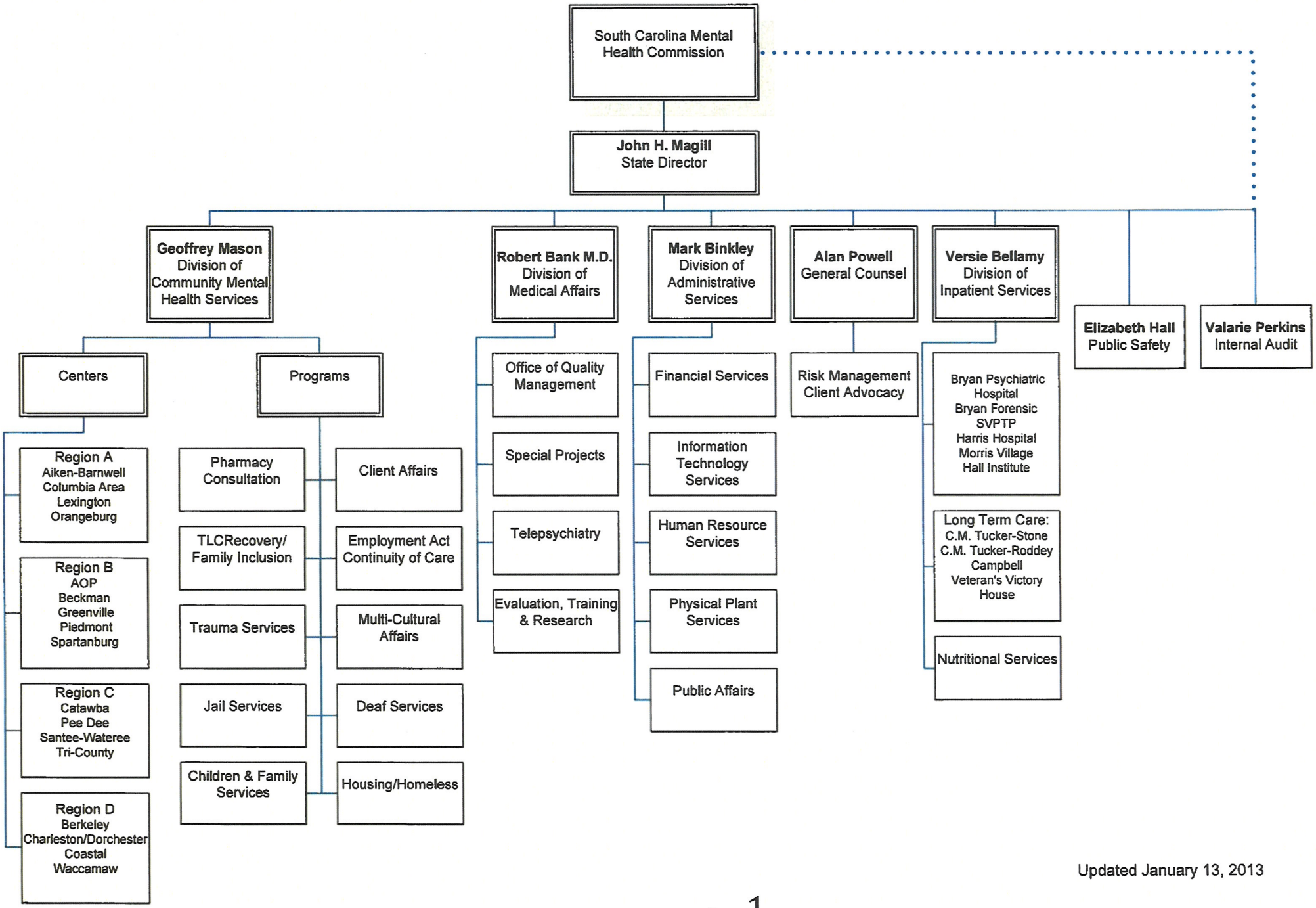
S.C. Department of Mental Health Organizational Chart



Updated January 13, 2013

SC DMH - Summary of Federal Funds

Award		*Available Amount in FY 2014*
Community Mental Health Services Block Grant [1]	$	8,797,093
Stage II Research on Outpatient Treatment for Adolescents with Comorbidity Clinical Trials Network	$	55,973
Primary & Behavioral health Care Integration	$	474,540
PATH	$	565,000
SC Data Infrastructure Grant for Quality Improvement	$	132,000
Shelter Plus Care	$	1,240,020

[1] The annual block grant award amount is $6,363,877. Block grant funds can be expended over a two-year federal fiscal year period, therefore, during any one state fiscal year, 3 block grants may be active. $8,797,093. represents the expected expenditures in fiscal year 2014.

SC DMH - Summary of Other Funds

Fund	Name	FY 2012 Disbursements	FY 2012 Cash Balance	FY 2013 December Cash Balance
Earmarked Funds				
3037	Special Deposits	$ 2,203,673	$ 9,188,420	$ 9,842,995
31S2	ARRA - Medicaid Assistance	$ 732,055	$ -	$ -
3466	Operation of Clinics	$ 15,409,379	$ (64,264)	$ 1,392,595
3467	Drug Addicts Treat & Rehab	$ 1,767,465	$ 45	$ 174,133
36H6	Health Care Annualization	$ 6,497	$ 29	$ -
3740	Patient Care & Maint Rev	$ 13,484,358	$ 288,796	$ 655,361
3743	Uncompensated Patient Care	$ (132,531)	$ 280,556	$ -
3757	Operating Revenue	$ 21,570,502	$ 18,806,000	$ 24,917,894
3764	Medicaid Assistance Pymts.	$ 131,804,840	$ 24,239,206	$ 27,043,002
3779	Patient Fee Account	$ 9,598,160	$ 11,983	$ 448,289
3958	Sale of Assets	$ 753	$ 50,097	$ 50,911
Capital Project Funds				
3497	Cap Project Exc D S Reserve	$ 70,355	$ 549,670	$ 67,377
3600	Cap Proj State Appropriation	$ 8,920	$ 29,149	$ 19,228
3603	State Approp Cap Exp Fund	$ 1,405,630	$ 751,168	$ 395,459
3907	Capital Proj Other Funds	$ 52,665	$ 597,648	$ 653,835
Trust & Agency Funds				
3031	Miscellaneous Employee Deductions	$ -	$ 22,066	$ 25,821
3041	Revenue Clearing	$ -	$ 3,869	$ 3,869
3528	Inventory Revolving Fund	$ (373,842)	$ 1,892,311	$ 1,672,635
3599	Individual COBRA Premiums	$ -	$ 1,729	$ 1,729
TOTAL OTHER FUNDS		**$ 197,608,878**	**$ 56,648,474**	**$ 67,365,132**

Notes:

Subfund 3037 balance includes revenue from multi-year non-federal contracts, multi-year non-federal grants and the sale of land. The majority of the cash balances must be used according to specific legal stipulations or contractual regulations.

Subfund 3757 cash balance includes $18,716,000 in funds set aside for the renovation of William S. Hall Psychiatric Institute (Children's Hospital).

Subfund 3764 FY 2012 cash balance includes cost settlements that are budgeted in the current year (FY 2013).

Accountability Report Appropriations/Expenditures Chart

Base Budget Expenditures and Appropriations

Major Budget Categories	FY 10-11 Actual Expenditures		FY 11-12 Actual Expenditures		FY 12-13 Appropriations Act	
	Total Funds	General Funds	Total Funds	General Funds	Total Funds	General Funds
Personal Service	$165,348,938	$ 85,421,977	$158,281,185	$ 81,197,434	$177,975,285	$ 88,812,103
Other Operating	$ 92,408,516	$ 18,948,002	$106,689,215	$ 20,148,213	$134,623,148	$ 28,329,408
Special Items	$ 300,000	$ -	$ -	$ -	$ 300,000	$ -
Permanent Improvements	$ 6,118,404	$ -	$ 1,666,763	$ -	$ -	$ -
Case Services	$ 11,436,168	$ 3,270,361	$ 10,300,410	$ 3,266,032	$ 12,960,144	$ 5,563,698
Distributions to Subdivisions	$ -	$ -	$ 207,857	$ -	$ -	$ -
Fringe Benefits	$ 59,180,809	$ 31,269,108	$ 53,596,322	$ 28,355,855	$ 64,462,451	$ 32,139,349
Non-recurring	$ 9,493,474	$ -	$ -	$ -	$ -	$ -
Total	$344,286,308	$138,909,449	$330,741,753	$132,967,535	$390,321,028	$154,844,558

Sources of Funds	FY 10-11 Actual Expenditures	FY 11-12 Actual Expenditures
Supplemental Bills	$ -	$ -
Capital Reserve Funds	$ -	$ -
Bonds	$ -	$ -

Major Program Areas

Program Number and Title	Major Program Area Purpose (Brief)	FY 10-11 Budget Expenditures	FY 11-12 Budget Expenditures	Cross References
II. A. Community Mental Health Centers	Services delivered from the 17 mental health centers that include: evaluation, assessment, and intake of consumers; short-term outpatient treatment; and continuing support services.	State: 43,023,379.98 Federal: 6,782,131.64 Other: 69,781,837.05 Total: 119,587,348.67 % of Total Budget: 35%	State: 42,148,203.89 Federal: 10,841,965.03 Other: 64,032,373.22 Total: 117,022,542.14 % of Total Budget: 36%	7.3-6
II. B. Inpatient psych	Services delivered in a hospital setting for adult and child consumers whose conditions are severe enough that they are not able to be treated in the community.	State: 31,826,692.00 Federal: 216,306.03 Other: 47,260,484.75 Total: 79,303,482.78 % of Total Budget: 23%	State: 29,489,487.65 Federal: 254,540.45 Other: 47,940,483.00 Total: 77,684,511.10 % of Total Budget: 24%	7.3-6 7.3-7
II. D. Tucker/ Dowdy	Residential care for individuals with mental illness whose medical conditions are persistently fragile enough to require long-term nursing care.	State: 1,336,158.52 Federal: 0.00 Other: 13,701,024.87 Total: 15,037,183.39 % of Total Budget: 4%	State: 2,613,817.75 Federal: 0.00 Other: 11,795,430.52 Total: 14,409,248.27 % of Total Budget: 4%	7.3-7
II. F. Support	Nutritional services for inpatient facilities, public safety, information technology, financial and human resources and other support services	State: 14,265,424.40 Federal: 74,247.08 Other: 8,429,086.56 Total: 22,768,758.04 % of Total Budget: 7%	State: 14,874,696.72 Federal: 1,855.85 Other: 6,205,962.79 Total: 21,082,515.36 % of Total Budget: 6%	
II. G. Veterans	Originally residential nursing care for veterans who also have a mental illness; role has now expanded beyond that so that any veteran is eligible who meets the admission criteria.	State: 9,813,024.98 Federal: 0.00 Other: 22,579,801.26 Total: 32,392,826.24 % of Total Budget: 10%	State: 8,063,884.21 Federal: 0.00 Other: 26,009,354.50 Total: 34,073,238.71 % of Total Budget: 10%	7.3-7
II. H. Sexual Predator	Treatment for civilly-committed individuals found by the courts to be sexually violent predators. Mandated by the Sexually Violent Predator Act, Section 44-48-10 et al.	State: 4,355,289.27 Federal: 0.00 Other: 2,034,308.37 Total: 6,389,597.64 % of Total Budget: 2%	State: 4,489,069.02 Federal: 0.00 Other: 3,704,420.84 Total: 8,193,489.86 % of Total Budget: 3%	7.3-7
III. Employer Contributions	Fringe benefits for all DMH employees	State: 31,269,108.44 Federal: 839,786.86 Other: 27,071,914.03 Total: 59,180,809.33 % of Total Budget: 18%	State: 28,355,855.43 Federal: 935,971.12 Other: 24,304,495.42 Total: 53,596,321.97 % of Total Budget: 16%	

Below: List any programs not included above and show the remainder of expenditures by source of funds.

