South Carolina

UNIFORM APPLICATION
FY 2023 Mental Health Block Grant Report

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 03/31/2022 - Expires 03/31/2025
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Center for Mental Health Services
Division of State and Community Systems Development

A. State Information

State Information

State DUNS Number

Number	043980093
Expiration Date	1/27/2023 12:00:00 AM

I. State Agency to be the Grantee for the Block Grant

Agency Name	South Carolina Department of Mental Health
Organizational Unit	Office of the State Director
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II. Contact Person for the Grantee of the Block Grant

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III. State Expenditure Period (Most recent State exependiture period that is closed out)

From	7/1/2021
To	6/30/2022

IV. Date Submitted

NOTE: This field will be automatically populated when the application is submitted.

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V. Contact Person Responsible for Report Submission

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Footnotes:

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B. Implementation Report

MHBG Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1

Priority Area: Accountability Report Baseline Performance Measures

Priority Type: MHS

Population(s): SMI, SED, Other

Goal of the priority area:

The goal of the priority area is to maximize the effective use of the resources of the Department in order to achieve the outcomes reflected in the Accountability Report Baseline Performance Measures (Measure) as each Measure represents a key area of focus for the Department and correlates closely with the Department's Strategic Planning initiatives.

Objective:

The intent is to measure the activities and achievements of the Department and compare said measurements to internal and external benchmarks, as available and appropriate, established over time.

Strategies to attain the goal:

Given the comprehensiveness of the measurement tools, changes in results from one year to the next generally are a reasonable determinant of the effectiveness of the mental health continuum - understanding that South Carolina has an integrated system of care over which SCDMH has significant influence and control since it is the primary service provider for inpatient and community services.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of under 18 year-old population in SC served by DMH will be within 0.1% of previous year's percentage.

Baseline Measurement: Percent of Under 18 Year Old Population Served - Baseline = 2.13%

First-year target/outcome measurement: 2.13%

Second-year target/outcome measurement: 2.13%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using current FY patient count and US Census estimate of previous year (most recent) - Central Office Internet Technology (IT)

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - equal to or greater than; Calculation Method = Under 18 population of SC served by DMH / total population of SC under 18

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Services will be available to people in need.; Notes - As population of SC increases, it is expected that more people will receive services but the percentage of population should be consistent.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 3.00%

Indicator #: 2

Indicator: Percentage of adult population in SC served by DMH will be within 0.1% of previous year's percentage.

Baseline Measurement: Percent of Adult Population Served - Baseline = 1.43%

First-year target/outcome measurement: 1.43%

Second-year target/outcome measurement: 1.43%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using current FY patient count and US Census estimate of previous year (most recent) - Central Office IT

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - equal to or greater than; Calculation Method = Percentage of adult population in SC served by DMH / total adult population of SC

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Services will be available to people in need.; Notes - Serves as an indicator that people needing services can receive them.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 2.00%

Indicator #: 3

Indicator: Number of inpatient "bed days" used will be equal to or greater than running average of previous five fiscal years.

Baseline Measurement: Number of Inpatient Bed Days - Baseline = 540,805

First-year target/outcome measurement: 523,643

Second-year target/outcome measurement: 523,643

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Central Office IT

New Data Source*(if needed)*:

Description of Data:

Value Type = Count - equal to or greater than; Calculation Method = Number of new patients admitted to inpatient forensic setting

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Services will be available to people in need.; Notes - Increase indicates SCDMH working to meet the need of local agencies.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Difficulty recruiting and retaining registered Nurses, Master's level Clinicians and Behavioral Health Assistants in inpatient facilities & CMHC & "During the height of the pandemic, infected patients were isolated from infected individuals. Staff serving either group did not have contact with either the other patients or the staff serving that population. This resulted in limiting the number of beds available and reduced the overall number of "bed days" at each site."

The agency is constantly working on recruitment and retention efforts. As the effects of COVID-19 lessened, these restrictions were lifted.

