LEGISLATIVE RESEARCH COMMISSION

IN-HOME AND COMMUNITY BASED MENTAL HEALTH SERVICES FOR YOUTH COMMITTEE

NORTH CAROLINA GENERAL ASSEMBLY

REPORT TO THE 2012 SESSION of the 2011 GENERAL ASSEMBLY OF NORTH CAROLINA

APRIL10, 2012

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TRANSMITTAL LETTER

May 16, 2012

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TO THE MEMBERS OF THE 2012 REGULAR SESSION
OF THE 2011 GENERAL ASSEMBLY

The Legislative Research Commission herewith submits to you for your consideration its report and recommendations to the 2012 Regular Session of the 2011 General Assembly. The report was prepared by the Legislative Research Commission's Committee on In-Home and Community Based Mental Health Services for Youth, pursuant to G.S. 120-30.70(1).

Respectfully submitted,

Senator Philip E. Berger
President Pro Tempore of the Senate

Representative Thomas R. Tillis
Speaker of the House of Representatives

Co-Chairs
Legislative Research Commission

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LEGISLATIVE RESEARCH COMMISSION MEMBERSHIP

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2011 – 2012

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PREFACE

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The Legislative Research Commission, established by Article 6B of Chapter 120 of the General Statutes, is the general purpose study group in the Legislative Branch of State Government. The Commission is co-chaired by the President Pro Tempore of the Senate and the Speaker of the House of Representatives and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigation into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" (G.S. 120-30.17(1)).

The Legislative Research Commission authorized the study of In-Home and Community Based Mental Health Services for Youth, under authority of G.S. 120-30.17(1). The Committee was chaired by Senator Fletcher Hartsell and Representative Mark Hollo, Co-Chairs of the Committee. The full membership of the Committee is listed under Committee Membership. A committee notebook containing the committee minutes and all information presented to the committee will be filed in the Legislative Library by the end of the **2011-2012** biennium.

COMMITTEE PROCEEDINGS

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The Legislative Research Commission's Committee on In-Home and Community Based Mental Health Services for Youth met 4 times after the 2011 Regular Session. The Committee's Charge can be found here. The following is a brief summary of the Committee's proceedings. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

January 12, 2012

The Committee held its first meeting on Thursday, January 12, 2012 at 10:00 a.m. in Room 544 of the Legislative Office Building. Representative Mark Hollo, Co-Chair, presided. Shawn Parker, Staff Attorney with the Research Division, presented the Committee's charge and an overview of the LRC committee process.

Kelly Crosbie, Licensed Clinical Social Worker and Chief of Behavioral Health Section in the Division of Medial Assistance (DMA), Department of Health and Human Services (DHHS) made a presentation to the Committee on the array of Medicaid-funded in-home and community based services available for children and adolescents under the age of 21. At the conclusion of her presentation, Ms. Crosbie introduced Ms. Shealy Thompson and Ms. Becky Ebron, both from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Community Policy Management Section. Ms. Crosbie, Ms. Thompson, and Ms. Ebron responded to committee members' questions about available services and the NC Treatment Outcomes and Program Performance System (TOPPS).

Ms. Annie Smith, NC State Director for Youth Villages and Mr. Lee Rone, Chief Operating Officer for Youth Villages made a presentation to the Committee entitled *Tracking Outcomes for Youth Mental Health Services*. Youth Villages is a non-profit organization that provides home and community-based mental health services to children and their families.

Mr. Rone presented information about intensive in-home and transitional living services offered by Youth Villages in North Carolina. Youth Villages' services are based upon evidenced-based practices. The agency routinely collects outcome data to measure and evaluate the impact on the children served by these programs.

Committee members had multiple questions and comments following each of the presentations. After the final presentation, Chairman Hollo offered members of the public the opportunity to address the Committee. No one from the public requested to speak.

February 9, 2012

The Committee held its second meeting on Thursday, February 9, 2012 at 10:00 a.m. in Room 544 of the Legislative Office Building. Senator Fletcher Hartsell, Co-Chair, presided.

