FLORIDA STATE UNIVERSITY

Designing Performance Metrics for Budgeting & Oversight

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The ongoing challenge

- **While members want to make strategic choices, traditional budgets provide little information to inform decisions**
- **Base budget is black hole**
  - **$ tracked by units, expense categories & line items, not programs**
  - **Little info on what agencies are doing or accomplishing**

As a result

- **Process seeks to reconcile revenues with continuation budget**
  - **Fights are about how to invest ‘new’ $**
  - **Cuts, when needed, are generally across the board**
- **There has got to be a better way...**
  - **Many legislators seek to create PM systems to inform choices**

The better way(s)

- Require agencies to report metrics
- Require agencies to provide program inventories
  - Categorized by level of effectiveness evidence
  - Establish funding preferences for evidence-based programs

PM systems

- **Most states require agencies to report some metrics in budget requests**

- **Alas, unless carefully managed, systems produce metrics that are fatally flawed & ignored during process**

Common challenges

- Metrics report outputs (caseloads), not outcomes
- Very incomplete – assess few programs
- Are difficult to interpret
- Metrics selected to make agency look good

Keys to overcoming challenges

- Leadership support is essential
- Requires multi-year commitment to create & fine-tune system & identify performance trends
- Central entity should oversee system & provide consistent vision

Keys to overcoming challenges

- **Requires ongoing training of executive & legislative staff**
  - **Some states have set up performance management academies**
  - **State universities can assist**
  - **Join the NCSL Governing for Results Network!**

Program inventories

- To illuminate appropriations base, can require agencies to report inventories of current programs
  - Need clear definition of ‘program’
  - Can also require agencies to classify programs by level of effectiveness evidence

Minnesota inventory

Service/Practice	Description	Category	Duration/ intensity of service	Target population (Age)	Oversight agency/funding source	Impact on outcomes	Crime
All Children Excel	Seeks to build resiliency in young (under 10) delinquent youth at high-risk of becoming violent offenders. The service integrates services across sectors with care coordination. Focuses on problem management, family engagement, and building protective factors.	Prevention	Varies, but multiple years	Under 10	County, DPS, private foundation	Theory-based	·
Aggression Replacement Training	A cognitive behavioral intervention. It targets chronically aggressive and violent youths. Treatment focuses on improving social skills, moral reasoning, as well as anger and emotional management. Provides youths with an opportunity to learn non-aggressive prosocial skills.	Residential; Supervision	20 sessions; 90 minutes per session	11 - 17	County, DOC supervision, MA/private insurance	Proven effective	Favorable
Building and empowering students together (BEST)	A monthly group meeting involving families, youth, law enforcement, school staff, corrections staff, and human services staff to assist families and youth in addressing concerns and celebrating successes at school, in the community, and at home.	Supervision	One session per month	12-15	County	Theory-based	·
Bullying prevention programming	Designed to stop juveniles from disrespecting others (i.e. lacking respect for the dignity, personal space, safety, and property of others). Programming includes lecture, videos, handouts, and group participation.	Prevention	One session; 3 hours	10-18	County	Theory-based	·
Career curricula and interview skills	Short term job search curriculums. Often include resume help, job search assistance, and interview training. These services differ from vocational programs because they do not teach job skills.	Residential; Supervision	1-3 months	10-18	County, DOC, DEED	Theory-based	·
Circle sentencing	Offenders sit in a circle with victims, other offenders, friends, family, and criminal justice and social service representatives. The group works together to identify steps needed for recovery and the appropriate sentencing plan. This approach comes from American Indian tradition principles.	Supervision	Varies, typically a hour weekly for 8-14 months.	12-18	County	Theory-based	·
Cognitive Behavioral Therapy (CBT)	Refers to a variety of combinations of cognitive and behavioral therapies, which are often adapted to address specific diagnoses. Programming focuses on discussing and restructuring individual perceptions and behaviors in challenging situations. The Therapist may provide guidance on emotional regulation, communication skills, and problem solving. Many different forms of CBT exist. Common models include Thinking for a Change, Becoming a Man, and Carey Guides.	Residential; Supervision	Varies	12-18	County, MA/private insurance	Proven effective	Favorable
Collaborative Intensive Bridging (CIB)	Combines family intensive therapy with a brief residential placement. Residential placement is followed by a second round of family intensive therapy. The program focuses on stabilizing behavior, assisting parents in developing relational skills, building crises management skills, and providing coordination throughout treatment. Addresses issues with: aggression, self-harm, depression, truancy, theft, and acting-out.	Residential; Supervision	Varies; 3 sessions per week; 6-9 months in duration	10-17	County	Theory-based	·
Community Specialists	Designed to support and encourage youth. Community specialists collaborate with probation officers to ensure youth have the community resources they need to become healthy and self-sufficient. To accomplish this, community specialists may assist in the development and implementation of case plans. They also assist in securing educational, employment, or prosocial programming.	Supervision	Weekly contact; Varies in duration	10-18	County	Theory-based	·

Evidence preferences

- **Can create funding preferences for programs with rigorous evidence that they are effective**
  - **Should define levels of evidence**
  - **Can increase percentage mandates over time**

It can be done – New Mexico

- **NM has been developing PM system for 20 years; LFC oversees it**
  - **Legislature made grand bargain with executive – trade line items for good performance information**
  - **Metrics are negotiated with agencies, reported quarterly**