How first year target was achieved *(optional)*:

FY2022 Result: 378,847

Indicator #: 4

Indicator: Patients requiring CMHC appointments will be seen in a timely manner according to protocol (priority, urgent, or routine). Target is average of previous five years.

Baseline Measurement: Percent of Appointments Meeting Timeliness Expectations - Baseline = 95%

First-year target/outcome measurement: 95.0%

Second-year target/outcome measurement: 95.0%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Community Mental Health Services Reporting (CMHS)

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - equal to or greater than; Calculation Method = Percent of patients seen in a timely manner / total number of patients

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Appointments will be prioritized by need and with goal of reducing hospital admissions.; Notes - Failure to provide community services when needed may result in unnecessary hospitalizations.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 96%

Indicator #: 5

Indicator: Upon discharge from an inpatient psychiatric facility, patients will have scheduled appointments at CMHCs at a rate equal to or less than the previous five-year average. Data measured is the average number of days between discharge and scheduled appointment.

Baseline Measurement: Median Number of Days from Discharge to Appointment at Community Mental Health Center - Baseline = 4.6

First-year target/outcome measurement: 4.6

Second-year target/outcome measurement: 4.96

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Community Mental Health Services

New Data Source*(if needed)*:

Description of Data:

Value Type = Count (whole number) - equal to or less than; Calculation Method = Average number of days between inpatient discharge and first scheduled CMHC appointment for previous five years.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Appointments will be prioritized by need and with goal of reducing hospital admissions.; Notes - Timely transition from hospital to community treatment is indicator of compliance with treatment and medication, decreasing readmissions.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 2.5

Indicator #: 6

Indicator: Percentage of patients requiring readmission within thirty days of discharge will be equal to or less than previous five-year average.

Baseline Measurement: Percentage of Patients Requiring Readmission within 30 Days of Discharge - Baseline = 1.20%

First-year target/outcome measurement: 1.5%

Second-year target/outcome measurement: 1.5%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Central Office IT

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - equal to or less than; Calculation Method = Number of patients requiring readmission within thirty days of discharge / total number of patients discharged

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Reduce the number of patients requiring readmission following discharge from SCDMH hospitals.; Notes - Increase of rapid readmissions may indicate a break in the continuity of care between hospitals and CMHCs.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

During the height of the pandemic, infected patients were isolated from non-infected individuals. Staff serving either group did not have contact with either the other patients or the staff serving that population. This resulted in limiting the number of beds available.

As the effects of COVID-19 lessened, these restrictions were lifted.

How first year target was achieved *(optional)*:

FY2022 Result: 2.00%

Indicator #: 7

Indicator: The number of hospitals utilizing SCDMH Telepsychiatry services will remain constant or increase.

Baseline Measurement: Number of Participating Hospitals - ED Telepsychiatry Consultation Program - Baseline = 23

First-year target/outcome measurement: 23

Second-year target/outcome measurement: 23

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Internal Records - Telepsychiatry Department

New Data Source*(if needed)*:

Description of Data:

Value Type = Count - equal to or increase; Calculation Method = Total number of community mental health centers participating in Telepsychiatry services on June 30, 2021

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Hospital Emergency Departments and CMHCs in rural or otherwise underserved areas will have access to SCDMH

physicians regardless of location.; Notes - Increased ability to provide services in emergency departments reduces hospitalizations and wait times in EDs and improves compliance with out-patient treatment.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 27 The numbers of Hospitals utilizing.

Indicator #: 8

Indicator: The number of Community Mental Health Centers utilizing Telepsychiatry services will remain constant or increase.

Baseline Measurement: Number of CMHCs Providing Services via Telepsychiatry - Baseline = 16

First-year target/outcome measurement: 16

Second-year target/outcome measurement: 16

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Internal Records - Telepsychiatry Department

New Data Source*(if needed)*:

Description of Data:

Value Type = Count - equal to or increase; Calculation Method = Total number of hospitals participating with Telepsychiatry Program on June 30, 2021.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Hospital Emergency Departments and CMHCs in rural or otherwise underserved areas will have access to SCDMH physicians regardless of location.; Notes - On July 1, 2019, Greenville and Piedmont CMHCs combined to form the Greater Greenville CMHC. Purpose of measure is to demonstrate efficient use of physician time in serving rural communities.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 16 CMHC utilizing.