Kelly Crosbie, Chief of the Behavioral Health Section Clinical Policy and Programs, DMA, DHHS, made a follow up presentation to her January 12, 2012, presentation on the array of Medicaid-funded in-home and community based services offered to children and adolescents with emotional, behavioral, substance abuse and mental health issues. In this presentation, she addressed the following issues:

- Annual utilization and cost of State-funded Home and Community Based Services (FY 2010-2011)
- NC-TOPPS outcomes for adolescent mental health consumers who completed treatment (FY 2011)
- NC-TOPPS outcomes for adolescent mental health consumers who didn't complete treatment (FY 2011)
- Day treatment facilities: number of school-based service settings, number of off-campus service settings and length of stay in day treatment
- Medicaid staffing requirements for Level IV Residential Facilities
- Number of youth in out-of-state Psychiatric Residential Treatment Facilities (PRTF) and expenditures (FY 2012)

Dr. Ann-Marie Iselin, Research Scientist, Center for Child and Family Policy, Duke University explained that evidence-based treatments have been shown to be effective at reaching consistent outcomes in rigorous studies by different researchers or providers. Evidence-based treatments provide reasonable expectations that allow for comparisons of different programs. Dr. Iselin also reviewed the outcomes and costs and benefits for four programs: Functional Family Therapy (FFT), Multisystemic Treatment (MST), Brief Strategic Family Therapy (BSFT), and Multidimensional Treatment Foster Care (MTFC). There are also factors beyond evidence-based treatments that are important for success, including prevention and service delivery practices.

Kevin Kelley, Section Chief, Child Welfare Services, DHHS, gave some information about children in foster care. The average number of children in foster care at any time is 8,500 and the top three placement settings are family foster home (37%), relative care (21%) and therapeutic foster home (13%). The median length of stay for children in foster care is just over a year and children leave foster care either by means of reunification with family, guardianship with a relative, adoption, custody to non-removal parent, custody with other court approved caretaker or emancipation. The first goal is to reunify a child in foster care with their family.

Brian Manness, Vice President, Children's Home Society and Donna Henderson, Divisional Director/Family Finding explained the Family Finding program that works to

locate family members of children in foster care and to establish permanent family connections and support. From 2008-2011, 10 counties have participated in a Family Finding pilot project in Buncombe, Burke, Catawba, Cleveland, Forsyth, Guilford, Lincoln, Pitt, Scotland, and Wake Counties. An evaluation is currently being conducted of the safety, permanency, and well-being of children receiving Family Finding Services compared with similar children not receiving Family Finding services. Two short-term outcomes are a large number of relatives committing to ongoing relationships and a large number of relatives committing to adoption or guardianship. The Children's Home Society is looking to expand this program to 25-30 sites in over 20 counties serving over 250 children annually by 2014. In addition to the improved outcomes for children in foster care, the Family Finding program also provides savings for the State. For example, services for the 10,287 children in the foster care system in 2010 cost the State about $421 million or approximately $39,000 per child.

March 20, 2012

The Committee held its third meeting on Tuesday, March 20, 2012 at 10:00 a.m. in Room 1027 of the Legislative Building. Representative Mark Hollo, Co-Chair, presided.

Ms. Pam Burton, Regional Mental Health and Substance Abuse Care Coordination Manager with PBH, (formerly Piedmont Behavioral Healthcare) presented an outline of PBH's proposal of an Managed Care Organization (MCO) provider's partnership that is result oriented and outcome driven. She asked the committee to endorse the proposed demonstration project between PBH and Youth Villages.

Ms. Annie Smith, North Carolina State Director of Youth Villages made a presentation on Youth Villages Intercept Approach. The presentation provided examples of how Youth Villages provides successful interventions for youth to avoid out-of-home care and reunifies youth with their families through Youth Villages' work in 11 states.

Shawn Parker, Staff Attorney with the Research Division, presented the Committee's charge and presented the committee issues discussed in the previous meetings for direction in preparing the committee's report to the full LRC.

After extensive discussion and suggestions regarding the recommendations, Senator Hartsell moved to authorize staff to prepare a report to the full LRC, consistent with what took place in the meeting, and with the recommendation identified in the committee handout as a first report.

April 10, 2012

The Committee held its fourth meeting on Tuesday, April 10, 2012 at 10:00 a.m. in Room 544 of the Legislative Office Building. Senator Fletcher Hartsell, Co-Chair, presided. The Committee voted to adopt its report as amended.

