changing nature of human service delivery in the State of North Carolina.

### *Significance of the Study*

The Mental Health System Reform Act mandates the Local Management Entity (LME) to develop high quality, accessible, and cost-effective services. Emphasis is placed on the concept of "best practices" which is interpreted to include clinical services, administrative structures, operations, and fiscal management. To meet the State Plan guidelines, active collection and analysis of data is required. This mandate includes those services provided through contract providers. In essence, system quality improvements must be broadly based and begins in-house. Even report cards are to be issued as a tool to manage the service delivery process.

### *Theoretical Framework*

The "community mental health movement" of the mid-20<sup>th</sup> century evolved from the empirical findings that long-term institutionalization had numerous unintended negative effects and, at best, provided humane custodial care. Also occurring during this period was the development of new treatments, especially medications to treat depression and psychosis. Federal funding of the mid-60's brought further development of the roles of the community mental health centers, focusing on community care and policies of deinstitutionalization. With the end of the 20<sup>th</sup> century, privatization and public/private sector collaboration have been the driving dynamics resulting in major changes in mental health delivery systems, largely pushed by fiscal constraints and increasing availability/competition from private vendors.

In North Carolina, the local mental health authorities are in a transition phase from a role of primary provider to that of a coordinator and manager of care with limited service provision. The implication of this change is that the local area authorities must develop the organizational flexibility associated with the private sector and must meet higher standards of clinical care -- a daunting task for a public bureaucracy to accomplish given budgetary restraints, a client population deemed difficult to serve, and an inability to successfully compete with the private sector for quality personnel.

### ***Major Divisions of the Study***

This evaluation is divided into three sections. Section I was introduced on the previous page. Section II outlines the methodology and procedures that were employed in carrying out this study. Section III presents an analysis of findings. Appendices of all relevant documents are also provided.

## **SECTION II**

### ***Methodology***

The purpose of this section is to discuss the methodology and procedures employed in conducting this analysis. The guiding questions, research design, sampling method, data collection, and the limitations of the analysis are discussed.

### ***Guiding Questions***

The following questions provided the framework for the study:

1. What are the operational experiences of the Center's staff as measured by the Time and Motion questionnaire?
2. Are there quantitative differences in those experiences as factored by position, duty area, education, and experience?

### ***Research Design***

The study's population consisted of the personnel employed through Cumberland County Mental Health Center utilizing an ex post facto research design (i.e., A Time and Motion Questionnaire). This design designates the researcher's focus only on one group, which serves as its own control, thus, no other comparisons are made with any other group. This design allows for the committee to analyze through the participant's experience the operational efficiency of CCMHC's clinical delivery system and its direct administrative mechanisms as specified in the 14 domains reviewed. The study's focus was cross sectional allowing for all personnel from the four disability areas as well as

administrative and support staff of the Center to report their experiences. The study's design did allow for limited variable analysis such as educational attainment, nature of duties, and experience.

### ***Sampling Method***

The technique of purposeful sampling was used in this study. Based on the sampling method, all employees of CCMHC being the target population, representativeness was not an issue. A detailed description of the employee sample is presented in the analysis section.

### ***Instruments and Data Collection***

One instrument was constructed for the purpose of data collection, titled "A Time and Motion Questionnaire" (see appendix B). The questionnaire consisted of 14 segments designed to obtain demographic data as well as data concerning Center employee input about their perceptions of the agency's strengths and weaknesses across a broad range of clinical services and administrative support functions. The finalized questionnaire evolved over an 8-week period of time as the tool was refined and pre-tested. The first "hard copy" instrument was completed by July 2001 and administered on a limited basis to Center personnel to help clarify its utility in obtaining the type of data desired. This instrument consisted of 17 segments. A secondary agenda was to canvas what agency personnel considered being important issues and if further inquiry was needed. The questionnaires were reviewed and data was tabulated (see appendix C). Preliminary findings from the instrument were perceived favorably concerning the issue of sensitivity; however, the raw data appeared more descriptive than quantitative in nature, which resulted in the changes leading to the final product previously mentioned. The finalized questionnaire was administered to agency staff, who could be accessed and were willing to participate. Of the agency's 389 work force the questionnaire was obtained from 180 (N=180). Not all questions were answered by the study's population resulting in further adjustments per domain. Additionally, weaknesses were noted in the data collection instrument itself, which allowed for multiple data fields to be endorsed per question. The questionnaires were given tracking numbers but designated by program only versus an individual basis to insure worker confidence with the issue of confidentiality. Additionally, all questionnaires were issued, directions provided by, and completed questionnaires secured by committee members.