Indicator #: 9

Indicator: Percentage of SCDMH patients having competitive employment will be equal to or greater than average of previous five years.

Baseline Measurement: Percent of SCDMH Patients having Competitive Employment - Baseline = 14.00%

First-year target/outcome measurement: 14.00%

Second-year target/outcome measurement: 13.60%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software. - Community Mental Health Services

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - equal to or greater than; Calculation Method = Number participating in SCDMH employment programs, gaining meaningful employment/ Total Number of SCDMH patients

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Patients will be able to achieve and maintain productive, meaningful employment.; Notes - People competitively employed generally have better self-esteem and have more social activity.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 54%

Indicator #: 10

Indicator: Percentage of patients participating in SCDMH employment programs, gaining meaningful employment, will meet or exceed average of previous five years. (National benchmark = 40%).

Baseline Measurement: Percent of Patients Gaining Meaningful Employment - Baseline = 52.00%

First-year target/outcome measurement: 52.00%

Second-year target/outcome measurement: 57.60%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Community Mental Health Services

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - equal to or greater than; Calculation Method = Number of SCDMH patients having competitive employment / Total Number of SCDMH patients

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Patients will be able to achieve and maintain productive, meaningful employment.; Notes - Represents benefit of SCDMH vocational training and placement as compared to general population of SCDMH patients.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 57% of patients participating.

Indicator #: 11

Indicator: Life expectancy at Roddy Pavilion (skilled nursing facility) will be equal to or greater than average of previous five years. (National average = 1.2 years.)

Baseline Measurement: Life Expectancy as Compared Internally and to National Average - Baseline = 6.6

First-year target/outcome measurement: 6.6

Second-year target/outcome measurement: 6.9

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software (actual calculation is length of stay) - Central Office IT

New Data Source*(if needed)*:

Description of Data:

Value Type = Ratio - equal to or greater than; Calculation Method = Average lifespan per patient in years

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Residents of SCDMH nursing facilities will enjoy high standards of medical care.; Notes - A determination of whether expected standards of care are achieved.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 8.6 life expectancy at Roddy Pavillion.

Indicator #: 12

Indicator: Life expectancy at Stone Pavilion (skilled nursing facility for veterans) will be equal to or greater than average of previous five years. (National average = 1.2 years.)

Baseline Measurement: Life Expectancy as Compared Internally and to National Average - Baseline = 2.3

First-year target/outcome measurement: 2.3

Second-year target/outcome measurement: 2.4

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software (actual calculation is length of stay) - Central Office IT

New Data Source*(if needed)*:

Description of Data:

Value Type = Ratio - equal to or greater than; Calculation Method = Average lifespan per patient in years

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Residents of SCDMH nursing facilities will enjoy high standards of medical care.; Notes - A determination of whether expected standards of care are achieved.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 3.4 Life expectancy at Stone Pavillion.

Indicator #: 13

Indicator: Use of restraints in SCDMH Bryan Hospital Civil inpatient facility will be equal to or below the average of the previous five years' data. National average = 0.46 hours per 1,000 hours of inpatient service (CY2018).

Baseline Measurement: Inpatient Restraint Rate as Compared Internally and to National Average - Baseline = 0.06

First-year target/outcome measurement: 0.156

Second-year target/outcome measurement: 0.156

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Department of Inpatient Services, Quality Management

New Data Source*(if needed)*:

Description of Data:

Value Type = Ratio - equal to or less than; Calculation Method = Average number of hours in restraints per patient per 1000 hours.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Standard of care in inpatient facilities will result in reduced need for patient restraint. ; Notes - Low incidence of seclusion or restraint indicates less intrusive treatments are employed effectively.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 0.07

Indicator #: 14

Indicator: Use of restraints in Patrick Harris Hospital inpatient facility will be equal to or below the average of the previous five years' data. National average = 0.46 hours per 1,000 hours of inpatient service (CY2018).