Remainder of Expenditures:			
I. Administration	State: 3,020,371.06 Federal: 440,137.29 Other: 359,393.87 Total: 3,819,902.22 % of Total Budget: 1%	State: 2,932,520.47 Federal: 0.00 Other: 80,601.50 Total: 3,013,121.97 % of Total Budget: 1%	

7.1 Mission Accomplishment Results

SCDMH measures for mission accomplishment may be grouped, as follows:

a) Child & Adolescent Clinical Outcomes
b) Adult Clinical Outcomes
c) Client Quality Of Life Outcomes and
d) Nursing Home Clinical Outcomes

a) Clinical Outcomes: Child and Adolescent Services

For well over a decade, the Department has been measuring treatment outcomes that are critical to children and families. How is the child functioning in his/her world? Is the child living at home with family? Are they in school? Are they out of trouble? How are their symptoms responding to treatment?

Beginning in FY2009, the Department began using Achenbach's Child Behavior Checklist (CBCL) to assess symptoms in children. The instrument is completed by parents, caregivers, and/or teachers. Assessments are done at intake, six-months and again at discharge. The CBCL yields standardized scores in four areas: Total Competence, Total Problems, Internalizing and Externalizing. Each area has a specific range which indicates the presence of clinical syndromes, as well as sub-clinical syndromes, meaning their symptoms fall just below the level of clinical severity.

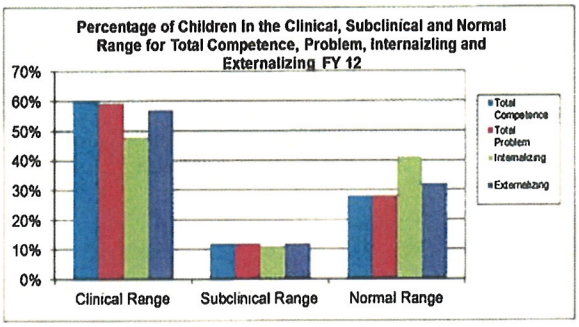


Figure 7.1-1

Figure 7.1-1 shows the percentage of children assessed with the CBCL who fell into the clinical, sub-clinical or normal range for each of the four domains. Sixty percent (60%) of children scored in the clinical range for Total Competence, 59% scored in the clinical range for Total Problems, 48% scored in the clinical range for Internalizing and 57% scored in the clinical range for Externalizing. As has been the case since FY 2009 the majority of the children served by SCDMH fell into either the clinical or sub-clinical categories, indicating that we are serving children with significant emotional disorders, our target population.

Figure 7.1-2 shows the percentage of children in the most severe category (clinical range) that showed improvement on a second CBCL for each of the domains measured in FY2010, FY2011, and FY2012.

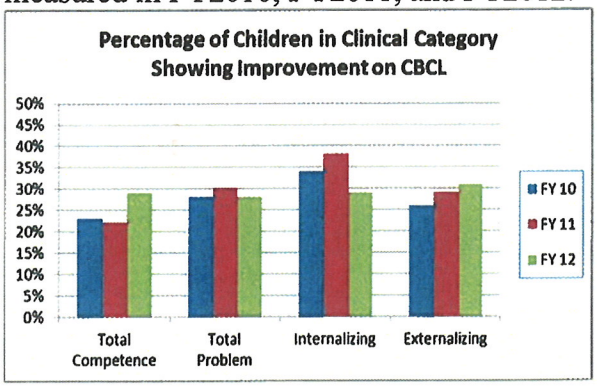


Figure 7.1-2

b) Clinical Outcomes: Adults Services.

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

Figure 7.1-3 shows the percentage of adults with an improved GAF score at discharge. GAF assesses the psychological, social and occupational functioning of adults.

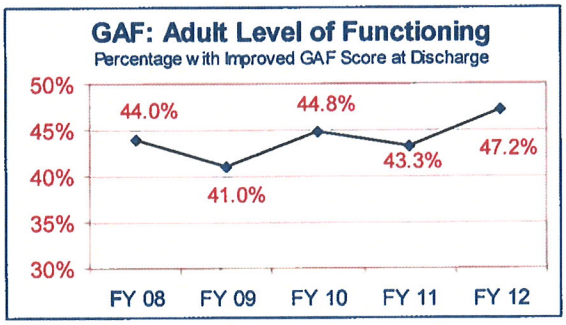


Figure 7.1-3 (Higher is Better)

c) Client Quality of Life Outcomes

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

In FY2012, SCDMH the employment rate for mentally ill clients ended a three year decline; possibly reflecting the state's overall economic situation for the same period. (Figure 7.1-4).

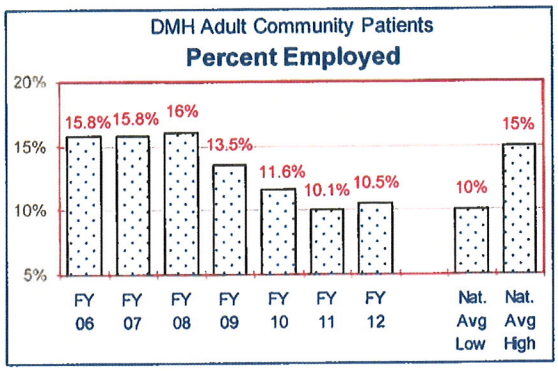


Figure 7.1-4 (Higher is Better)

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

The IPS Employment Programs produce an employment rate two and a half times that of traditional employment programs (Figure 7.1-5).

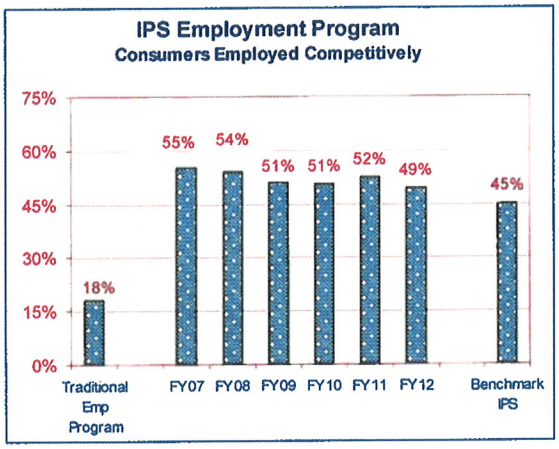


Figure 7.1-5 (Higher is Better)

Working through partnerships with private nonprofits and local CMHCs, the Department's Housing and Homeless Program has provided state matching funds for approximately twenty years for the development of new supportive housing that is affordable for clients living in the community. Due to budget constraints, SCDMH did not provide state matching funds for the development of additional

housing units through the Housing and Homeless Program in FY2012. (Figure 7.1-6)

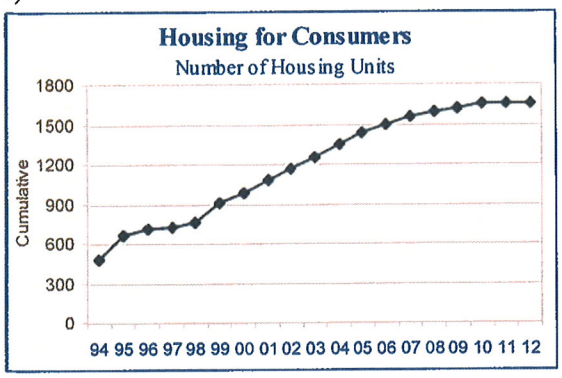


Figure 7.1-6 (Higher is Better)

While not all clients require assistance with housing or employment, many do. Having support in these areas can improve their likelihood of successfully living in the community.

This program also administers and monitors ten HUD Shelter Plus Care (SPC) programs that provide rental assistance each night for almost 300 clients and their family members in fourteen counties.

The SPC programs are partnerships between SCDMH, private nonprofit sponsors, and CMHCs located in the program areas. The Housing and Homeless Program also administers the HHS Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program, which provides funding for homeless outreach and other clinical services for homeless individuals. Both SPC and PATH specifically target homeless individuals with mental illnesses and co-occurring disorders and their family members.

d) Clinical Outcomes: Nursing Home Residents.

The most fundamental measure of clinical effectiveness for a nursing home is that of Health/Safety. Nationally, life expectancy following admission to a nursing care facility is slightly over two years. At C.M. Tucker Nursing Care Center (Tucker Center), residents average 8.2 years. (Figure 7.1-7).

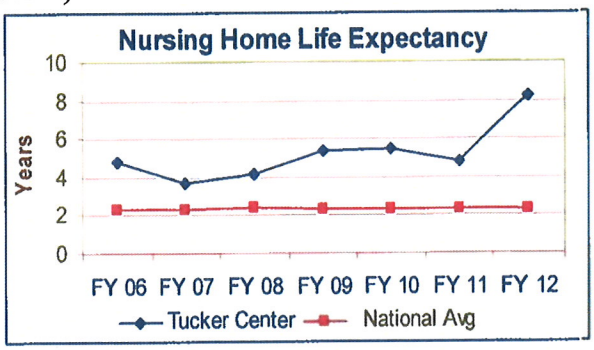


Figure 7.1-7 (Higher is Better)

Two critical factors impacting the increased longevity of Tucker Center residents are the low incidence of bed sores (below both state and national averages) and the low rate of falls with serious injuries, both common occurrences in homes for the elderly, and both life-threatening.