### ***Study Limitations***

The most obvious limitation of “descriptive research” is that the emphasis is on describing what is occurring rather than any attempt to judge or interpret what is occurring. Additionally, there is no control group or other relevant population (i.e., personnel of another mental health authority) to compare the data. The benefit of descriptive research as it pertains to this questionnaire is its ability to validate/refine existing perceptions, which can then be more thoroughly investigated.

### SECTION III

#### *Analysis of Findings*

The findings of the study are presented in this section. Data on the demographic profile of the work force who completed the questionnaire is first presented. In the remainder of the section, data on each domain question is presented and analyzed in relationship to each guiding question.

#### *Demographic Data*

As previously noted, the sample comprised of 180 individuals. Several respondents dually identified themselves (i.e., Children’s/Access, Clinical/Administrative) or elected not to complete the data field (i.e., Education). Table I provides a specific breakdown by duty area, position, years of employment, previous mental health experience and educational attainment. Of the Center’s work force, the largest respondent group in this study is broadly defined as Administrative (i.e., Personnel, Finance, Data) with the smallest response occurring from Roxie Avenue. Employees involved in clinical service delivery constitute the largest category based on position data with the fewest in Medical Records. The work force profile indicates approximately 40 % of the work force has been employed through CCMHC in excess of six years. Less than 13 % of the work force has been employed through the Center less than one year. The majority of Center employees have worked in other mental health settings prior to employment with CCMHC, and the mean educational attainment for Center employees is a Bachelor’s degree.

<b>TABLE I DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>DUTY AREA</b>	
1. CHILD AND YOUTH	28

2. ADULT SERVICES	26
3. DEVELOPMENTAL DISABILITIES	12
4. FAMILY RECOVERY	23
5. RESIDENTIAL SERVICES	19
6. ROXIE AVENUE	9
7. ADMINISTRATION	65
<b>POSITION DATA</b>	
1. CLINICAL SERVICES	73
2. DATA SERVICES	13
3. MEDICAL RECORDS	10
4. CLERICAL	31
5. OTHER	57
<b>YEARS OF EMPLOYMENT</b>	
1. LESS THAN ONE YEAR	24
2. 1 TO 2 YEARS	40
3. 3 TO 5 YEARS	47
4. OVER 6 YEARS	73
<b>PREVIOUS MENTAL HEALTH EXPERIENCE</b>	
1. YES	101
2. NO	83
<b>EDUCATION</b>	
1. HIGH SCHOOL EDUCATION OR LESS	54
2. ASSOCIATE DEGREE	22
3. BACHELOR'S DEGREE	68
4. MASTER'S DEGREE	31
5. BEYOND MASTER'S DEGREE	4

### *Experiential Data*

#### Findings Related to the Guiding Questions Are Analyzed

As noted in Table II, “accessing medical charts,” 123 employees who responded indicated that accessing medical charts is a duty requirement and 28 employees reported that it is not a requirement of their job. Sixty five percent of the work force responding indicated some degree of difficulty in assessing medical records. In regard to range, staff complaints are highest at Roxie Avenue (100%), with no complaints occurring in Administration (i.e., Finance, Managed Care, and HR). For other programs, the data is as follows: Children’s Services (75%), Family Recovery, (67%), Adult Services (63%), HIM/Access (49%), Residential Services (33%), and Developmental Disabilities (18%). Across all programs or service areas, the most common factor identified is difficulty in locating charts. Severity of this concern is rated “moderate” based upon a total Center profile.