New Mexico

- **LFC issues quarterly agency report cards based on metrics**
  - **Show trends & focus on problem areas**
  - **Used in annual report to members identifying key issues for legislative consideration during Session**

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

PERFORMANCE REPORT CARD: First Quarter, FY22
Behavioral Health Collaborative

The Human Services Department's (HSD's) Behavioral Health Services Division (BHSD) and the Behavioral Health Collaborative (BHC) are working to improve access to behavioral health services and outcomes. Expanding funding and access to the provision of behavioral health services through telehealth has increased behavioral health service provision across the state. Other performance measures meeting the targets for the first quarter include "percent of adults on Medicaid with depression receiving medication," "percent of readmissions of children and youth discharged from residential treatment centers and inpatient care," and "persons receiving behavioral health services via the telephone."

Performance measures performing less effectively are "percent of children and youth on Medicaid discharged from inpatient psychiatric hospitalization receiving community-based follow-up at seven days," and "percent of emergency department visits for Medicaid members ages 13 and older with alcohol or drug dependence who receive follow-up at seven and 30 days." The report card only includes performance measures with quarterly data although BHSD added additional performance measures that provide annual or biannual data. However, lacking quarterly data makes it difficult in the near term to determine if the state's behavioral health investment is effectively serving New Mexicans.

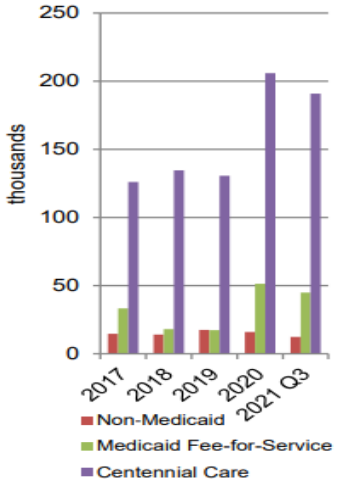
Existing Problem

New Mexico suffered from among the poorest substance use and behavioral health outcomes in the country even before the Covid-19 pandemic further exacerbated anxiety, depression, psychological distress, and substance use. In New Mexico, 19 percent of adults experience mental illness, and as of 2018, New Mexico had the highest suicide rate in the nation, a rate of 25 per 100 thousand people. BHSD reports over 60 percent of adults with moderate mental illness and over 30 percent of adults with serious mental illness in the past year did not receive treatment.

ACTION PLAN

Submitted by agency?	Yes
Timeline assigned?	No
Responsibility assigned?	No

Individuals Served Annually in State-Funded Substance Abuse or Mental Health Programs



million in federal funds to support treatment services for individuals with mental health and substance use disorders. Priorities are to train and provide ongoing coaching to providers on evidence-based practices that can rapidly be delivered via telehealth, enhance the New Mexico Crisis and Access Line (NMCAL), implement peer recovery supports, and support the network of crisis response, including telepsychiatry, crisis triage, and mobile outreach. NMCAL created a dedicated crisis line open 24/7 for healthcare workers and first responders to provide professional counseling and support for those on the front lines of the state's pandemic response, and launched NMConnect, an app that connects New Mexicans to crisis counseling.

network of crisis response, including telepsychiatry. The FEMA and SAMHSA grants are operating collaboratively with certified peer support workers (CPSW) who make behavioral health "check-ins" on quarantined individuals with Covid-19.

Budget: $756,044.1 **FTE:** 53	**FY20 Actual**	**FY21 Actual**	**FY22 Target**	**FY22 Q1**	**FY22 Q2**	**FY22 Q3**	**Rating**
Adult Medicaid members diagnosed with major depression who received continuous treatment with an antidepressant medication	40.6%	38.3%	35%	42%			G
Medicaid members ages 6 to 17 discharged from inpatient psychiatric hospitalization stays of 4 or more days receiving follow-up community-based services at 7 days	43.2%	53.7%	51%	53%			G
Medicaid members ages 18 and older discharged from inpatient psychiatric hospitalization stays of four or more days who receive follow-up community-based services at seven days	43.2%	53.7%	51%	39%			R
Increase in persons served through telehealth in rural and frontier counties*	308%	68.8%	N/A	-10%			Y
Readmissions to same level of care or higher for children or youth discharged from residential treatment centers and inpatient care	8.9%	10.8%	5%	5%			G
Individuals served annually in substance use or mental health programs from the Behavioral Health Collaborative and Medicaid	273,198	200,932	172,000	200,932			G
Emergency department visits for Medicaid members ages 13 and older with a principal diagnosis of alcohol or drug dependence who receive follow-up visit within seven days and 30 days	14.3% 7 day; 21.8% 30 day	13.3% 7 day; 19.7% 30 day	25%	13.6% 7 day; 20.7% 30 day			R
Persons receiving telephone behavioral health services in Medicaid and non-Medicaid programs	NEW	NEW	60,000	30,609			G
Program Rating	R	R					Y

Measure is classified as explanatory and does not have a target.

New Mexico

- **Metrics & evidence are regular part of debate**
  - **Agencies routinely asked about metrics & trends during hearings**
- **Creating ‘LegisStat’ process where key staff of both branches regularly meet to discuss performance trends**

Penn State Evidence to Impact Collaborative

- **Results First Clearinghouse Database**
- **Case studies of state activity**
- **Results First Benefit-Cost model**