Tucker Center implemented a Fall Prevention and Management Program in December of 2010. Each fall is investigated and discussed in a weekly meeting and interventions are put in place. This has greatly reduced the number of falls and minimizes our injury rate which is at 4.13% for the FY2012. (Figure 7.1-8)

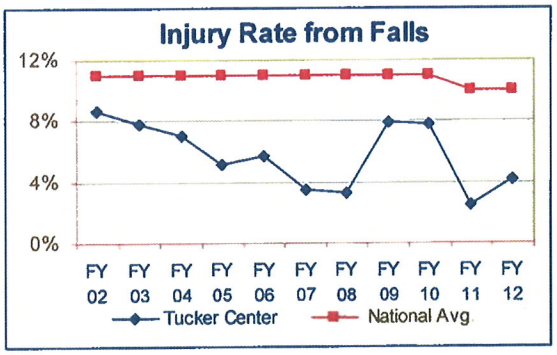


Figure 7.1-8 (Lower is Better)

7.2 Client Satisfaction Results

SCDMH measures client satisfaction through:

a) Adult Perception of Care;

b) Youth and Family Perception of Care; and

c) Nursing Home Resident and Family Satisfaction.

a) Adult Client Perception of Care:

Client perception of care is assessed with the MHSIP Client Satisfaction Survey, and SCDMH has been consistently rated highly by clients (Figure 7.2-1). Data from the MHSIP is shared with all centers and hospitals.

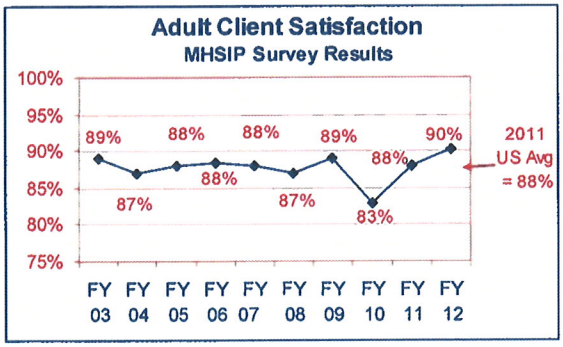


Figure 7.2-1 (Higher is Better)

b) Youth and Family Perception of Care:

The MHSIP Youth Services Survey and the Family Satisfaction Survey were introduced in FY2005. The SCDMH Youth Survey (Figure 7.2-2) shows the satisfaction level remains high for FY2012. National Youth MHSIP comparison data has not yet been released.

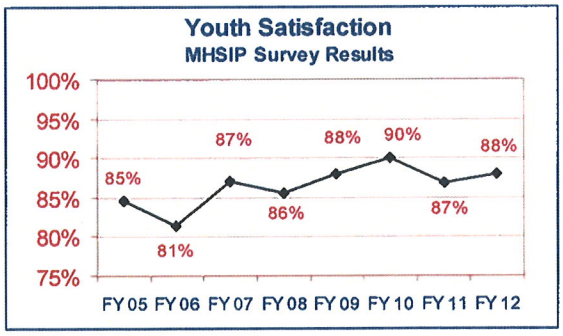


Figure 7.2-2 (Higher is Better)

The Family Satisfaction score, for FY2012, is at the second-highest level since survey was first conducted. (Figure 7.2-3).

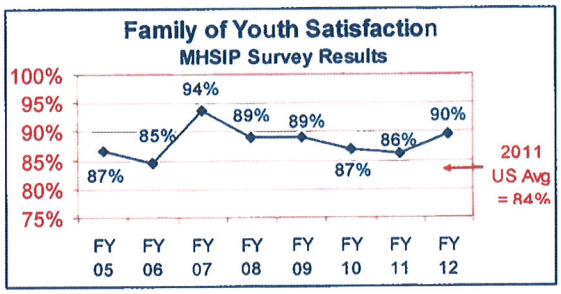


Figure 7.2-3 (Higher is Better)

c) Nursing Home Resident and Family Satisfaction

Both residents and their family members are assessed at C.M. Tucker Nursing Care Center for level of satisfaction. Results ("Usually Satisfied" or "Exceptionally Satisfied") have increased in the past two years of available data (Figure 7.2-4).

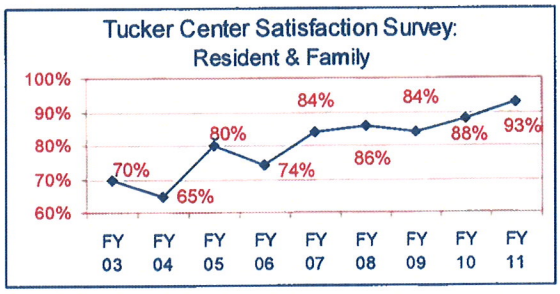


Figure 7.2-4 (Higher is Better)

7.3 Financial Performance Results

For FY2012, the Department's operating revenue (all fund sources) fell to its lowest level since FY2005 (Figure 7.3-1). Despite steady reductions in state appropriations and Medicaid revenue, the Department again finished the FY without a deficit.

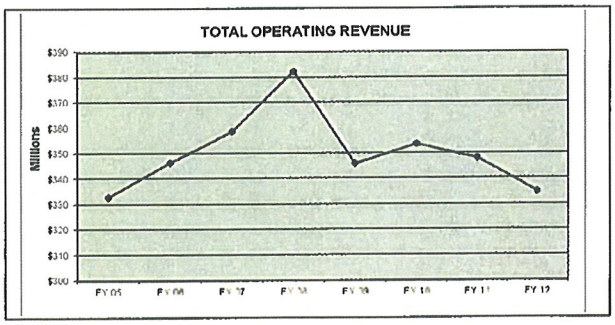


Figure 7.3-1 (Higher is Better)

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

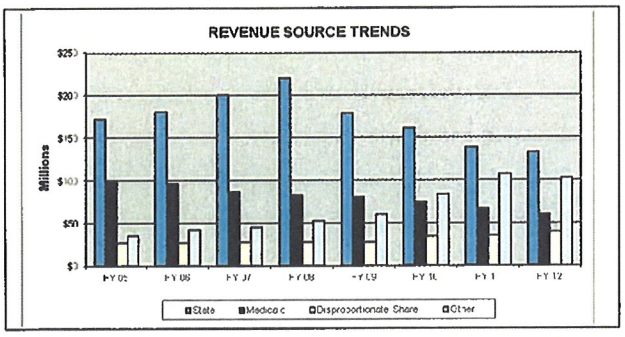


Figure 7.3-2 (Higher is Better)

In FY2012, SCDMH was awarded $28,272,067 in grant dollars. (Figure 7.3-3).

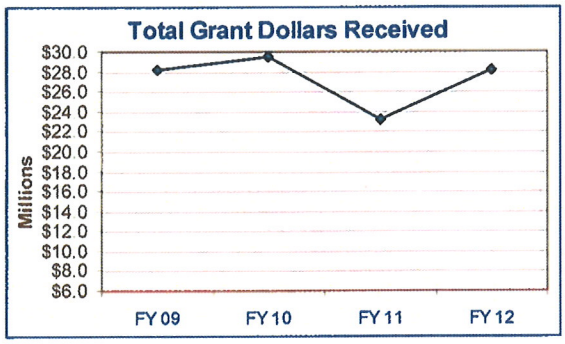


Figure 7.3-3 (Higher is Better)

While State Accident Fund Premiums have decreased in the past two years (Figure 7.3-4), the number of claims is down well over 50% since FY2001 (see Figure 7.4-2). Claims data is not yet available.

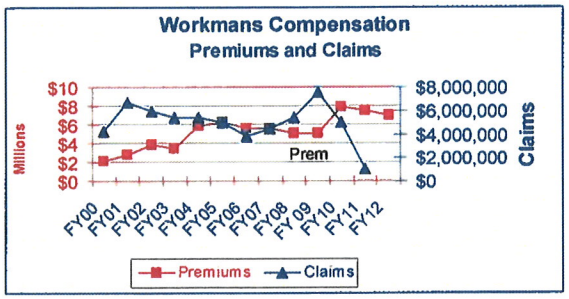


Figure 7.3-4 (Lower is Better) FY2012

The TLC program, which began in 1991, is designed to return long-term psychiatric inpatient clients to live in the community through intensive support from CMHCs. To date, over 3,296 clients with serious and persistent mental illness, 2,105 from an institutional setting have participated in the program.

Figure 7.3-5 compares the average one-year cost of maintaining a client in the hospital with the cost associated with TLC community enrollment.

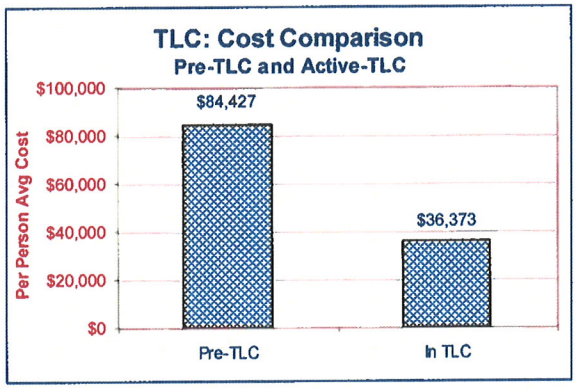


Figure 7.3-5 (Lower is Better)

For the ninety-three individuals enrolled in the TLC program two years ago (the most recent year for which data is available), there was a $4.4 million cost savings (or redirection) directly attributable to TLC Program participation. The costs reflect their actual hospital costs in the year before TLC with the actual net costs during their first year in the TLC Program (CMHC case management, hospitalizations, etc.).

Not only is community-based treatment the right thing to do, it is also a much more efficient use of fiscal resources. A comparison of pre and post-TLC placement demonstrates a reduction in hospital admissions by 72% and hospital days by 77% for TLC participants. It is for these reasons that the Department aggressively promotes crisis programs in the community to prevent unnecessary hospitalizations and promotes community preparation programs in the inpatient facilities to assist clients in

learning the life skills they need to succeed in their community transition.

Despite continued efforts to better serve clients in outpatient settings, funds supporting those services have declined. Inpatient expenditures have remained relatively stable, as shown in Figure 7.3-6. (Note: In FY2011 report, FY2011 data were estimates and have been updated. In this report, FY2012 data are estimates as of 8/31/2012).

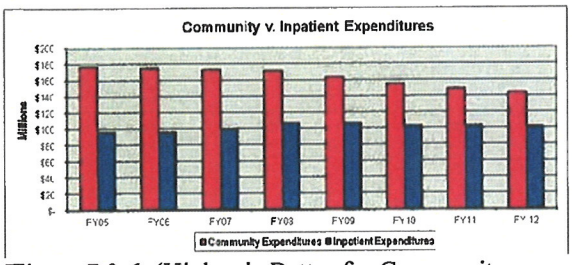


Figure 7.3-6 (Higher is Better for Community; Lower is Better for Inpatient)

The Department actively seeks to contain the costs associated with inpatient care. Bed-Day costs (Figure 7.3-7) reflect the expenses of providing inpatient care within the specialized facilities. (Note: In FY2011 report, FY2011 data were estimates and have been updated. In this report, FY2012 data are estimates as of 8/31/2012).