<p><b>TABLE II</b> <b>ACCESSING MEDICAL RECORDS</b></p>
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<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>ACCESSING MEDICAL RECORDS</b>	
1. REQUIRED	123
2. NOT REQUIRED	28
<b>HAS EXPERIENCED DIFFICULTY</b>	
1. YES	72
2. NO	57
<b>CATEGORIZATION OF THE PROBLEM</b>	
1. SLOW RESPONSE TIME	23
2. DIFFICULTY LOCATING	50
3. POOR COOPERATION	18
4. PROGRAM RULES	8
5. OTHER*	14
<b>SEVERITY OF PROBLEM</b>	
1. MINOR	26
2. MODERATE	35
3. SEVERE	17

- (refer to appendices)

As noted in TABLE III, “closure of medical records,” 148 employees responded to this question. Approximately 46 percent of the respondents report closure of records is a duty requirement. Surprisingly, 37 staff members required to close records indicated having no awareness of the effective average time frame to close a chart although this may have significance in itself. Employee recommendations/comments are however quite interesting. The issue of impact, however, did elicit a strong staff response with the majority of employees endorsing more than one data field. Forty eight percent of the staff perceives the severity of this issue as “moderate.” This concern appears to be most keenly experienced in Family Recovery and Access/HIM with 75% and 56% of respondents respectively describing the impact as “severe.”

<b>TABLE III CLOSURE OF MEDICAL RECORDS</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>CLOSING OF MEDICAL CHARTS</b>	
1. REQUIRED	69
2. NOT REQUIRED	79
<b>TIME FRAMES</b>	
1. ONE WEEK OR LESS	4
2. 2 TO 3 WEEKS	10
3. 1 MONTH OR MORE	28
4. UNKNOWN	38

<b>IMPACT</b>	
1. WASTED TIME	25
2. BILLING ERRORS	18
3. EXTRA PAPERWORK	39
4. UNKNOWN	23
<b>SEVERITY</b>	
1. MILD	23
2. MODERATE	34
3. SEVERE	14

- (refer to appendices)

As noted in Table IV, “accessing screening form,” 142 employees responded to this question. Obviously not all data fields were completed. The overwhelming majority of the staff indicates accessing screening forms is a duty requirement, however this is not perceived as a significant problem. When problems have arisen, the greatest complaint is of locating the form. There was no attempt to categorize the issue of severity.

<b>TABLE IV ACCESSING SCREENING FORMS</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>REQUIREMENT OF JOB?</b>	
1. IS A FUNCTIONAL REQUIREMENT	84
2. IS NOT A FUNCTIONAL REQUIREMENT	58
<b>HAS EXPERIENCED DIFFICULTY</b>	
1. YES	34
2. NO	56
<b>CATEGORIZATION OF PROBLEM</b>	
1. DIFFICULTY LOCATING	27
2. POOR COOPERATION	4
3. UNCLEAR ROUTING	16
4. PROGRAM RULES	4
5. OTHER*	3

(\* Refer to appendices)

As noted in Table V, “computerized schedules,” approximately one third of the staff customarily receive a daily-computerized client schedule (i.e., clinical/medical staff). Significantly, forty six percent of the work force indicate their duties require access to the schedule of others (i.e., supervisory/administrative). The two most common needs for

this information involve the scheduling of clients and the locating of staff members. Overall, however, this is not an issue of great significance regardless of program.

<b>TABLE V COMPUTERIZED SCHEDULE</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>RECEIVE COMPUTERIZED SCHEDULE</b> 1. DOES RECEIVE PRINTOUT 2. DOES NOT RECEIVE PRINTOUT	 47 100
<b>DUTIES REQUIRE ACCESS TO OTHER'S SCHEDULES</b> 1. IS REQUIRED 2. IS NOT REQUIRED	 38 44
<b>CATEGORIZE THE NEED FOR OTHER'S SCHEDULES</b> 1. LOCATE STAFF 2. SCHEDULING OF CLINICAL MEETINGS 3. SCHEDULING OF ADMINISTRATIVE MEETINGS 4. SCHEDULING OF CLIENTS 5. OTHER*	 21 7 6 23 13
<b>TYPE OF DIFFICULTIES EXPERIENCED</b> 1. SLOW RESPONSE 2. NO RESPONSE 3. INCOMPLETE SCHEDULES 4. LACK OF UPDATES 5. OTHER*	 5 5 9 10 9
<b>SEVERITY OF PROBLEM</b> 1. MINOR 2. MODERATE 3. SEVERE	 22 6 5
<b>IMPACT ON POSITION</b> 1. WASTED TIME 2. INCORRECT INFORMATION 3. OTHER*	 18 10 9

- (refer to appendices)