FINDINGS AND RECOMMENDATIONS

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Finding: In-home and community based mental health services offer youths and their families an effective and less costly alternative to institutionalization.

- Home and community-based mental health services allow youth to receive treatment while remaining in their homes and communities and close to their families.

Finding: In-home and community based mental health services are an appropriate alternative for most youths, with more restrictive and costly residential treatment reserved for those with the more severe needs or who cannot be treated safely in a community setting.

- Residential services are an appropriate, effective, and important component in the spectrum of children's mental health services but their use should be reserved for and limited to those with the most severe needs.
- Home and community based services can effectively be used to divert or transition youth from higher cost residential treatment programs.

Finding: DHHS, through the Divisions of Medical Assistance and Mental Health Services/Developmental Disabilities/Substance Abuse Services, offers an array of mental health home and community based services, in addition to residential treatment programs to serve children and their families. The programs include

- Outpatient Child Mental Health Services
- Intensive In-home Mental Health Services (IIH)
- Multisystemic Therapy (MST)
- Substance Abuse Intensive Outpatient Program (SAIOP)
- Residential Childcare
- Therapeutic Foster Care
- Group Homes
- Psychiatric Residential Treatment Facilities (PRTF)

Recommendation 1:

North Carolina should use State, federal, and other resources to maximize the availability of home and community-based mental health services for youths and their families.

Finding: Evidenced-based treatment approaches have undergone rigorous research and evaluation with documented results of their effectiveness. Research indicates that evidence-based programs are effective in improving mental health outcomes for youth, reduce or prevent the need for residential care, and can reduce recidivism, out-of-home placement, substance abuse and school failure

- *Evidence Based Treatment is defined as the use of systematic decision-making processes or provision of services which have been shown, through available scientific evidence, to consistently improve measurable client outcomes. Instead of tradition, gut reaction or single observations as the basis for making decisions, evidenced-based approaches are based upon data collected through experimental research ...*[1].

Finding: Evidenced-based treatment includes, but is not limited to:

- Functional Family Therapy (FFT) - a short-term family-focused intervention program with an average of 12 sessions over a 3-4 month period. Services are provided in both clinic and home settings, and can also be provided in a variety of other settings including schools, child welfare facilities, and mental health facilities.
- Multisystemic Therapy (MST) - addresses the multiple causes of serious antisocial and other disorders in children and adolescents. The MST approach views individuals as part of a complex network of interconnected systems that include the youth, family, peers, school, and the community. Intervention may be necessary in any one or a combination of these systems
- Brief Strategic Family Therapy (BSFT) – focuses on factors in the child's and parent's relationships which contribute to problem behaviors
- Multidimensional Treatment Foster Care (MTFC) – provides consistent, immediate teaching and reinforcement to the child in a structured environment and teaches effective parenting skills

Finding: Some evidenced-based mental health treatment services are provided in North Carolina but are not available on state-wide basis. Local Management Entities (LMEs) determine which child mental health services will be offered in their catchment areas

Recommendation 2:

As the mental health service delivery system in North Carolina transitions to a behavioral health managed care environment, LMEs are encouraged to increase the availability and use of home and community-based child mental health services that evidenced-based and outcome driven.

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[1] Evidence-Based Practice Institute, University of Washington School of Medicine (Evidence Based Practice Institute - University of Washington)

Finding: DHHS does not have a system in place to track the use of the evidence-based treatment programs or document their effectiveness.

- The Department utilizes the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS) to collect data on the effectiveness of the children's mental health services funded with Medicaid or State general funds.

- NC-TOPPS is not a comprehensive, state-wide database as mental health service providers are not required to report or submit outcome data to NC-TOPPS

Finding : Tracking the outcomes of mental health treatment services with standardized measures is important to help identify those services that have positive outcomes over time. Tracking should be limited to non-evidence-based treatment services since they have been proven to produce consistent outcomes.

Recommendation 3:

DHHS, in cooperation with the NC –TOPPS Taskforce, LMEs, and local providers, shall determine what data needs to be collected to track the outcomes of services, develop standardized measures for data collection, determine whether LMEs or providers will be responsible for collecting and maintaining the data, and how to make the data accessible to consumers so they can compare services.

Finding: Consistent with the System of Care philosophy of providing care in the least restrictive most normative environment, efforts should be increased to reduce the number of children and adolescents placed in Residential Treatment Services.