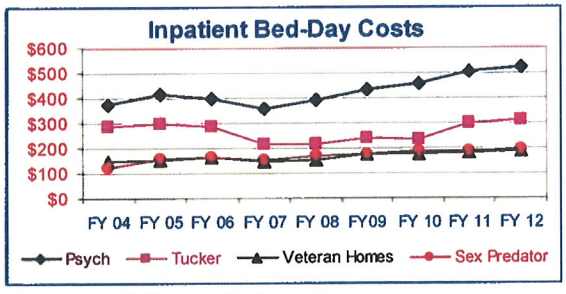


Figure 7.3-7 (Lower is Better)

While budget constraints have impacted decisions, commitment to community-based services has allowed SCDMH to reduce hospital beds and close wards. Reduced funds and rising costs also contribute to a reliance on private hospitals for short-term psychiatric admissions.

For approximately twenty years, the commitment to a community system spurred SCDMH to enter into housing development by partnering with housing authorities and non-profit organizations to create single and multi-family residences for clients who, otherwise, may have no housing alternative outside of institutional life. SCDMH has achieved a 4:1 leveraging of its housing funds. Funds for this purpose were not available in FY2012, and not planned for FY2013. (Figure 7.1-6).

Finally, the commitment to community care means decreasing the number of children who are placed in out-of-home care and the dollars associated with this level of care. The over 70% reduction in the number of children placed in out-of-home care (Figure 7.3-8) has resulted in more than an 85% reduction in the overall costs (Figure 7.5-5).

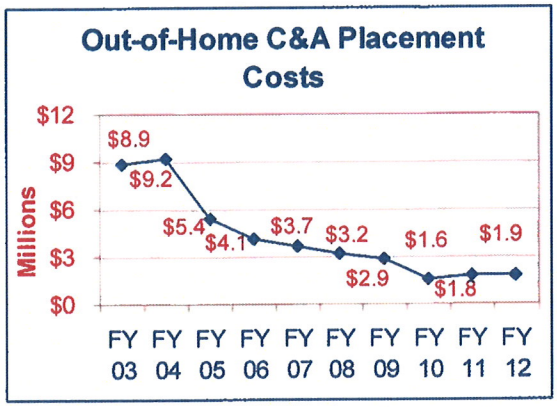


Figure 7.3-8 (Lower is Better)

7.4 Workforce Results

In January, 2011 SCDMH implemented a Nursing Assistant program, which has been certified by the SC Department of Health and Human Services, at the C.M. Tucker Nursing Care Center. Since January, 2011, the program graduated sixty-three Certified Nursing Assistants (CNAs). The program has reduced dependency on outside staffing

agencies, thereby reducing costs for Tucker Center.

SCDMH provided each of its 4,038 employees with an average of 4.15 hours of training in FY2011, compared to the 4.0 hours of training provided to 4,324 employees in FY2010. Included in those numbers were the hours of training conducted via videoconferencing. Using videoconferencing for training allows SCDMH the ability to reach a larger audience and eliminates the need for staff to travel to Columbia to attend training. This reduces the costs associated with travel and allows clinical staff to see patients before and/or after the training, thereby allowing them to bill for services.

SCDMH has an on-line learning system in place which allows staff to take training, which is required by regulatory and accrediting agencies, on line. In FY2010, there were 61 modules on-line. In FY2011, the number of modules increased to 101. Tailored curriculums have been developed for staff that provide care to meet the special needs of our patients. Of the 101 modules, 29 are mandatory for all staff annually to meet CARF, TJC, DHEC, OSHA and/or requirements of other regulatory agencies. In addition there are 55 other modules that are required to be taken by the clinical staff. If the modules were not available on-line, each staff member would be required to take training in the classroom. For clinical staff, this would have a negative impact on their productivity and ability to bill for services. The estimated man-hour cost savings to SCDMH for the on-line learning modules for FY2011 was $5,128,775. This does not include travel time to and from Columbia. This man hour cost savings is realized when employees remain in place for training and the loss of revenue producing hours due to training is reduced.

In addition, SCDMH provided 2,100 hours of employee training directly related to meeting the goals of the agency's Strategic Plan in FY2012.

Figure 7.4-1 (Higher is Better)

SCDMH's actions to improve the working environment are reflected in reduced workers' compensation claims. Figure 7.4-2 shows a steady reduction in the number of claims since FY2001.

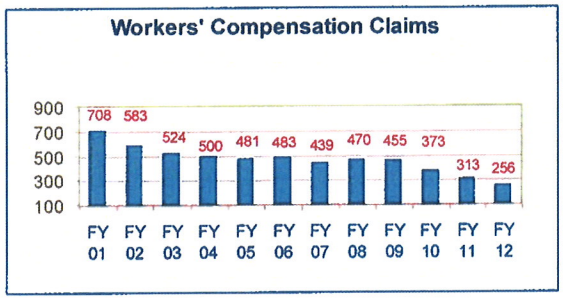


Figure 7.4-2 (Lower is Better)

The employee turn-over rate decreased in FY2012 and remains well below average for similar agencies. (Figure 7.4-3). Data for comparable agencies is based upon FY2010 data.

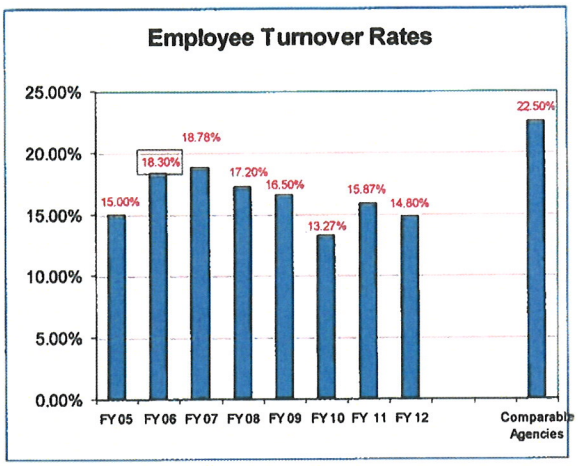


Figure 7.4-3 (Lower is Better)

Figure 7.4-4 shows the percent of affirmative action goals met by the agency each year since FY2004.

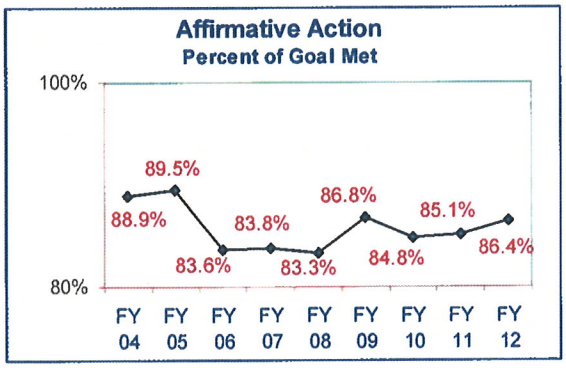


Figure 7.4-7 (Higher is Better)

7.5 Organizational Effectiveness and Efficiency Results

The SCDMH measures for organizational effectiveness may be grouped as follows:

a) Community Services to Priority Populations

b) CMHC Services Clinical Effectiveness

c) Inpatient Services Clinical Effectiveness

d) Support Processes Outcomes

a) Community Services to Priority Populations:

Development of a community-based system of care is core to the Department's philosophy and has been a driving force in program development since early in the 1990s. SCDMH assesses the extent to which it reaches the adults and children who need mental health services (penetration rate), and compares its efforts to the "level of penetration" of other states.

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

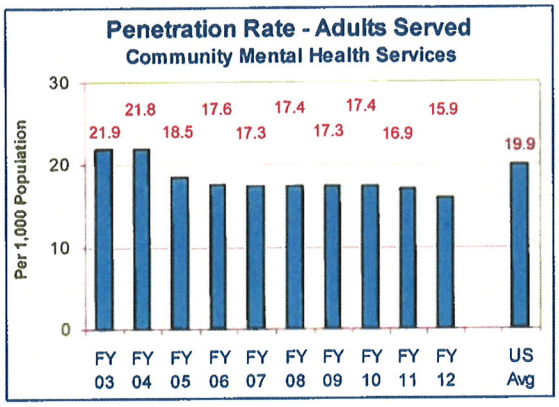


Figure 7.5-1 (Higher is Better)

The gradual decrease in the adult penetration rate most likely reflects the Department's focused reduction in treating persons who are not severely mentally ill and intensifying services to those who meet the criteria for severely mentally ill (SMI) and seriously and persistently mentally ill (SPMI). Alternatively, these numbers may reflect the growing population vs. the relatively stable number of adults we have served over the years.

Eighty-eight percent of all SCDMH adult clients meet the definition of SMI, and 85% of all FY2012 adult client contacts are with SMI clients (Figure 7.5-2).

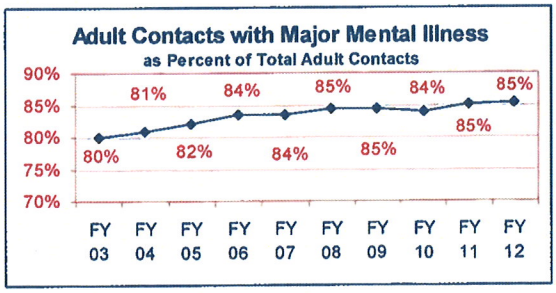


Figure 7.5-2 (Higher is Better)

SCDMH has also continued to increase its focus on providing services to children and adolescents. Penetration data (Figure 7.5-3) has typically shown we exceed the national average in children served under the age of seventeen.

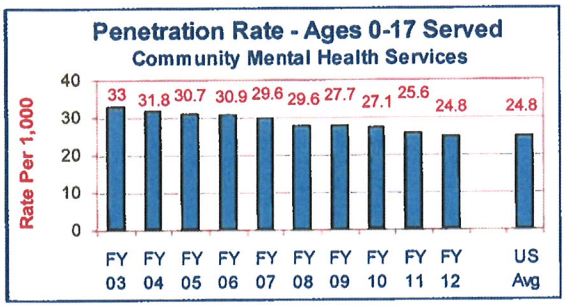


Figure 7.5-3 (Higher is Better)

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

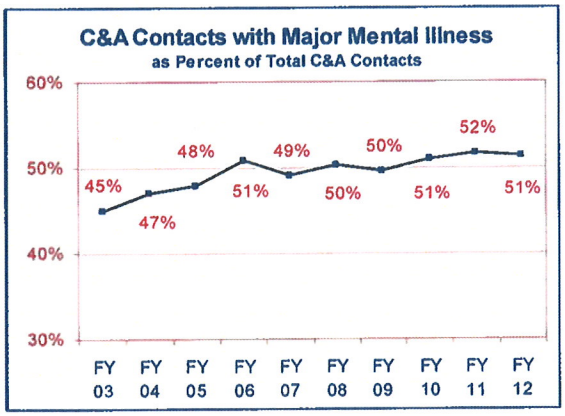


Figure 7.5-4 (Higher is Better)

SCDMH believes that children should be treated within the family system, and removing the child from the family unit should be a last resort. As such, reducing out-of-home placements has been a goal across all CMHCs. Figure 7.5-5 shows a decrease of over 70% in the number of children in out-of-home placements over the past ten years.