Baseline Measurement: Inpatient Restraint Rate as Compared Internally and to National Average - Baseline = 0.01

First-year target/outcome measurement: 0.31

Second-year target/outcome measurement: 0.31

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Department of Inpatient Services, Quality Management

New Data Source*(if needed)*:

Description of Data:

Value Type = Ratio - equal to or less than; Calculation Method = Average number of hours in seclusion rooms per patient per 1000 hours.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Standard of care in inpatient facilities will result in reduced need for patient restraint. ; Notes - Not applicable.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 0.04 Patrick Harris Hospital.

Indicator #: 15

Indicator: Use of seclusion rooms in SCDMH Bryan Hospital Civil inpatient facility will be equal to or below the average of the previous five years' data. National average = 0.36 hours per 1,000 hours of inpatient service (CY2018).

Baseline Measurement: Inpatient Seclusion Rate as Compared Internally and to National Average - Baseline = 0.28

First-year target/outcome measurement: 0.28

Second-year target/outcome measurement: 0.214

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Department of Inpatient Services, Quality Management

New Data Source*(if needed)*:

Description of Data:

Value Type = Ratio - equal to or less than; Calculation Method = Average number of hours in restraints per patient per 1000 hours.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Standard of care in inpatient facilities will result in reduced need for patient restraint. ; Notes - Low incidence of seclusion or restraint indicates less intrusive treatments are employed effectively.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Seclusion hours per 1000 patient hours at BPH was above the goal (target) of 0.34 due to patient aggression requiring use of seclusion. Although there was at least one month in which the goal was met, the hospital is not able to continuously sustain a rate that low over a 12-month period due to the patient population: children, adolescents, adolescents from DJJ, forensic and persistently as well as more acute psychiatric patient populations.

The recommendation is to reset the goal to, “the hospital will be at or below the national average for health care facilities reporting data to NRI for seclusion”.

How first year target was achieved *(optional)*:

FY2022 Result: 0.31

Indicator #: 16

Indicator: Use of seclusion rooms in Patrick Harris Hospital inpatient facility will be equal to or below the average of the previous five years' data. National average = 0.36 hours per 1,000 hours of inpatient service (CY2018).

Baseline Measurement: Inpatient Seclusion Rate as Compared Internally and to National Average - Baseline = 0.01

First-year target/outcome measurement: 0.44

Second-year target/outcome measurement: 0.44

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Department of Inpatient Services, Quality Management

New Data Source*(if needed)*:

Description of Data:

Value Type = Ratio - equal to or less than; Calculation Method = Average number of hours in restraints per patient per 1000 hours.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Standard of care in inpatient facilities will result in reduced need for patient restraint. ; Notes - Not applicable.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Seclusion hours per 1000 patient hours at Patrick Harris Hospital was above the goal (Target) of 0.36 due to patient aggression requiring use of seclusion. The hospital is not able to continuously sustain a rate that low over a 12-month period due to the patient population: children, adolescents, adolescents from DJJ, forensic and persistently as well as more acute.
The recommendation is the goal is re-set to "The hospital will be at or below the national average for health care facilities reporting data to NRI for seclusion"

How first year target was achieved *(optional)*:

FY2022 Result: 0.44 hours per 1000 Hours compared to national average of 0.36 per 1000 hours.

Indicator #: 17

Indicator: Percentage of adults expressing satisfaction with SCDMH services will meet or exceed national averages (US average 88%).

Baseline Measurement: Percent of Adults Expressing Satisfaction with SCDMH Services - Baseline = 97%

First-year target/outcome measurement: 97%

Second-year target/outcome measurement: 95%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Central Office IT

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - equal to or greater than; Calculation Method = number of adults expressing satisfaction with SCDMH services / total number surveyed

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - SCDMH staff throughout all settings will be highly trained and able to provide highest standards of care.; Notes - Indicates SCDMH is providing services which improve patients' lives.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 96% of adults are expressing satisfaction.