Finding: B3 services, if approved by the Centers of Medicare and Medicaid Services, can be utilized to as Customized Community Integration Services which are intended to:

- Assist in reducing cost and lengths of stay in child residential services.
- Assist children in reaching and maintaining progress on treatment goals.
- Support families by improving communication and conflict resolution skills and assisting youth and family build connection within the local community.
- Reduce recidivism of youth in residential treatment

Finding: PBH, a Local Management Entity, operates under a 1915 b/c waiver which provides flexibility within the State Medicaid program for providers to demonstrate beneficial outcomes for Medicaid recipients through alternative programs. Youth Villages has provided information which tends to show that they have provided successful interventions for youth to avoid out-of home care and reunification of youth with their families through their work in 11 states. The Committee has expressed support for the partnership between PBH and Youth Villages to implement a demonstration program (Customized Community Integration Services) that utilize B3 services targeted at youths age 6-20 to reduce lengths of stay or to divert residential placements when the placement is not appropriate or medically necessary.

Recommendation 4:

The Committee encourages all LMEs to explore, develop and utilize innovative programs based on evidence- and outcome-based practices that provide successful interventions and improve services for youth in an in-home or community based setting.

Finding: The General Assembly would benefit from having a method to measure what evidence- and outcome-based services are being provided by LMEs and to compare methods and outcomes using a tool and report in a format similar to the quarterly report on LME performance included in Appendix D (Critical Measures at a Glance).

Recommendation 5:

The Committee recommends that the General Assembly direct the Department of Health and Human Services to develop criteria for the measurement of the effectiveness of LMEs' evidence- and outcome-based programs for youth, and to report to the General Assembly. The Committee further recommends that on an annual basis, the General Assembly review the effectiveness of various evidence- and outcome-based services and treatment programs to determine beneficial approaches towards achieving approved and desired outcomes for children served.

COMMITTEE MEMBERSHIP

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2011-2012

President Pro Tempore of the Senate Appointments:

Senator Fletcher Hartsell, Co-Chair

Senator Austin Allran
Senator Stan Bingham
Senator Martin Nesbitt
Senator Tommy Tucker

Speaker of the House of Representatives Appointments:

Representative Mark Hollo, Co-Chair

Representative William Brisson
Representative Justin Burr
Representative Pat Hurley
Representative Verla Insko

COMMITTEE CHARGE

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Study the development and implementation of a demonstration program for mental health providers providing in home and community based services to youth up to age 20 under the State Medicaid program, the purpose of which is to establish reimbursement and regulatory flexibility for providers that demonstrate beneficial outcomes for Medicaid recipients served.

STATUTORY AUTHORITY

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NORTH CAROLINA GENERAL STATUTES
ARTICLE 6B.

Legislative Research Commission.

§ 120-30.17. Powers and duties.

The Legislative Research Commission has the following powers and duties:

(1) Pursuant to the direction of the General Assembly or either house thereof, or of the chairmen, to make or cause to be made such studies of and investigations into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner.

(2) To report to the General Assembly the results of the studies made. The reports may be accompanied by the recommendations of the Commission and bills suggested to effectuate the recommendations.

(3), (4) Repealed by Session Laws 1969, c. 1184, s. 8.

(5), (6) Repealed by Session Laws 1981, c. 688, s. 2.