As noted in Table VI, "locating a therapist to conduct a screening," this question is primarily directed to select administrative and supervisory staff who interface between clients and service providers. Thirty-six staff members indicated locating a therapist to conduct a screening is a duty requirement. More than half of the staff indicated that it requires more than 10 minutes to simply locate a therapist to fulfill this function. The actual sample data is very small which may skew the information. However, from a

program specific perceive the data is as follows (i.e., 10 minutes or more): Developmental Disabilities (100%), Roxie Avenue (100%), Access/HIM (75%), Residential Services (50%), Family Recovery (50%), Adult Services (33%), and Children's (30%). In regard to "categorization," non-availability of the clinician is the overwhelmingly identified problem. The issue of "poor cooperation" may be the more insidious concern since staff members are expected to be productive at all times which may reduce availability, but the lack of perceived professionalism is hard to justify. For most programs, screenings (either by phone/person) generally occur on a non-scheduled basis.

<b>TABLE VI LOCATING THERAPIST TO CONDUCT SCREENING</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>DUTES REQUIRE YOU TO LOCATE THERAPIST FOR SCREENING</b>	
1. REQUIRED	36
2. NOT REQUIRED	125
<b>TIME REQUIRED TO IDENTIFY A THERAPIST</b>	
1. 5 MINUTES OR LESS	14
2. 10 TO 15 MINUTES	10
3. MORE THAN 15 MINUTES	8
<b>CATEGORIZATION OF PROBLEM</b>	
1. POOR COOPERATION	8
2. NONAVAILABILITY OF CLINICIAN	18
3. OTHER*	3

- refer to appendices

As noted in Table VII, "locating a therapist to conduct an intake," 28 staff members indicate this is a duty requirement. Excluding emergencies, intakes are generally scheduled events with specified clinical staff assigned. The issue of "poor cooperation" is reduced by 50% although ironically the issue of non-availability of the clinician increases by 25% based upon comparison of Table VI and VII. For other details, refer to the table below.

<b>TABLE VII LOCATING THERAPIST TO CONDUCT INTAKE</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>LOCATING A THERAPIST TO CONDUCT INTAKE</b>	
1. REQUIRED	28
2. NOT REQUIRED	128
<b>TIME NEEDED TO IDENTIFY A THERAPIST</b>	
1. 5 MINUTES OR LESS	7
2. 10 TO 15 MINUTES	16

3. MORE THAN 15 MINUTES	9
<b>CATEGORIZATION OF THE PROBLEM</b>	
1. POOR COOPERATION	4
2. NON AVAILABILITY OF CLINICIAN	24
3. OTHER*	4
<b>SEVERITY IF THE PROBLEM</b>	
1. MINOR	13
2. MODERATE	11
3. MAJOR	3

- refer to appendices

As noted in Table VIII, “assessing psychiatric/medical services,” a significant minority of Center employees responding to the questionnaire indicated a need to access Psychiatric Services as part of their duty requirements. The perceived average waiting period is in excess of one month or longer. Of the clinical service delivery areas only Residential Services and Roxie Avenue report an average window of 30 days or less (it is noted that clients within either program are established by entry). The waiting period appears to be most acutely experienced in Adult Services and Family Recovery. Staffing shortages are perceived as the primary causative factor, although scheduling practices are also statistically significant. The recommendations/comments appendices should be reviewed concerning this item. The respondents perceive poor client compliance to be positively correlated with the lack of psychiatric access.

<b>TABLE VIII ACCESSING PSYCHIATRIC SERVICES</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>ACCESSING PSYCHIATRIC SERVICES</b>	
1. REQUIRED	69
2. NOT REQUIRED	86
<b>WAITING PERIOD</b>	
1. ONE WEEK OR LESS	8
2. 2 TO 4 WEEKS	15
3. 1 MONTH OR MORE	20
4. 2 MONTHS OR MORE	17
<b>WAITING TIME A PROBLEM FOR CLIENTS?</b>	
1. NO	21
2. YES	42
<b>PERCEIVED CAUSE</b>	
1. SCHEDULING PRACTICES	22
2. UTILIZATION RATE	6
3. STAFF SHORTAGES	35
4. OTHER*	8
<b>IMPACT ON CLIENT CARE</b>	

1. NO IMPACT NOTED	2
2. LOSS OF REVENUE	21
3. POOR CLIENT COMPLIANCE	30
4. OTHER*	19

\* refer to appendices

As noted in Table IX, “Accessing Psychological Services,” approximately one third of the staff responding to the questionnaire indicated accessing Psychological Services for their clients is a duty requirement. One month or longer is the average perceived waiting period for this service. The long duration appears to be most acutely experienced in Children’s Services and Family Recovery. Clients appear to be equally divided concerning this issue although once again this appears to be most acutely experienced within the Children’s Services at a 3 to 2 ratio. The lack of available staff is the overwhelmingly identified causative factor.