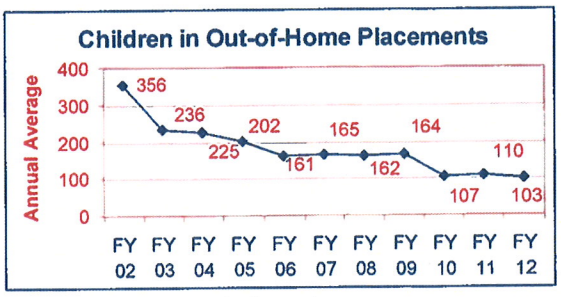


Figure 7.5-5 (Lower is Better)

The total number of persons, all ages, served throughout the community centers from FY2007 – FY2012 is shown in Figure 7.5-6.

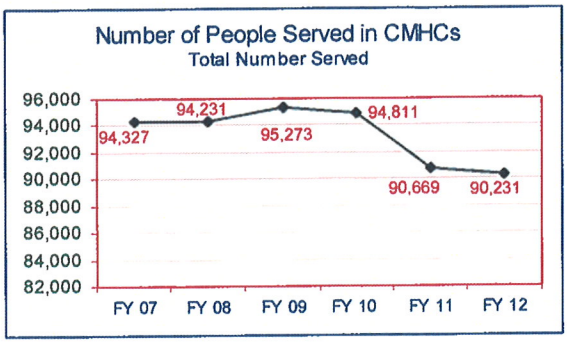


Figure 7.5-6

b) CMHC Services: Clinical Effectiveness

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

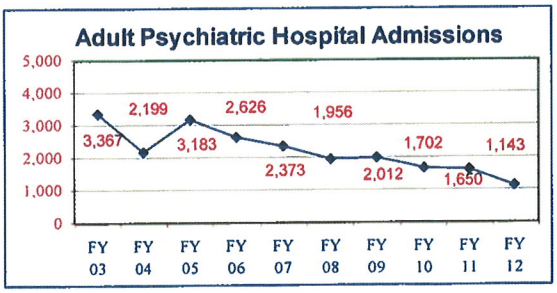


Figure 7.5-7 (Lower is Better)

In fact, there are probably multiple reasons for over a 50% decrease in psychiatric hospital admissions over the past five years:

- The agency is operating fewer in-patient beds than in previous years (Eighty beds were closed in FY2009 alone);
- Improved crisis diversion programs in the community;
- The ongoing departmental funding of community based, inpatient treatment, both substance abuse and psychiatric, for those in crisis; and
- The increase in the percentage of patients who stay in the hospital longer than 90 days, resulting in a decrease in acute care beds available to admit short-term patients (Figure 7.5-17).

The Department has a limited number of beds and these remain at near 100% occupancy. For many people requiring an inpatient admission, a SCDMH hospital is not a readily available option.

South Carolina has paralleled the country with a phenomenal growth in Emergency Department (ED) use by persons in crisis, both behavioral health and all other categories. This increase in emergency department use has had a major impact on the public healthcare system and SCDMH.

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

In FY2012, SCDMH funded special initiatives totaling over $5.5M to assist hospital emergency departments with addressing an increase in behavioral health care urgent needs. The funding is dedicated to a variety of crisis initiatives throughout the state. These programs consist of crisis stabilization teams.

Additionally, dedicated crisis funding can be utilized to divert those in emergency departments to local private inpatient facilities for short-term stabilization. Contracting for short-term use of beds in non-SCDMH hospitals not only effectively utilizes limited SCDMH inpatient beds; it also provides crisis care near the patient's home and enhances local, community-based options. Figure 7.5-8 shows the continuing trend in this treatment option while figure 7.5-9 demonstrates SCDMH staff activity in utilizing these contract beds to divert individuals from the ED and out of the ED.

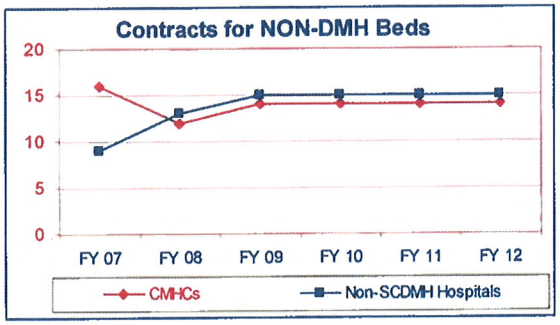


Figure 7.5-8 (Higher is Better)

As a result of these and other efforts, the average total number of persons waiting in ERs decreased by 14% From FY2009-FY2011. During the same time period, the average number of persons waiting in the ER more than 24 hours decreased 17% as well (Figure 7.5-9).

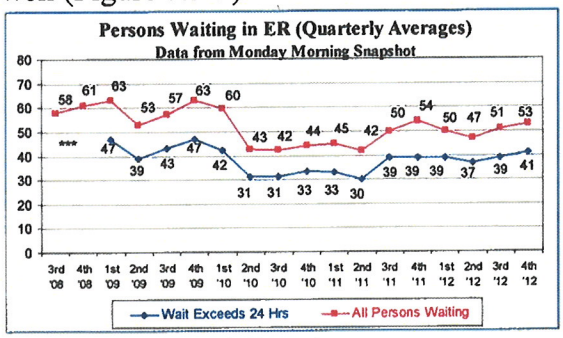


Figure 7.5-9 (Lower is Better)

Particularly challenging to SCDMH is that a significant number of persons who present themselves in the EDs with a primary diagnosis of mental illness and/or alcohol/drug are unknown to SCDMH. Figure 7.5-10 shows a continuing trend that nearly three-fourths of people presenting for ED services were not previously treated, in any capacity, by SCDMH.

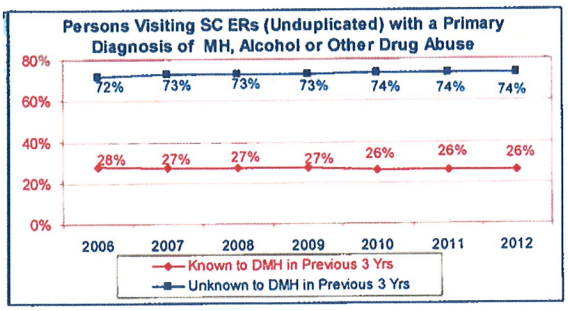


Figure 7.5-10

Long-term solutions will require a concerted effort with our key partners

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

Individuals identified for the TLC Program receive intensive support through the CMHCs, helping them adjust to community life and secure daily living skills. Figure 7.5-11 shows the capacity of the TLC program.

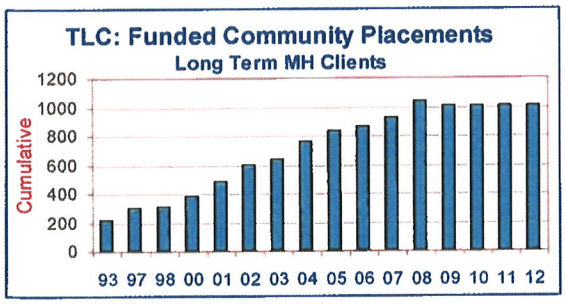


Figure 7.5-11 (Higher is Better)

TLC continues to serve over a thousand long-term, severely mentally ill clients in the community (Figure 7.5-12). To date, 2,197 patients have left institutional settings for TLC programs. With effective outpatient services, most TLC clients do not present in emergency departments nor occupy limited hospital beds.

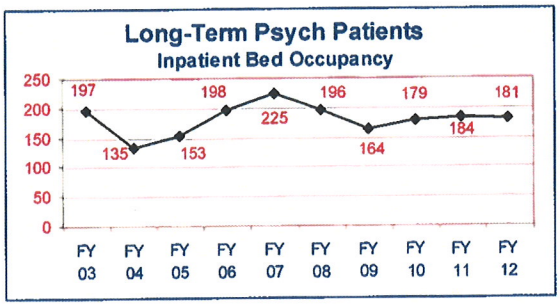


Figure 7.5-12 (Lower is Better)

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

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

Senior management and the Commission review data quarterly on the number of days between inpatient discharge and the date of their first appointment at a local community mental health center (Figure 7.5-13).

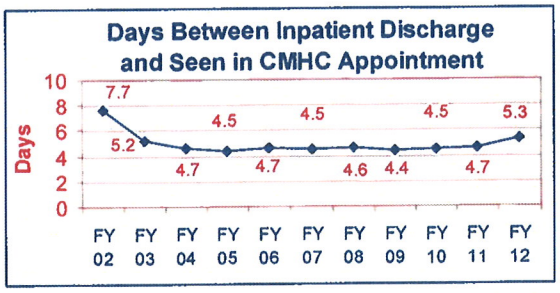


Figure 7.5-13 (Lower is Better)

SCDMH's average of 5.3 days remains well under our seven-day standard.

c) Inpatient Services: Clinical Effectiveness

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

A low 30-day psychiatric re-admission rate reflects adequacy of inpatient treatment, as well as effective follow-up and maintenance in the community following discharge. Figure 7.5-14 shows that SCDMH remains below the national average.

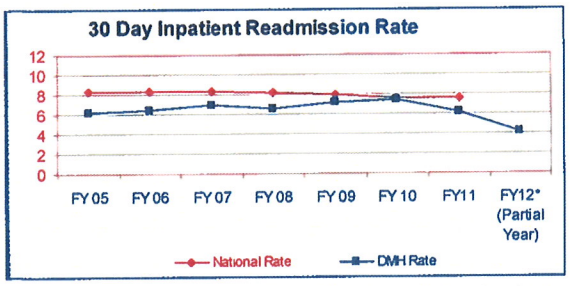


Figure 7.5-14 (Lower is Better) * 10 Months data

Other key ORYX measures for inpatient facilities include the use of restraint and seclusion, defined as the number of hours clients spent in restraint or seclusion for every 1,000 inpatient patient hours (Figures 7.5-15 and 16).

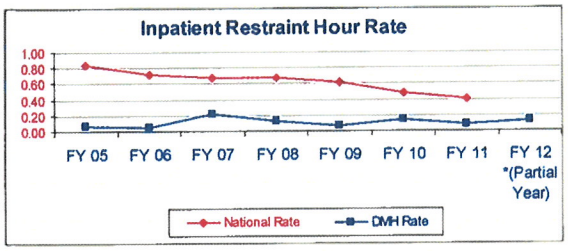


Figure 7.5-15 (Lower is Better)

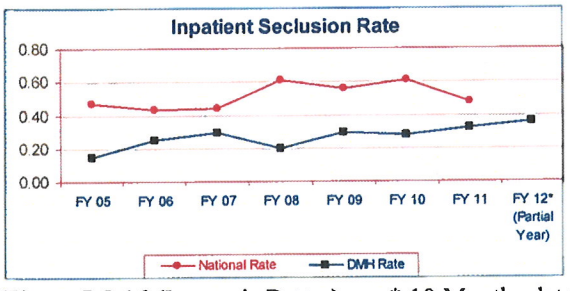


Figure 7.5-16 (Lower is Better) * 10 Months data

Senior leadership also monitors inpatient bed availability weekly. The impact of long-term patients in short-term beds erodes SCDMH's capacity to admit new patients, creates problems for EDs, and raises the costs of inpatient services (Figure 7.5-17). The percentage of SCDMH's inpatient population, remaining longer than ninety days, has been trending upwards for several years.