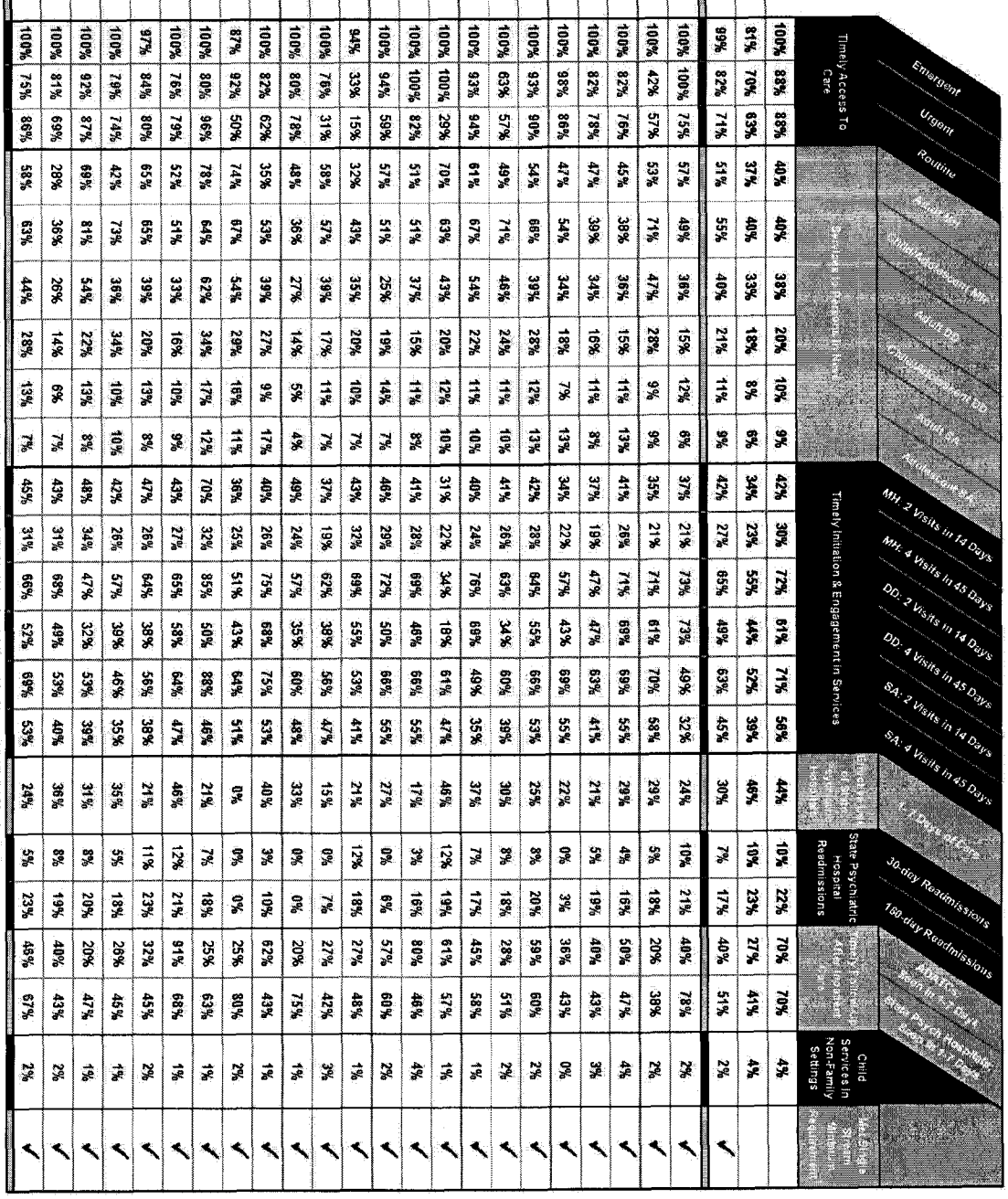
(7) To obtain information and data from all State officers, agents, agencies and departments, while in discharge of its duty, pursuant to the provisions of G.S. 120-19 as if it were a committee of the General Assembly.

(8) To call witnesses and compel testimony relevant to any matter properly before the Commission or any of its committees. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Commission and its committees as if each were a joint committee of the General Assembly. In addition to the other signatures required for the issuance of a subpoena under this subsection, the subpoena shall also be signed by the members of the Commission or of its committee who vote for the issuance of the subpoena.

(9) For studies authorized to be made by the Legislative Research Commission, to request another State agency, board, commission or committee to conduct the study if the Legislative Research Commission determines that the other body is a more appropriate vehicle with which to conduct the study. If the other body agrees, and no legislation specifically provides otherwise, that body shall conduct the study as if the original authorization had assigned the study to that body and shall report to the General Assembly at the same time other studies to be conducted by the Legislative Research Commission are to be reported. The other agency shall conduct the transferred study within the funds already assigned to it.