Indicator #: 18

Indicator: Percentage of youths in School Mental Health Services receiving SCDMH services will remain consistently high (no national average available for youth satisfaction rates).

Baseline Measurement: Percent of Youth in School Mental Health Services Receiving SCDMH Services - Baseline = 97%

First-year target/outcome measurement: 97%

Second-year target/outcome measurement: 95%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Central Office IT

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - equal to or greater than; Calculation Method = number of youths in School Mental Health Services receiving SCDMH services / number of youths in School Mental Health Services

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - SCDMH staff throughout all settings will be highly trained and able to provide highest standards of care.; Notes - Indicates SCDMH is providing services which improve patients' lives.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 97% of youths in school, Mental Health services receiving.

Indicator #: 19

Indicator: All Community Mental Health Centers will meet Centers for Medicare and Medicaid Studies' rules for emergency preparedness when surveyed for compliance (at least once every three years).

Baseline Measurement: CMHCs will Meet the New Regulatory Requirements for Emergency Preparedness as Per 42-CFR-485.920 - Baseline = 100%

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Internal Records - Community Mental Health Services

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - Maintain; Calculation Method = number of community mental health center meeting compliance / number of community mental health centers surveyed

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - SCDMH will trained and prepared for emergencies affecting itself and surrounding communities.; Notes - Any deficiency could potentially result in loss of Medicaid reimbursement for that CMHC.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 100%, all CMHC meet.

Indicator #: 20

Indicator: SCDMH will have trained personnel prepared to staff the State Emergency Operation's Center (SEOC) throughout all drills and "real world" emergency situations. (Minimum = 4 staff).

Baseline Measurement: SCDMH will have Staff Available to Assist State and County Emergency Operations Centers - Baseline = 75%

First-year target/outcome measurement: 75%

Second-year target/outcome measurement: 100%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

County Records - Administration

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - equal to or greater than; Calculation Method = Each staff member represents 25%

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - SCDMH will trained and prepared for emergencies affecting itself and surrounding communities.; Notes - Indicates compliance with responsibilities outlined in SC Emergency Operations Plan.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 100% Personnel Trained.

Indicator #: 21

Indicator: Number of people awaiting beds will be equal to or less than average of previous five years' data.

Baseline Measurement: Number of Individuals Waiting in ER - Baseline = 1,993

First-year target/outcome measurement: 2,223

Second-year target/outcome measurement: 2,223

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Central Office IT

New Data Source*(if needed)*:

Description of Data:

Value Type = Count - equal to or less than; Calculation Method = Total count of people awaiting beds. Data is based upon a "Monday morning snapshot" of hospital emergency departments.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Reduce number of patients in hospital emergency rooms needing inpatient beds for mental health or substance abuse treatment.; Notes - Lower numbers indicate Department's efforts to reduce ED wait times are effective.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

During the height of the pandemic, infected patients were isolated from non-infected individuals. Staff serving either group did not have contact with either the other patients or the staff serving that population. This resulted in limiting the number of beds available.

As the effects of COVID-19 lessened, these restrictions were lifted.

How first year target was achieved *(optional)*:

FY2022 Result: 2562

Indicator #: 22

Indicator: The number of patients awaiting beds, at time of Monday snapshot (8:30AM), not discharged by 5:00PM, will be equal to or less than average of previous five years' data.

Baseline Measurement: Number of Individuals Still in ED at 5:00PM - Baseline = 1,442

First-year target/outcome measurement: 1,667

Second-year target/outcome measurement: 1,667

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software - Central Office IT

New Data Source*(if needed)*:

Description of Data:

Value Type = Count - equal to or less than; Calculation Method = Number indicates patients in ED at 8:30 AM still in ED at 5:00PM.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - Reduce number of patients in hospital emergency rooms needing inpatient beds for mental health or substance abuse treatment.; Notes - Lower numbers indicate intervention efforts by Department are effective.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

During the height of the pandemic, infected patients were isolated from non-infected individuals. Staff serving either group did not have contact with either the other patients or the staff serving that population. This resulted in limiting the number of available.