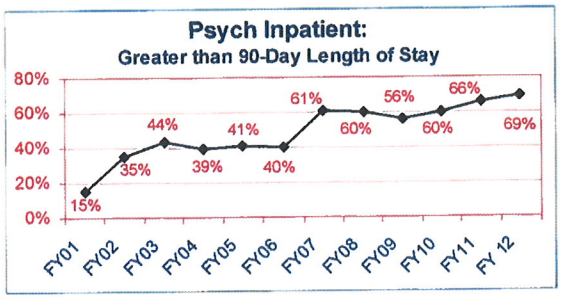


Figure 7.5-17 (Lower is Better)

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

At the end of last year, support for counties and detention centers was cut significantly resulting in decreased funding for mental health services. Consequently, the number of people being referred and their acuity increased noticeably. (Figure 7.5-18).

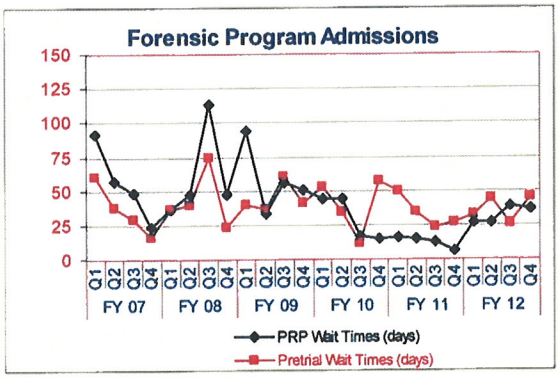


Figure 7.5-18 (Lower is Better)

Telepsychiatry has proven an effective option for hospital emergency departments

without a psychiatrist on staff or not readily available. Initially and still largely funded by the Duke Endowment Foundation, the Department of Mental Health employs psychiatric staff who remain available for long-distance consultations to both speed the effective placement or release of people in emergency departments and at a reduced cost per visit. Further, data shows that, on average, telepsychiatry consultations result in lengthier periods between emergency room visits for participating clients.

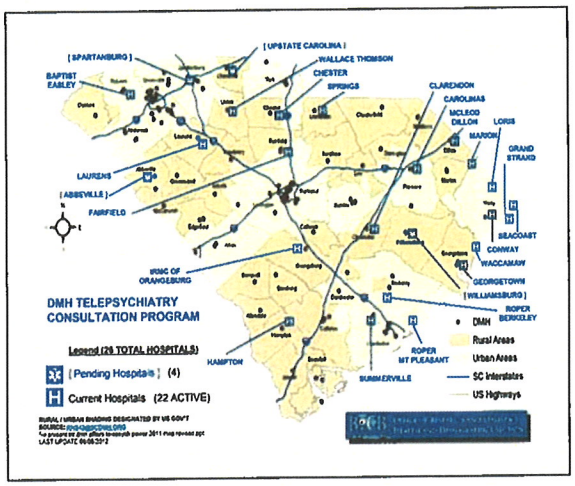


Figure 7.5-19

Figure 7.5-19 shows the hospital emergency departments participating in telepsychiatry at the end of FY2012.

d) Support Processes Outcomes

Figure 7.5-20 identifies the Department's key support/business processes and the performance level of each.

Glossary of Terms and Abbreviations

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

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

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

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

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

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

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

CME – Continuing Medical Education, physician continuing education credits.

CMHC – Community Mental Health Center.

CRCF – Community Care Residential Facility

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

Client – person with mental illness served by the SCDMH.

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

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

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

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

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

DMH – South Carolina Department of Mental Health.

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

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

FY – Fiscal Year is the period beginning July 1 and ending June 30 of the following calendar year.

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

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

IPS – Individual Placement and Support.

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

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

MHA – Mental Health Association.

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

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

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

Pathlore – a computerized employee training registration and documentation system.

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

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

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

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

SAMHSA – Substance Abuse and Mental Health Services Administration.

SAP – computerized financial management system.

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

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

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

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

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

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

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

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

AGREED UPON PROCEDURES REPORT

JUNE 30, 2011

State of South Carolina

Office of the State Auditor

1401 MAIN STREET, SUITE 1200
COLUMBIA, S.C. 29201

RICHARD H. GILBERT, JR., CPA
DEPUTY STATE AUDITOR

(803) 253-4160
FAX (803) 343-0723

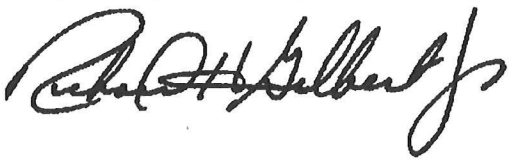
May 24, 2012

The Honorable Nikki R. Haley, Governor
and
Members of the Commission
South Carolina Department of Mental Health
Columbia, South Carolina

This report on the application of certain agreed-upon procedures to the accounting records of the South Carolina Department of Mental Health for the fiscal year ended June 30, 2011, was issued by WebsterRogers, LLP, Certified Public Accountants, under contract with the South Carolina Office of the State Auditor.

If you have any questions regarding this report, please let us know.

Respectfully submitted,



Richard H. Gilbert, Jr., CPA
Deputy State Auditor

RHGjr/cwc

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
Columbia, South Carolina

CONTENTS

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CERTIFIED PUBLIC ACCOUNTANTS ♦ CONSULTANTS

Florence ♦ Charleston ♦ Myrtle Beach ♦ Georgetown ♦ Sumter ♦ Litchfield ♦ Columbia ♦ Summerville

Independent Accountants' Report on Applying Agreed-Upon Procedures

Mr. Richard H. Gilbert, Jr., CPA
Interim State Auditor
State of South Carolina
Columbia, South Carolina

We have performed the procedures described below, which were agreed to by the governing board and management of the South Carolina Department of Mental Health and the South Carolina Office of the State Auditor (the specified parties), solely to assist you in evaluating the performance of the South Carolina Department of Mental Health (the Department) for the fiscal year ended June 30, 2011, in the areas addressed. The Department's management is responsible for its financial records, internal controls, and compliance with State laws and regulations. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of the specified parties in this report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are as follows:

1. **Cash Receipts and Revenues**

   - We inspected 25 recorded receipts to determine if these receipts were properly described and classified in the accounting records in accordance with the Department's policies and procedures and State regulations.
   - We inspected 25 recorded receipts to determine if these receipts were recorded in the proper fiscal year.
   - We made inquiries and performed substantive procedures to determine if revenue collection and retention or remittance were supported by law.
   - We compared current year recorded revenues at the subfund and account level from sources other than State General Fund appropriations to those of prior year. We investigated changes in the general, earmarked, and federal funds to ensure that revenue was classified properly in the Department's accounting records. The scope was based on agreed upon materiality levels of $1,900 in the general fund, $300,000 in the earmarked fund, and $22,000 in the federal fund and ± 10%.

   The individual transactions selected were chosen judgmentally. We found no exceptions as a result of the procedures.

2. **Non-Payroll Disbursements and Expenditures**

   - We inspected 25 recorded non-payroll disbursements to determine if these disbursements were properly described and classified in the accounting records in accordance with the Department's policies and procedures and State regulations, were bona fide disbursements of the Department, were paid in conformity with State laws and regulations, and if the acquired goods and/or services were procured in accordance with applicable laws and regulations.

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2. **Non-Payroll Disbursements and Expenditures** (Continued)

- We inspected 25 recorded non-payroll disbursements to determine if these disbursements were recorded in the proper fiscal year.
- We compared current year expenditures at the subfund and account level to those of the prior year. We investigated changes in the general, earmarked, and federal funds to ensure the expenditures were properly classified in the Department's accounting records. The scope was based on agreed upon materiality levels of $210,000 for the general fund, $270,000 for the earmarked fund, and $20,000 for the federal fund and ± 10%.

The individual transactions selected were chosen judgmentally. We found no exceptions as a result of the procedures.

3. **Payroll Disbursements and Expenditures**

- We inspected 25 payroll disbursements to determine if the selected payroll transactions were properly described, classified, and distributed in the accounting records; persons on the payroll were bona fide employees; payroll transactions, including employee payroll deductions, were properly authorized and were in accordance with existing legal requirements and processed in accordance with the Department's policies and procedures and State regulations.
- We inspected payroll transactions for 5 new employees and 5 who terminated employment to determine if the employees were added and/or removed from the payroll in accordance with the Department's policies and procedures, that the employee's first and/or last pay check was properly calculated, and that the employees leave payout was properly calculated in accordance with applicable State law.
- We compared current year payroll expenditures at the subfund and account level to those of the prior year. We investigated changes in the general, earmarked and federal funds to ensure that expenditures were classified properly in the Department's accounting records. The scope was based on agreed upon materiality levels of $210,000 for the general fund, $270,000 for the earmarked fund, and $20,000 for the federal fund and ± 10%.
- We compared the percentage change in recorded personal service expenditures to the percentage change in employer contributions; and computed the percentage change in employer contributions; and computed the percentage distribution of recorded fringe benefit expenditures by fund source and compared the computed distribution to the actual distribution of recorded payroll expenditures by fund source. We investigated changes of ± 5% to ensure that payroll expenditures were classified properly in the Department's accounting records.

The individual transactions were chosen randomly. We found no exceptions as a result of the procedures.

4. **Journal Entries, Operating Transfers and Appropriation Transfers**

- We inspected 10 recorded journal entries, 5 recorded operating transfers, and 5 recorded appropriation transfers to determine if these transactions were properly described and classified in the accounting records; they agreed with the supporting documentation, the purpose of the transaction was documented and explained, the transactions were properly approved, and were mathematically correct; and the transactions were processed in accordance with the Department's policies and procedures and State regulations.

The individual transactions were chosen judgmentally. We found no exceptions as a result of the procedures.

5. General Ledger and Subsidiary Ledgers

- We inspected selected entries and monthly totals in the subsidiary records of the Department to determine if the amounts were mathematically accurate, the selected monthly totals were accurately posted to the general ledger, and selected entries were processed in accordance with the Department's policies and procedures and State regulations.

The transactions were chosen judgmentally. We found no exceptions as a result of the procedures.

6. Composite Reservoir Accounts

Reconciliations

- We obtained all monthly reconciliations prepared by the Department for the year ended June 30, 2011, and inspected selected reconciliations of balances in the Department's accounting records to those on the State Treasurer's Office monthly reports to determine if accounts reconciled. For the selected reconciliations, we determined if they were timely performed and properly documented in accordance with State regulations, recalculated the amounts, agreed the applicable amounts to the Department's general ledger, determined if reconciling differences were adequately explained and properly resolved, and determined, if necessary, adjusting entries were made in the Department's accounting records.