<b>TABLE IX ACCESSING PSYCHOLOGICAL SERVICES</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>IS ACCESSING PSYCHOLOGICAL SERVICE REQUIRED</b>	
1. REQUIRED	58
2. NOT REQUIRED	103
<b>WAITING PERIOD</b>	
1. ONE WEEK OR LESS	27
2. 2 TO 4 WEEKS	19
3. 1 MONTH OR MORE	21
4. 2 MONTHS OR MORE	8
<b>INITIAL WAITING TIME A PROBLEM FOR CLIENTS</b>	
1. YES	27
2. NO	27
<b>PERCEPTION OF PROBLEM</b>	
1. SCHEDULING PRACTICES	7
2. UTILIZATION RATES	2
3. STAFFING SHORTAGES	28
4. OTHER*	3
<b>IMPACT ON CARE</b>	
1. NO IMPACT NOTED	4
2. FAILURE TO COMPLY WITH COURT ORDERS	8
3. TREATMENT/DIAGNOSTIC QUESTIONS UNANSWERED	28
4. OTHER*	3

\* Refer to appendices

As noted in Table X, “Accessing Residential Services,” 52 staff members responding to the questionnaire indicated that in the delivery of their duties they are required to access residential services as a component in client care. The expectation of accessing a residential “bed” for a client is two weeks or more. The respondents indicate this is a problem for a majority of their clients. This concern appears to exist across all disability areas. The primary causative factor is perceived to be an inadequate number of facilities to access. It is unclear if respondents are referring to a limited number of facilities operated by CCMHC and/or private facilities easily assessable by CCMHC personnel. Staff concerns about this “impact” appear relatively intertwined.

<b>TABLE X RESIDENTIAL SERVICES</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>ACCESSING RESIDENTIAL SERVICES</b>	
1. REQUIRED	52
2. NOT REQUIRED	74
<b>WAITING PERIOD</b>	
1. WITHIN ONE DAY	0
2. 2 TO 6 DAYS	12
3. 1 WEEK OR MORE	6
4. 2 WEEKS OR MORE	29
<b>WAITING TIME FOR CLIENTS A PROBLEM?</b>	
1. YES	29
2. NO	21
<b>PERCEPTION OF PROBLEM</b>	
1. ADMISSION PRACTICES	8
2. UTILIZATION RATES	0
3. INADEQUATE NUMBER OF FACILITIES	28
4. OTHER*	3
<b>IMPACT ON CLIENT CARE</b>	
1. NO IMPACT	5
2. AGENCY/STAFF LIABILITY	8
3. STANDARDS OF CARE UNMET	18
4. POOR CLIENT COMPLIANCE WITH TREATMENT	12
5. OTHER*	2

As noted in Table XI, “Accessing Other Specialized Programs or Services,” this question was intentionally broad based. Specifically mentioned were sex offender, parenting evaluations, child custody evaluations, PSR, CBI, and CAP/MR. A total of 49 staff members indicated a need to provide or arrange for the services listed below. A small number of responses were also obtained from Center employees concerning such services such as occupational therapy, physical therapy, speech therapy, interpreter services and vocational rehabilitation which are not generally provided by Center employees. Given the extremely small sample (N=4), inclusion within the Table below did not occur.

TABLE XI OTHER SPECIALIZED PROGRAMS OR SERVICES	
CHARACTERISTICS	NUMBER
<b>ACCESSING SPECIALIZED SERVICES (<i>aggregate presentation</i>)</b>	
1. REQUIRED	49
2. NOT REQUIRED	106
<b>BY PROGRAM OR SERVICE</b>	
1. SEX OFFENDER	14
2. PARENTING EVALUATION	10
3. CHILD CUSTODY	2
4. PSR	12
5. CBI	18
6. CAP/MR	13

	1 WEEK OR LESS	2 TO 4 WEEKS	1 TO 2 MONTHS	2+ MONTHS
1. SEX OFFENDER	4	4	0	4
2. PARENTING EVAL	1	5	0	4
3. CHILD CUSTODY	0	1	0	1
4. PSR	1	5	4	2
5. CBI	8	4	3	3
6. CAP/MR	0	3	1	9

<b>WAITING TIME A PROBLEM FOR CLIENTS?</b>	
1. YES	31
2. NO	13
<b>PERCEPTION OF PROBLEM (<i>in aggregate data</i>)</b>	
1. STAFFING SHORTAGES	21
2. HIGH DEMAND	16
3. LACK OF TRAINING/EXPERTISE	7
4. ORGANIZATIONS ISSUES	16
5. OTHER*	8
<b>IMPACT ON CLIENT CARE</b>	
1. NO IMPACT	2
2. FAILURE TO COMPLY WITH COURT ORDERS	4
3. STANDARDS OF CARE UNMET	28
4. POOR CLIENT OUTCOMES	22
5. OTHER*	2

As noted in TABLE XII, “Accessing Generalists,” 88 staff members indicate a need to access the “Generalists” for client care purposes. Of those individuals, 28% indicate they or their clients have experienced “significant” problems. This issue appears to be most concentrated within Adult Services with 12 of 21 persons: (57%) responding to this question with said response. Ironically, even the “administrative” staff (i.e., Finance, Managed Care) indicated that they have experienced “significant” difficulty with this service. The shortage of staff is the primary identified concern. Based upon those persons responding, this issue is considered to be of a “moderate” concern with the greatest impact consisting of “wasted time.”

<b>TABLE XII ACCESSING GENERALISTS</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>ACCESSING GENERALISTS</b>	
1. REQUIRED	88
2. NOT REQUIRED	68
<b>EXPERIENCED SIGNIFICANT DIFFICULTY ACCESSING?</b>	28
1. YES	58
2. NO	
<b>PERCEIVED CAUSE</b>	
1. SHORTAGE OF STAFF	20
2. LONG WAITING TIMES	6
3. NO LUNCH TIME COVERAGE	7
4. OTHER*	18
<b>SEVERITY OF PROBLEM</b>	
1. MINOR	12
2. MODERATE	20
3. SEVERE	7
<b>IMPACT ON CLIENT CARE</b>	
1. NO IMPACT NOTED	6
2. WASTED TIME	23
3. LOSS OF REVENUE	14
4. OTHER*	8

\* See attached appendices

As noted in TABLE XIII, “Accessing Support Services,” 82 staff members report an active need to access support staff. Thirty-five staff members report experiencing “significant” difficulties in doing so. Causation appears reasonably broad based although the primary causation is attributed to the agency’s organizational structure. Responses suggest this is a “moderate” concern with “wasted time” and “lack of professionalism” roughly equal as the impact of such. Unfortunately, the issue of “professionalism” returns rather dramatically.

<b>TABLE XIII SUPPORT SERVICES</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>ACCESSING SUPPORT SERVICES</b>	
1. REQUIRED	82
2. NOT REQUIRED	70
<b>EXPERIENCED SIGNIFICANT DIFFICULTY</b>	
1. YES	35
2. NO	47
<b>PERCEIVED CAUSE</b>	
1. ORGANIZATION STRUCTURE	23
2. SYSTEMS COMPLEXITY	21
3. NO TEAM WORK	18
4. POOR COMMUNICATION OF PROCEDURAL CHANGES	15
5. OTHER*	11
<b>SEVERITY OF PROBLEM</b>	
1. MINOR	5
2. MODERATE	18
3. SEVERE	12
<b>IMPACT ON CLIENT CARE</b>	
1. NO IMPACT NOTED	1
2. WASTED TIME	26
3. LACK OF PROFESSIONALISM	22
4. OTHER*	7

\* SEE attached appendices

As noted in TABLE XIV, “Barriers Impacting Duty Performance,” 66 employees positively indicate they believe “systems” barriers, negatively impact their capacity to perform their job. The data from the questionnaire suggests this belief is widely shared across all duty areas. Causation is also perceived to be broad based. For other details refer to the Table.