Appendix D

Critical Measures at a Glance: SFY 2011 Second Quarter LME Performance



SFY2011 Statewide Goal	100%	88%	88%	40%	40%	38%	20%	10%	9%	42%	30%	72%	61%	71%	58%	44%	10%	22%	70%	70%	4%	
SFY2011 Performance Standard	81%	70%	63%	37%	40%	33%	18%	8%	6%	34%	23%	55%	44%	52%	39%	46%	10%	23%	27%	41%	4%	
Statewide Average	99%	82%	71%	51%	55%	40%	21%	11%	9%	42%	27%	65%	49%	63%	45%	30%	7%	17%	40%	51%	2%	✓
Alamance-Caswell	100%	100%	75%	57%	49%	36%	15%	12%	6%	37%	21%	73%	73%	49%	32%	24%	10%	21%	40%	78%	2%	✓
Beacon Center	100%	42%	57%	53%	71%	47%	28%	9%	9%	35%	21%	71%	61%	70%	58%	29%	5%	18%	20%	38%	2%	✓
CenterPoint	100%	82%	76%	45%	38%	36%	15%	11%	13%	41%	26%	71%	69%	69%	55%	29%	4%	16%	50%	47%	4%	✓
Crossroads	100%	82%	78%	47%	39%	34%	16%	11%	8%	37%	19%	47%	47%	63%	41%	21%	5%	19%	40%	43%	3%	✓
Cumberland	100%	98%	86%	47%	54%	34%	18%	7%	13%	34%	22%	57%	43%	69%	55%	22%	0%	3%	36%	43%	0%	✓
Durham Center	100%	93%	90%	54%	66%	39%	28%	12%	13%	42%	28%	64%	55%	66%	53%	25%	8%	20%	59%	60%	2%	✓
ECBH	100%	63%	57%	49%	71%	46%	24%	11%	10%	41%	26%	63%	34%	60%	39%	30%	8%	18%	28%	51%	2%	✓
Eastpointe	100%	93%	94%	61%	67%	54%	22%	11%	10%	40%	24%	76%	69%	49%	35%	37%	7%	17%	45%	58%	1%	✓
Five County	100%	100%	29%	70%	63%	43%	20%	12%	10%	31%	22%	34%	18%	61%	47%	46%	12%	19%	61%	57%	1%	✓
Guilford Center	100%	100%	82%	51%	51%	37%	15%	11%	8%	41%	28%	69%	46%	66%	55%	17%	3%	16%	80%	46%	4%	✓
Johnston	100%	94%	59%	57%	51%	25%	19%	14%	7%	46%	29%	72%	50%	68%	55%	27%	0%	6%	57%	60%	2%	✓
Mecklenburg	94%	33%	15%	32%	43%	35%	20%	10%	7%	43%	32%	69%	55%	53%	41%	21%	12%	18%	27%	48%	1%	✓
Mental Health Partners	100%	76%	31%	58%	57%	39%	17%	11%	7%	37%	19%	62%	38%	56%	47%	15%	0%	7%	27%	42%	3%	✓
Onslow-Carteret	100%	80%	78%	48%	36%	27%	14%	5%	4%	49%	24%	57%	35%	60%	48%	33%	0%	0%	20%	75%	1%	✓
Orange-Person-Chatham	100%	82%	62%	35%	53%	39%	27%	9%	17%	48%	26%	75%	68%	75%	53%	40%	3%	10%	62%	43%	1%	✓
Pathways	87%	92%	50%	74%	67%	54%	29%	16%	11%	36%	25%	51%	43%	64%	51%	0%	0%	0%	25%	80%	2%	✓
PBH	100%	80%	96%	78%	64%	62%	34%	17%	12%	70%	32%	85%	50%	88%	46%	21%	7%	18%	25%	63%	1%	✓
Sandhills Center	100%	76%	79%	52%	51%	33%	16%	10%	9%	43%	27%	65%	58%	64%	47%	46%	12%	21%	91%	68%	1%	✓
Smoky Mountain Center	97%	84%	80%	65%	65%	39%	20%	13%	8%	47%	26%	64%	38%	56%	38%	21%	11%	23%	32%	45%	2%	✓
Southeastern Center	100%	78%	74%	42%	73%	36%	34%	10%	10%	42%	26%	57%	39%	46%	35%	35%	5%	18%	26%	45%	1%	✓
Southeastern Regional	100%	92%	87%	68%	81%	54%	22%	13%	8%	48%	34%	47%	32%	53%	38%	31%	8%	20%	20%	47%	1%	✓
Wake	100%	81%	69%	28%	36%	26%	14%	6%	7%	43%	31%	68%	49%	53%	40%	36%	8%	19%	40%	43%	2%	✓
Western Highlands Network	100%	73%	86%	58%	63%	44%	28%	13%	7%	45%	31%	66%	52%	69%	53%	24%	5%	23%	48%	67%	2%	✓

[1] A checkmark in the column indicates the LME has met the performance standards for at least 65% of the critical measures, which is one of the requirements for consideration to receive single stream funding.