Cash Receipts and Revenues

- We inspected 5 recorded receipts to determine if these receipts were properly described and classified in the accounting records in accordance with the Department's policies and procedures and State regulations.
- We inspected 5 recorded receipts to determine if these receipts were recorded in the proper fiscal year.
- We made inquiries and performed substantive procedures to determine if revenue collection and retention or remittance were supported by law. We obtained all monthly reconciliations prepared by the Department.

Non-Payroll Disbursements and Expenditures

- We inspected 5 recorded non-payroll disbursements to determine if these disbursements were properly described and classified in the accounting records in accordance with the Department's policies and procedures and State regulations, were bona fide disbursements of the Department and were paid in conformity with State laws and regulations if the acquired goods and/or services were procured in accordance with applicable laws and regulations.
- We inspected 5 recorded non-payroll disbursements to determine if these disbursements were recorded in the proper fiscal year.

The reconciliations selected were chosen randomly. The cash receipts and non-payroll disbursements were chosen judgmentally. We found no exceptions as a result of the procedures.

7. Appropriation Act

- We inspected Department documents, observed processes, and/or made inquiries of Department personnel to determine the Department's compliance with Appropriation Act general and Department specific provisos.

We found no exceptions as a result of the procedures.

8. Closing Packages

- We obtained copies of all closing packages as of and for the year ended June 30, 2011, prepared by the Department and submitted to the State Comptroller General. We inspected them to determine if they were prepared in accordance with the Comptroller General's *GAAP Closing Procedures Manual* requirements and if the amounts reported in the closing packages agreed with the supporting workpapers and accounting records.

We found no exceptions as a result of the procedures.

9. Schedule of Federal Financial Assistance

- We obtained a copy of the schedule of federal financial assistance for the year ended June 30, 2011, prepared by the Department and submitted to the State Auditor. We inspected the schedule of federal financial assistance to determine if it was prepared in accordance with the State Auditor's letter of instruction and if the amounts agreed with the supporting workpapers and accounting records.

We found no exceptions as a result of the procedures.

10. Status of Prior Findings

- We inquired about the status of the findings reported in the Accountant's Comments section of the Independent Accountant's Report on the Department resulting from their engagement for the fiscal year ended June 30, 2007, to determine if the Department had taken corrective action. We applied no procedures to the Department's accounting records and internal controls for the years ended June 30, 2010, 2009 and 2008.

We found no exceptions as a result of the procedures.

We were not engaged to and did not conduct an audit, the objective of which would be the expression of an opinion on the accounting records. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the Governor, the governing body and management of the South Carolina Department of Mental Health, and the South Carolina Office of the State Auditor and is not intended to be and should not be used by anyone other than these specified parties.

Webster Rogers LLP

Columbia, South Carolina
May 15, 2012

ACCOUNTANTS' COMMENTS

SECTION A – STATUS OF PRIOR FINDINGS

During the current engagement, we reviewed the status of corrective action taken on findings reported in the Accountants' Comment section of the Independent Accountants' Report on the Department for the fiscal year ended June 30, 2007, and dated June 20, 2008. We applied no procedures to the Department's accounting records and internal controls for the years ended June 30, 2010, 2009 and 2008. We determined the Department has taken adequate corrective action on each of the findings.

Proviso Change Request Summary

Agency	South Carolina Department of Mental Health	Code	J12	Section	35

FY 2012-13 Number	FY 2013-14 Renumbered	Proviso Title	Action	Explanation	Fiscal Impact of Provisos N/R	GF	eOF	rOF	FF	Total
23.1	35.1	Patient Fee Account	Amend	Combine FY2013 Provisos 23.1. and 23.2.	$ -	$ -	$ -	$ -	$ -	$ -
23.2	35.2	Patient Fee Account	Delete	Combine FY2013 Provisos 23.1. and 23.2.	$ -	$ -	$ -	$ -	$ -	$ -
23.8	35.7	Crisis Stabilization	Delete	The $2 million threshold is no longer relevant	$ -	$ -	$ -	$ -	$ -	$ -
23.14	35.12	Medicaid Beneficiary Choice	Delete	Proviso is no longer relevant	$ -	$ -	$ -	$ -	$ -	$ -
23.15	35.13	Sexually Violent Predator Program	Delete	Proviso is no longer relevant	$ -	$ -	$ -	$ -	$ -	$ -
					$ -	$ -	$ -	$ -	$ -	$ -
					$ -	$ -	$ -	$ -	$ -	$ -
					$ -	$ -	$ -	$ -	$ -	$ -
					$ -	$ -	$ -	$ -	$ -	$ -
					$ -	$ -	$ -	$ -	$ -	$ -
					$ -	$ -	$ -	$ -	$ -	$ -
					$ -	$ -	$ -	$ -	$ -	$ -
					$ -	$ -	$ -	$ -	$ -	$ -
					$ -	$ -	$ -	$ -	$ -	$ -
Please Insert Any Additional Rows Above This Row										
				Total Fiscal Impact	$ -	$ -	$ -	$ -	$ -	$ -

Proviso Change Request Form

Agency: South Carolina Department of Mental Health **Code: J12** **Section: 35**

A. Proviso Number
Using the renumbered FY 2013-14 proviso base provided on the OSB website, indicate the proviso number *(If new indicate "New #1", "New #2", etc.)*:

35.1.

B. Appropriation
Related budget category, program, or non-recurring request (*Leave blank if not associated with funding)*:

II. A. 1. – Community Mental Health Centers
II. B. 1. – Psychiatric Rehab
II. B. 2. – Bryan Psychiatric Hospital
II. B. 3. – Hall Psychiatric Hospital
II. B. 4. – Morris Village
II. B. 5. – Harris Psychiatric Hospital
II. C. – Tucker/Dowdy-Gardner
II. E. 1. – Stone Pavilion
II. E. 2. – Campbell Veterans Home
II. E. 3. – Veterans' Victory House
II. F. – Sexual Predator Treatment

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency's section that has had consequences?

This is an agency-specific proviso.

D. Requested Action
(Indicate Add, Delete, Amend, or Codify):

Amend

E. Title
Descriptive Proviso Title:

Medicare Revenue

F. Summary
Summary of Existing or New Proviso:

FY2013 Proviso 23.1. requires SCDMH to remit $290,963 to the General Fund on an annual basis to support the administrative cost for the collection of Medicare benefits.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to recent codification, note the section of the Code of Laws where the language has been codified):

This amended proviso would combine FY2013 Provisos 23.1. and 23.2. Proviso 23.1. requires SCDMH to remit $290,963 to the General Fund on an annual basis to support the administrative cost for the collection of Medicare benefits. Proviso 23.2. considers from revenue earned and collected from various sources, the Department is authorized to expend $6,214,911 for operations and in addition, all fees collected at Campbell Veterans Nursing Home and all other veterans facilities, which are also used for

operations. This proviso further requires the agency transfer from these revenues $400,000 for the Continuum of Care, $50,000 for the Alliance for the Mentally Ill, $250,000 for S.C. Share.

Provisos 23.1. and 23.2. both address the retention and expenditure of funds; therefore, it is reasonable to combine the provisos into one directive.

H. Fiscal Impact (Include impact on each source of funds – state, federal, and other

N/A

1. Proposed Proviso Text

Paste FY 2012-13 text below, then bold and underline insertions, strikethrough deletions. If new, type below.

35.1. (DMH: Patient Fee Account) The Department of Mental Health is hereby authorized to retain and expend its Patient Fee Account funds. In addition to funds collected for the maintenance and medical care for patients, Medicare funds collected by the Department from patients' Medicare benefits, and funds collected by the Department from its veteran facilities shall be considered as patient fees. The Department is authorized to expend these funds for departmental operations, for capital improvements and debt service under the provisions of Act 1276 of 1970, and for the cost of patients' Medicare Part B premiums. The Department shall remit $290,963 to the General Fund and $400,000 to the Continuum of Care, $50,000 to the Alliance for the Mentally Ill, and $250,000 to S.C. Share Self Help Association Regarding Emotions.

Proviso Change Request Form

Agency: South Carolina Department of Mental Health **Code: J12** **Section: 35**

A. Proviso Number
Using the renumbered FY 2013-14 proviso base provided on the OSB website, indicate the proviso number *(If new indicate "New #1", "New #2", etc.)*:

35.2.

B. Appropriation
Related budget category, program, or non-recurring request (*Leave blank if not associated with funding)*:

II. A. 1. – Community Mental Health Centers
II. B. 1. – Psychiatric Rehab
II. B. 2. – Bryan Psychiatric Hospital
II. B. 3. – Hall Psychiatric Hospital
II. B. 4. – Morris Village
II. B. 5. – Harris Psychiatric Hospital
II. C. – Tucker/Dowdy-Gardner
II. E. 1. – Stone Pavilion
II. E. 2. – Campbell Veterans Home
II. E. 3. – Veterans' Victory House
II. F. – Sexual Predator Treatment

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency's section that has had consequences?

This is an agency-specific proviso.

D. Requested Action
*(*Indicate Add, Delete, Amend, or Codify):

Delete

E. Title
Descriptive Proviso Title:

Patient Fee Account

F. Summary
Summary of Existing or New Proviso:

Proviso 23.2. considers from revenue earned and collected from various sources, the Department is authorized to expend $6,214,911 for operations and in addition, all fees collected at Campbell Veterans Nursing Home and all other veterans facilities, which are also used for operations. This proviso further requires the agency transfer from these revenues $400,000 for the Continuum of Care, $50,000 for the Alliance for the Mentally Ill, $250,000 for S.C. Share.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to recent codification, note the section of the Code of Laws where the language has been codified):

Provisos 23.1. and 23.2. both address the retention and expenditure of funds; therefore, it is reasonable to combine the provisos into one directive, 35.1.

Proviso Change Request Form

H. Fiscal Impact (Include impact on each source of funds – state, federal, and other

N/A

I. Proposed Proviso Text

Paste FY 2012-13 text below, then bold and underline insertions, strikethrough deletions. If new, type below.

~~35.2. (DMH: Patient Fee Account) In addition to other payments provided in Part I of this act, the Department of Mental Health is hereby authorized during the current fiscal year, to provide the funds budgeted herein for $6,214,911 for departmental operations, $400,000 for the Continuum of Care, $50,000 for the Alliance for the Mentally Ill, $250,000 for S.C. SHARE Self Help Association Regarding Emotions, and all fees collected at the Campbell Nursing Home and other veterans facilities for day-to-day operations, from the Patient Fee Account which has been previously designated for capital improvements and debt service under provisions of Act 1276 of 1970. The Department of Mental Health is authorized to fund the cost of Medicare Part B premiums from its Patient Fee Account up to $150,000. The South Carolina Alliance for the Mentally Ill and the South Carolina Self-Help Association Regarding Emotions shall provide an itemized budget before the receipt of funds and quarterly financial statements to the Department of Mental Health. DMH is authorized to use unobligated Patient Paying Fee Account funds for community transition programs. The funds made available shall be utilized consistently with the Transition Leadership Council's definition of severely mentally ill children and adults. The department shall report their use of these funds to the Senate Finance Committee and the House Ways and Means Committee. This amendment is made notwithstanding other obligations currently set forth in this proviso.~~

Proviso Change Request Form

Agency: South Carolina Department of Mental Health **Code: J12** **Section: 35**

A. Proviso Number
Using the renumbered FY 2013-14 proviso base provided on the OSB website, indicate the proviso number *(If new indicate "New #1","New #2", etc.)*:

35.7.