<b>TABLE XIV BARRIERS IMPACTING DUTY PERFORMANCE</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>ARE THERE BARRIERS IMPACTING DUTY PERFORMANCE</b>	
1. YES	66
2. NO	88
<b>CATEGORIZATION OF THE BARRIERS</b>	
1. ENVIRONMENTAL	16
2. PROCEDURAL	43
3. PERSONNEL	46
4. ORGANIZATIONAL	38
5. LACK OF TRAINING	33

6. OTHER*	25
<b>WITH WHOM DISCUSSED</b>	
1. NO ONE	2
2. CO-WORKERS	54
3. SUPERVISOR	76
4. PRGORAM DIRECTOR	27
5. DEPARTMENT HEAD	17
6. OTHER*	7

\* SEE attached appendices

As noted in Table XV, “receiving Telephone Calls,” the overwhelming majority of the staff that report receiving incoming telephone calls indicate that this is a normative part of their duty. Seventy percent of the staff report receiving misdirected phone calls with the majority of the staff indicating this is a daily occurrence. Regardless of frequency, this does not appear to be a significant concern for most of the staff.

<b>TABLE XV RECEIVING TELEPHONE CALLS</b>	
<b>CHARACTERISTICS</b>	<b>NUMBER</b>
<b>DUTY REQUIREMENT</b>	
1. REQUIRED	135
2. NOT REQUIRED	25
<b>RECEIVE MISDIRECTED CALLS?</b>	
1. YES	106
2. NO	41
<b>FREQUENCY OF THIS PROBLEM</b>	
1. LESS THAN ONCE A WEEK	32
2. ONE TIME A DAY	39
3. ONE TIME A WEEK	25
4. SEVERAL TIMES A WEEK	29
<b>SEVERITY OF THIS PROBLEM</b>	
1. MINOR	78
2. MODERATE	22
3. SEVERE	4

### ***Initial Conclusions and Recommendations***

The information presented in the above Tables primarily reflects an analysis of “aggregate” data with very limited discussion from a program specific perspective. As this data is intended to be an initial presentation, further analysis is possible having a greater focus on multiple variables, which the data collection instrument allows. The reader should also be aware the questionnaire was intended to have a broad focus looking at various operational and clinical perceptions. Based upon a review of the data obtained

from the questionnaire to specifically include individual recommendations and comments, the following themes are extracted:

- (1) Center employees perceive CCMHC as a large and complex program providing a vast array of services to the community.
- (2) Employees recurrently identify multiple tension points in the performance of their duties.
- (3) The etiology of the tension points appears to have multiple causes.
- (4) Although there some “biting” comments from some individuals, employee frustrations generally convey a positive trend, a belief that clients should receive a high quality of clinical care and that all staff members should conduct themselves professionally.
- (5) Some employees perceive the Center as being highly compartmentalized. Even duty areas within a specific disability area may be perceived as lacking integration.
- (6) Service delivery appears to significantly degrade when specific services are needed which involve greater clinical ability or reflect more complex needs.
- (7) The issue of employee competency, employee selection processes, and adequacy of training were questioned by some.

### ***Practice Implications***

The reader should be aware that this type of questionnaire is intended to solicit critical feedback from respondents (which it did). Additionally, the time frame from the administration of the questionnaire to the preliminary analysis has been approximately one year and numerous changes within CCMHC have occurred (validating employee frustrations) with many more changes pending in the immediate future. A small sample of individual interviews would be recommended to update any significant change in a “mindset” and/or clarify issues raised. From the data provided the implications are listed below:

- (1) The organization structure should be reviewed with emphasis on creation of a more unified “command.” This action would have the potential to reduce the frequency of reported systems friction and mutual finger pointing.
- (2) As accountability standards steadily increase, employees’ (especially the “Professional Staff”) must be capable of successfully completing the mission at entry. Recruitment standards should be reviewed and/or upgraded as needed.
- (3) The active employment of technology has substantially shown the capacity to reduce the volume of paperwork, and better track client flow (this also results in a reduced need for personnel). Electronic records and centralized scheduling has become the norm for an increasing number of medical/mental health practices with positive results reducing costs in providing care and increasing revenue generation.