As the effects of COVID-19 lessened, these restrictions were lifted.

How first year target was achieved *(optional)*:

FY2022 Result: 1,833

Indicator #: 23

Indicator: The percentage of schools in South Carolina with Mental Health Services will increase.

Baseline Measurement: Percent of South Carolina Schools with Access to a School Mental Health Program Counselor - Baseline = 64%

First-year target/outcome measurement: 64.0%

Second-year target/outcome measurement: 66.9%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Internal Records - Community Mental Health Services

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent - equal to or greater than; Calculation Method = schools in South Carolina with Mental Health Services / 1292 schools

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - School Mental Health Clinicians will be embedded throughout South Carolina schools to manage compliance with appointments and better serve partnering schools.; Notes - Higher number indicates more school-aged children have easier access to mental health services.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

School districts are now hiring non-DMH clinicians to provide mental health services at salaries above what DMH is currently able to offer making employee recruiting and retention a challenge.

SCDMH is looking to increase salaries of current and any incoming school mental health clinicians.

How first year target was achieved *(optional)*:

FY2022 Result: 50%

Indicator #: 24

Indicator: SCYSPI will partner with an increasing number of schools in SC.

Baseline Measurement: Number of Schools Partnered with SCYSPI - Baseline = 45

First-year target/outcome measurement: 45

Second-year target/outcome measurement: 50

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Internal Records - South Carolina Youth Suicide Prevention Initiative

New Data Source*(if needed)*:

Description of Data:

Value Type = Count - equal to or greater than; Calculation Method = Number of partnerships

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - The South Carolina Youth Suicide Prevention Initiative (SCYSPI) will collaborate with a variety of healthcare providers and support agencies to reduce the risk of suicide in teens and young adults.; Notes - Higher number indicates increased opportunity to engage school administration and students.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 90 number of schools.
(Please see the footnotes)

Indicator #: 25

Indicator: SCYSPI will be in partnerships with a CMHC, Federally Qualified Health Center, a hospital ED, and an inpatient hospital.

Baseline Measurement: Partnerships as a Percent of the Total By Organizational Type - Baseline = 75%

First-year target/outcome measurement: 75%

Second-year target/outcome measurement: 100%

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Internal Records - South Carolina Youth Suicide Prevention Initiative

New Data Source*(if needed)*:

Description of Data:

Value Type = Percent Complete - Complete; Calculation Method = Each partnership will be 25% of achieving goal.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - The South Carolina Youth Suicide Prevention Initiative (SCYSPI) will collaborate with a variety of healthcare providers and support agencies to reduce the risk of suicide in teens and young adults.; Notes - Indicates progress toward goal of reducing youth suicides in SC.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☑ Achieved ☐ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

FY2022 Result: 75%
(Please see the Footnotes)

Priority #: 2

Priority Area: First Episode Psychosis Program

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

The goal of the priority area is to maximize the effective use of the resources of the Department in order to achieve the outcomes reflected below as these First Episode Psychosis Program(s) are a key area of focus for the Department and correlate closely with the Department's Strategic Planning initiatives.

Objective:

The intent is to address the needs of persons with early psychotic disorders, specifically first episode psychosis, either through enhancing existing program activities or development of new activities.

Strategies to attain the goal:

The Department has specifically cited Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) as the treatment modalities it will deploy utilizing a portion of the Ten Percent Set Aside. These treatment modalities have been identified as appropriate and effective for persons experiencing First Episode Psychosis (FEP). It has also been found that maximum effectiveness is attainable when the two modalities are deployed together. MI serves as the engagement modality and CBT serves as the therapy modality.

SCDMH will also deploy NAVIGATE as its CSC (Coordinated Specialty Care) program utilizing a portion of the Ten Percent Set Aside.

Edit Strategies to attain the objective here:
(if needed)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: First Episode Psychosis Program(s)

Baseline Measurement: Total Number of Patients Served - Baseline = 288

First-year target/outcome measurement: 288

Second-year target/outcome measurement: 323

New Second-year target/outcome measurement*(if needed)*:

Data Source:

Calculated using reporting software. - Community Mental Health Services

New Data Source*(if needed)*:

Description of Data:

Value Type = Count - Total; Calculation Method = Total number of patients served.