NOTE: Percentages in green font have met or exceeded the SFY2011 performance standard for the measure.

Critical Measures at a Glance

Introduction

This matrix was developed in response to S.L. 2008-107 (HB2436) to provide a quarterly summary of the Local Management Entities' status on critical measures that are included in the annual *DHHS-LME Performance Contract*. An LME is required to meet the Performance Standard on at least 65% of these measures to be eligible for single stream funding. The detailed information that generates this chart is presented each quarter in the *Community Systems Progress Report*, which is published on the DMH/DD/SAS website at http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm .

How To Read the Chart

The **21 critical measures** are presented across the top of the chart and grouped by type of measure. They include:

> Timely Access to Care: This is a measure of **how long it takes an individual to enter care**. Persons with emergent needs are expected to be provided access to care within 2 hours of requesting it. Those with urgent needs should be seen within 48 hours. Persons with routine needs are expected to be seen within 14 days.

> Services to Persons In Need: This measures **how many people that are estimated to have MH/DD/SA problems each year receive publicly-funded MH/DD/SAS services**. This measure is often called "treated prevalence" or "penetration rate."

> Timely Initiation and Engagement In Services: Initiation measures **how quickly a person receives treatment or supports** after entering care. Engagement measures whether they begin to receive **enough services** to reduce the occurrence of crises and to improve chances for recovery and stability.

> Effective Use of State Psychiatric Hospitals: This is a measure of **how many people are entering the state hospitals for crisis stabilization**. An effective community crisis service system, good person-centered planning, and adequate community services are expected to reduce short-term stays in the state hospitals, keeping them available for persons with very complex needs.

> State Psychiatric Hospital Readmissions: This measures the effectiveness of **coordination between the state hospitals and community services**. Good hospital-LME communication, thorough person-centered planning, and adequate community services after individuals are discharged from the hospitals are expected to reduce the need for readmissions.

> Timely Follow-Up After Inpatient Care: This measures the **continuity of care** after a person is discharged from the hospital. Each person is expected to receive a follow-up service in the community within 7 days of being discharged from a state facility to ensure adequate medications and engagement in continuing care.

> Child Services in Non-Family Settings: This measures the percent of **children (ages 0-18) who are placed in non-family residential service settings** (residential treatment Level II-Program Type, Level III and Level IV). Effective supports for families and sufficient alternative family settings, such as therapeutic foster care, are expected to reduce the need for residential child services.

The **"SFY Statewide Goals"** are shown in the first row of the chart. The Division sets statewide goals for the service system at the beginning of the year to reflect current needs, priorities, available resources, and what it believes to be an achievable improvement for the year. Some goals may remain the same from one year to the next while others may increase to reflect where the Division wants community systems to focus their efforts.

The **"SFY Performance Standards"** of the *DHHS-LME Performance Contract* for the indicators are presented in the second row of the chart. The standards are based on recent statewide averages for each indicator and anticipated resource constraints at the time the annual Contract is put into place. Beginning in SFY2010, the performance standards are being reviewed quarterly and adjusted as necessary to reflect changes in available resources.

The **"Statewide Average"** is the performance of the entire state on the critical measures for the quarter being reported.

The 23 **Local Management Entities (LMEs)** are listed in the first column, with their performance on each measure in the rows across the chart. The green numbers indicate that the LME met or exceeded the current SFY Performance Standard. Note that a number equal to or lower than the Performance Standard is desirable for "Effective Use of State Psychiatric Hospitals," "Hospital Readmissions," and "Child Services in Non-Family Settings." A number equal to or higher than the Performance Standard is desired for all other measures. The greyed cells indicate measures for which no data was available.

The **"Met Single Stream Minimum Requirement"** column indicates whether each LME met the Performance Standard for at least 65% of the measures (14 out of 21). This is a requirement to be eligible for single stream funding.