B. Appropriation
Related budget category, program, or non-recurring request (*Leave blank if not associated with funding)*:

II. A. 1. – Community Mental Health Centers

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency's section that has had consequences?

This is an agency-specific proviso.

D. Requested Action
*(*Indicate Add, Delete, Amend, or Codify):

Delete

E. Title
Descriptive Proviso Title:

Crisis Stabilization

F. Summary
Summary of Existing or New Proviso:

During the current fiscal year, the Department must expend for crisis stabilization program not less than $2 million. Funds expended by the Department for crisis stabilization must be used to implement and maintain a crisis stabilization program, or to provide access to a crisis stabilization program through the purchase of local psychiatric beds, in each community mental health center catchment area.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to recent codification, note the section of the Code of Laws where the language has been codified):

The Department consistently expends more than $2 million for crisis stabilization programs. In FY2010, FY2011, and FY2012, the Department expended, respectively, $4,002,459, $4,021,840, and $5,517,232. The threshold of $2 million is no longer relevant.

H. Fiscal Impact (Include impact on each source of funds – state, federal, and other

N/A

I. Proposed Proviso Text
Paste FY 2012-13 text below, then bold and underline insertions, strikethrough deletions. If new, type below.

Proviso Change Request Form

~~35.7. (DMH: Crisis Stabilization) During the current fiscal year, the Department of Mental Health must expend for crisis stabilization programs not less than $2 million. Funds expended by the department for the crisis stabilization program must be used to implement and maintain a crisis stabilization program, or to provide access to a crisis stabilization program through the purchase of local psychiatric beds, in each community mental health center catchment area. As used in this proviso, "crisis stabilization program" means a community-based psychiatric program providing short-term, intensive, mental health treatment in a non-hospital setting for persons who are experiencing a psychiatric crisis and who are either unable to safely function in their daily lives or are a potential threat to themselves or the community, with treatment available twenty-four hours a day, seven days a week. The department must submit a quarterly report, not later than thirty days after the end of each calendar quarter, to the Governor, the Chairman of the Senate Finance Committee, and the Chairman of the House Ways and Means Committee, identifying the crisis stabilization program in each community mental health center catchment area, the number of persons served, and the expenditures for the crisis stabilization program for the reporting period. The quarterly report must also include information on the number of persons and the duration of stay for persons who are held in hospital emergency rooms when the crisis stabilization program is unable to serve the person.~~

Proviso Change Request Form

Agency: South Carolina Department of Mental Health **Code: J12** **Section: 35**

A. Proviso Number
Using the renumbered FY 2013-14 proviso base provided on the OSB website, indicate the proviso number *(If new indicate "New #1", "New #2", etc.)*:

35.12.

B. Appropriation
Related budget category, program, or non-recurring request (*Leave blank if not associated with funding)*:

II. A. 1. – Community Mental Health Centers

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency's section that has had consequences?

This is an agency-specific proviso.

D. Requested Action
(Indicate Add, Delete, Amend, or Codify):

Delete

E. Title
Descriptive Proviso Title:

Medicaid Beneficiary Choice

F. Summary
Summary of Existing or New Proviso:

For Medicaid covered community based paraprofessional rehabilitative behavioral health services for which the Department of Mental Health provides state identified matching funds, the Department must allow a Medicaid beneficiary to receive medically necessary community based paraprofessional rehabilitative behavioral health services from any qualified Medicaid provider enrolled by DHHS as of July 1, 2011.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to recent codification, note the section of the Code of Laws where the language has been codified):

As of July 1, 2012, the funds related to Medicaid covered community based paraprofessional rehabilitative behavioral health services for which the Department of Mental Health provides state identified matching funds have been transferred to SCDHHS along with overall responsibility for the program. This proviso is no longer relevant.

H. Fiscal Impact (Include impact on each source of funds – state, federal, and other

N/A

I. Proposed Proviso Text
Paste FY 2012-13 text below, then bold and underline insertions, strikethrough deletions. If new, type below.

~~35.12. (DMH: Medicaid Beneficiary Choice) For Medicaid covered community based paraprofessional rehabilitative behavioral health services for which the Department of Mental Health provides state identified matching funds, the department must allow a Medicaid beneficiary to receive medically necessary community based paraprofessional rehabilitative behavioral health services from any qualified Medicaid provider enrolled by the Department of Health and Human Services as of July 1, 2011.~~

Proviso Change Request Form

Agency: South Carolina Department of Mental Health **Code: J12** **Section: 35**

A. Proviso Number

Using the renumbered FY 2013-14 proviso base provided on the OSB website, indicate the proviso number *(If new indicate "New #1","New #2", etc.)*:

35.13.

B. Appropriation

Related budget category, program, or non-recurring request (*Leave blank if not associated with funding)*:

II. F. – Sexual Predator Treatment

C. Agency Interest

Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency's section that has had consequences?

This is an agency-specific proviso.

D. Requested Action

*(*Indicate Add, Delete, Amend, or Codify):

Delete

E. Title

Descriptive Proviso Title:

Sexually Violent Predator Program

F. Summary

Summary of Existing or New Proviso:

The South Carolina Department of Mental Health and the South Carolina Department of Corrections are directed to prepare a report evaluating the feasibility and desirability of transferring the SVP Program to the Department of Corrections.

G. Explanation of Amendment to/or Deletion of Existing Proviso

(If request to delete proviso is due to recent codification, note the section of the Code of Laws where the language has been codified):

The deliverable mentioned in this proviso is due May 1, 2013. This date falls outside the scope of FY2014. This proviso is no longer relevant.

H. Fiscal Impact (Include impact on each source of funds – state, federal, and other

N/A

I. Proposed Proviso Text

Paste FY 2012-13 text below, then bold and underline insertions, strikethrough deletions. If new, type below.

~~35.13. (DMH: Sexually Violent Predator Program) The Department of Mental Health and the Department of Corrections shall prepare a report evaluating the feasibility and desirability of transferring the Sexually Violent Predator Program to the Department of Corrections. This report must include~~

~~population and cost projections for the next five years, and must also explore and make recommendations regarding opportunities to further expand the private sector's role in operating this program. An update on the status of this report shall be provided to the Chairman of the Senate Finance Committee, the Chairman of the Senate Medical Affairs Committee, the Chairman of the Senate Corrections and Penology Committee, the Chairman of the House Ways and Means Committee, the Chairman of the House Judiciary Committee, and the Chairman of the Medical, Military, Public, and Municipal Affairs Committee by January 8, 2013 and the final report shall be provided by May 1, 2013.~~

Proviso Change Request Form

Agency: South Carolina Department of Mental Health **Code: J12** **Section: 35**

A. Proviso Number
Using the renumbered FY 2013-14 proviso base provided on the OSB website, indicate the proviso number *(If new indicate "New #1","New #2", etc.)*:

New #1

B. Appropriation
Related budget category, program, or non-recurring request (*Leave blank if not associated with funding)*:

II. A. 1. – Community Mental Health Centers
II. B. 1. – Psychiatric Rehab
II. B. 2. – Bryan Psychiatric Hospital
II. B. 3. – Hall Psychiatric Hospital
II. B. 4. – Morris Village
II. B. 5. – Harris Psychiatric Hospital
II. C. – Tucker/Dowdy-Gardner
II. E. 1. – Stone Pavilion
II. E. 2. – Campbell Veterans Home
II. E. 3. – Veterans' Victory House
II. F. – Sexual Predator Treatment

C. Agency Interest
Is this proviso agency-specific, a general proviso that affects the agency, or a proviso from another agency's section that has had consequences?

This is an agency-specific proviso.

D. Requested Action
*(*Indicate Add, Delete, Amend, or Codify):

Add

E. Title
Descriptive Proviso Title:

Deferred Maintenance, Capital Projects, Ordinary Repair and Maintenance

F. Summary
Summary of Existing or New Proviso:

Based on a request to identify deferred maintenance funding sources, SCDMH would establish a fund to be utilized for deferred maintenance, capital projects and ordinary repair and maintenance.

G. Explanation of Amendment to/or Deletion of Existing Proviso
(If request to delete proviso is due to recent codification, note the section of the Code of Laws where the language has been codified):

N/A

H. Fiscal Impact (Include impact on each source of funds – state, federal, and other

N/A

Proviso Change Request Form

1. **Proposed Proviso Text**
Paste FY 2012-13 text below, then bold and underline insertions, strikethrough deletions. If new, type below.

New #1. (DMH: Deferred Maintenance, Capital Projects, Ordinary Repair and Maintenance) The Department of Mental Health is authorized to establish an interest bearing fund with the State Treasurer to deposit funds appropriated for deferred maintenance and other one-time funds from any source. After receiving any required approvals, the Department is authorized to expend these funds for the purpose of deferred maintenance, capital projects, and ordinary repair and maintenance. These funds may be carried forward from the prior fiscal year into the current fiscal year to be used for the same purpose.

South Carolina Department of Mental Health
Proviso 89.85 - Fines and Fees
Fiscal Year 2012

Title	Amount	Statute or Proviso	Revenue Generated	Items Supported
PATIENT FEE (See Note)	14,027,695.83	Title 44 Chapter 11 of the South Carolina Code of Laws	Fees collected from on behalf of or from patients	SC Mental Health System
PHOTOCOPY FEE	15,632.04	Section 30-4-30 of the South Carolina Code of Laws	Photocopy fee	SC Mental Health System
PUBLIC SAFETY FINE	370.00	Section 56-21-110 of the South Carolina Code of Laws	Public Safety fines	SC Mental Health System
TOTAL	14,043,697.87			

Note:
Proviso 23.1 Bonded Indebtedness - $ 603,880
Proviso 23.1 Transfer to General Fund - $ 290,963
Proviso 23.3 Departmental Operations - $ 10,622,873.33
Proviso 23.3 Alliance for Mentally Ill - $ 50,000
Proviso 23.3 SC Share - $ 250,000
Proviso 23.3 Continum of Care - $ 400,000

Department of Mental Health Travel Report (as published by CG's Office)		
FY 2004	$	945,729
FY 2005	$	988,181
FY 2006	$	811,355
FY 2007	$	867,297
FY 2008	$	794,488
FY 2009	$	547,946
FY 2010	$	372,097
FY 2011	$	371,730
FY 2012	$	344,660
FY 2004	$	945,729
FY 2012	$	344,660
$ Decrease	$	(601,070)
% Decrease		-64%