New Description of Data:*(if needed)*

Data issues/caveats that affect outcome measures:

Strategy Description - FEP Program(s) will receive referrals as appropriate and maintain program requirements for CSC programs.; Notes - Not applicable

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: ☐ Achieved ☑ Not Achieved *(if not achieved,explain why)*

Reason why target was not achieved, and changes proposed to meet target:

Difficulty recruiting and retaining registered Nurses, Master's level Clinicians and Behavioral Health Assistants in inpatient facilities & CMHC

The agency is constantly working on recruitment and retention efforts. Working on startup of the program in the new startup areas and identifying the patients.

How first year target was achieved *(optional)*:

FY2022 Result: 200

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Footnotes:

Indicator No. 24 and No. 25: (As per email instruction dated 11/10/2022 from State Officer we made following changes)

Name of program under this indicator previously as "SCYSPI" will be partner with an increasing number of schools in SC. But program name above "SCYSPI" has ended, but has continued on another different name, but same services are being provided.
New Program name: "Zero Suicide and SCDMH office of suicide prevention"

We have already updated Indicator No. 24 and No. 25 as above under FY2022 applications.

COVID Testing and Mitigation Program Report

For the Community Services Mental Health Block Grant (MHBG)

Federal Fiscal Year Ending September 30, 2022

For the federal fiscal year ending September 30, 2022, The South Carolina Department of Mental Health proposed to:

- ✓ Promote behaviors that prevent the spread of COVID-19 and other infectious diseases (healthy hygiene practices, stay at home when sick, practice physical distancing to lower the risk of disease spread, cloth face coverings, getting vaccinated).
- ✓ Maintain healthy environments (clean and disinfect, ensure ventilation systems operate properly, install physical barriers and guides to support social distancing if appropriate).

South Carolina Department of Mental Health was awarded additional grants specifically for PPE, so spending under the MHBG Mitigation was not as high as expected. However, as these additional awards are coming to an end and the number of COVID -19 cases are rising again, SCDMH will use these funds for these vital purposes in the near future. South Carolina Department of Mental Health continues promoting healthy behaviors and maintaining healthy environments with the below expenditures.

COVID Testing and Mitigation Program report for STATE	
Item/Activity	**Amount of Expenditure**
Maxima Ear loop Mask L3 TWN Blue -5 CS	$269.57
Criterion Glove PF Nitrile LF Large -2 CS	$110.16
Criterion Glove PF Nitrile LF Med.- 1 CS	$55.08
Total	$434.81

The South Carolina Department of Mental Health's highest priority continues to be the safety and wellbeing of its patients, residents, and staff. SCDMH made good progress adapting to the extremely unusual situation the state and the nation faces.

C. State Agency Expenditure Reports

MHBG Table 3 - Set-aside for Children's Mental Health Services

Reporting Period Start Date: 7/1/2021 Reporting Period End Date: 6/30/2022

Statewide Expenditures for Children's Mental Health Services			
Actual SFY 1994	**Actual SFY 2021**	**Estimated/Actual SFY 2022**	**Expense Type**
$6,076,364	$21,706,236	$20,394,871	(•) Actual ( ) Estimated

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

States and jurisdictions are required not to spend less than the amount expended in FY 1994.

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Footnotes:

C. State Agency Expenditure Reports

MHBG Table 6 - Maintenance of Effort for State Expenditures on Mental Health Services

Period (A)	Expenditures (B)	B1 (2020) + B2 (2021) 2 (C)
SFY 2020 (1)	$93,251,367	
SFY 2021 (2)	$95,312,807	$94,282,087
SFY 2022 (3)	$84,701,636	

Are the expenditure amounts reported in Column B "actual" expenditures for the State fiscal years involved?

SFY 2020	Yes	X	No	
SFY 2021	Yes	X	No	
SFY 2022	Yes	X	No	

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

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Footnotes: