John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

TO: Office of the Governor
Commissioner of Administration
House Appropriations Committee
House Health and Welfare Committee
Senate Finance Committee
Senate Health and Welfare Committee
Legislative Fiscal Office

FROM: Rebekah Gee MD
Secretary

RE: FY 2016 Annual Management and Program Analysis Report (AMPAR)

DATE: December 5, 2016

In accordance with Louisiana Revised Statute 36:8, the Department of Health and is submitting its Annual Management and Program Analysis Report (AMPAR) for the 2015-2016 fiscal year. These reports summarize the activities of each office relating to management and program analysis, outstanding accomplishments, areas where we are making significant progress and specific management/operational issues that exist within the agency.

If there are any questions regarding these reports, you may contact Elizabeth Davis at 225-342-5608 or via email at Liz.Davis@la.gov.

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
300 Jefferson Parish Human Services Authority

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Alicia English Rhoden**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Ambulatory Detoxification and Medication Assisted Treatment (MAT)

A. What was achieved?

Jefferson Parish Human Services Authority (JPHSA) submitted a grant application for a Health Resources and Services Administration (HRSA) Substance Abuse Expansion Grant for Ambulatory Detox and Medication Assisted Treatment (MAT) to gain resources for the treatment of opioid abuse. (Jefferson Parish has the highest number of opioid-related

overdose deaths in the state.) HRSA sent notice of an award in February 2016: $325,000 per year for three years. This allowed for the implementation of the Ambulatory Detox and MAT program housed at JPHSA's JeffCare West Jefferson Health Center.

Additionally, JPHSA, through its JeffCare program, initiated dispensing of Narcan to individuals and families impacted by opiate addiction in April of 2016. To ensure appropriate and safe use, JeffCare implemented a procedure that included family and/or significant other training to administer Narcan. Narcan was made available to any individual with an opiate issue and residing in Jefferson Parish whether seeking services or not. Twenty-two individuals and/or their families received Narcan during May and June 2016. (Note: Narcan is a prescribed medication that is used to block the effects of opioids and to reverse overdoses. It cannot be used to get "high" nor does it have any effect on an individual who has not taken opioids.)

B. Why is this success significant?

As stated previously, Jefferson Parish has the highest incidence of opioid-related overdose deaths in the state. According to HRSA Secretary Sylvia M. Burwell:
"The opioid epidemic is one of the most pressing public health issues in the United States today…Health centers treat some of the most at-risk patients in the country. These awards position health centers to be at the forefront of the fight against opioid abuse in underserved communities."

C. Who benefits and how?

Individuals with opioid use disorders who live in Jefferson Parish and their families will benefit from access to detoxification services and follow-up treatment regardless of ability to pay. Further, the distribution of Narcan per JPHSA procedures will save lives for those individuals who have not yet agreed to treatment. It is believed these efforts will also support mitigation of illegal activity conducted to procure funds for the purchase of opiates, use of expensive emergency department visits, and deaths associated from overdoses. Per the Jefferson Parish Sheriff's Office: "Today, heroin use crosses all social economic boundaries and includes individuals from all segments of our society. For that reason, it is my belief that the availability of drug abuse treatment is one of the most important elements in a multi-pronged approach to combatting the drug abuse dilemma."

D. How was the accomplishment achieved?

The project work plan included the following components presented in abbreviated format: analysis of need and existing services accessible to the underserved and at-risk populations; identification of service gaps; program development and expansion; team recruitment and training; facility modification; implementation of Screening, Brief Intervention, and Referral to Treatment (Evidence-Based Practice) procedures; review of JPHSA's Risk Management and Prevention Plan; link to Centralized Care Coordination; link to JPHSA's integration model; collaboration with local stakeholders; and, development of outcome measures.

E. Does this accomplishment contribute to the success of your strategic plan?

Ambulatory Detoxification and Medication Assisted Treatment (MAT) contributes to both Goals of JPHSA's Strategic Plan. The program improves quality of life for individuals in crisis or with serious and persistent addiction; and, Evidence-Based Practices and Best Practices are integrated into all components of the program to ensure favorable outcomes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

This program is based on both Evidence-Based and Best Practices. All Local Governing Entities, such as JPHSA, should be well versed in both.

Accomplishment #2: Universal Design

A. What was achieved?

Universal Design, quality care that embraces everyone, is part of Jefferson Parish Human Services Authority's (JPHSA) cultural evolution and an integral component to total service integration. Universal Design encompasses full access to services and supports regardless of age, gender, disability or anything else that makes an individual unique. All staff must complete mandatory in-service education, and all program and service development and ongoing quality monitoring as well as facility retooling incorporates Universal Design into the planning process.

JPHSA includes Dignity of Risk as a key element of Universal Design. Dignity of Risk is essentially the right to take risks when engaging in life experiences and the right to fail in taking these risks. It is applied to communications, respect, decision-making, and interpersonal interactions with individuals regardless of their physical, emotional, or intellectual abilities and includes seeking a balance between the duty to provide care and the rights of individuals to decide their own course in life.

B. Why is this success significant?

Universal Design helps ensure ease and convenience of access as well as safety. It addresses the needs of individuals with disabilities (intellectual and developmental disability as well as mental illness and substance use disorders and chronic physical conditions) and goes further by recognizing there is a wide spectrum of human abilities. Everyone, even the most able-bodied individuals, passes through childhood, periods of temporary illness, injury and old age. By designing programs, services and supports, and facilities for this human diversity, JPHSA will continue to improve ease of accessibility and service recipient satisfaction.

C. Who benefits and how?

Universal Design benefits all service recipients in that it takes into account the full range of human diversity including: physical abilities, perceptual and cognitive abilities as well as different body sizes and shapes. Universal Design and Dignity of Risk are particularly well suited to the provision of services and supports to vulnerable populations.

D. How was the accomplishment achieved?

Universal Design is being enculturated through overt linkage to JPHSA's Strategic Plan including Vision, Mission, and Philosophy as well as the Authority's Service Statement: encouraging individuals to be independent and productive to the greatest extent possible; supporting a person-centered and recovery-oriented philosophy; support a welcoming environment; and, treating people with courtesy and respect. In-service education underscores Universal Design as simply the right thing to do; and, the JPHSA Executive Management Team weaves Universal Design into ongoing program and service monitoring and planning as well as including it in supervision. Finally, the JPHSA Board of Directors through endorsement of the concept, ensured support for assignment of resources.

E. Does this accomplishment contribute to the success of your strategic plan?

As stated in the previous section, Universal Design is linked to JPHSA's Vision, Mission and Philosophy and directly supports achievement of Strategic Plan Goal 1: *Provide coordinated services and supports which improve the quality of life and community participation for persons in crisis and/or with serious and persistent mental illness, emotional and behavioral disorders, addictive disorders and/or developmental disabilities, while providing appropriate and best practices to individuals with less severe needs.*

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Universal Design is a best practice and should be considered by entities providing human services.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

- **Please provide a brief analysis of the overall status of your strategic progress.** Jefferson Parish Human Services Authority (JPHSA) remained on target toward achieving Strategic Plan Goals and Objectives. Strategies outlined in the current Strategic Plan continued to be effective and were strengthened by a strong commitment to continuous Performance and Quality Improvement throughout every division and program within the Authority.

- **Where are you making significant progress?**
  JPHSA reports continued progress on Strategic Plan Goals based on available quantitative and qualitative data, including client level data, survey research, guided discussion, comparative data, and outcome reporting by each Division Director on individual Annual Plans in place to support achievement of the Strategic Plan.

  Goal 1: Provide coordinated services and supports which improve the quality of life and community participation for persons in crisis and/or with serious and persistent mental illness, emotional and behavioral disorders, addictive disorders and/or developmental disabilities, while providing appropriate and best practices to individuals with less severe needs.

  Goal II: Improve personal outcomes through effective implementation of best practices and data-driven decision-making.

  Please note:

  Integration of primary care into clinical services at JPHSA is the assimilation of primary care services delivered by family practice practitioners/prescribers (medical doctors and advanced practice registered nurses) within the East Jefferson and West Jefferson JeffCare Health Centers. The providers delivering primary care services also deliver basic behavioral health services. Adults, adolescents, and children with higher levels of acuity receive the support of JPHSA psychiatrists, licensed clinicians, and paraprofessional staff. Daily "huddles" among JeffCare primary care and behavioral health providers underpin a holistic and collaborative approach to the delivery of services. Additionally, JeffCare providers receive specialized training on the delivery of integrated services to individuals with developmental disabilities and their families. The JeffCare Chief Executive Officer, Developmental Disabilities Community Services Division Director, and Behavioral Health Community Services Division Director meet each Monday (and will continue to do so) to ensure ongoing collaboration and integrated work flows among the three service delivery areas of JPHSA. The Centralized Care Coordination program further supports integration of services with a total focus on care coordination. It should also be noted that JPHSA uses a single Electronic Health Record (Success EHS) for behavioral health and primary care services; at the close of the Fiscal Year, Developmental Disabilities Community Services had limited access to the system; however, broader access will be provided during Fiscal Year 2016-2017 particularly for those individuals responsible for eligibility determination and appointment scheduling.

  The Substance Abuse and Mental Health Services Administration (SAMHSA) established an integration model: Six Levels of Collaboration/Integration: Level 1/Minimal Collaboration; Level 2/Basic Collaboration at a Distance; Level 3/Basic Collaboration Onsite; Level 4/Close Collaboration Onsite with Some System Integration; Level 5/Close Collaboration Approaching an Integrated Practice; and, Level 6/Full Collaboration in a Transformed/Merged Integrated Practice. At the conclusion of Fiscal Year 2015-2016, JPHSA's integration level was 5.5 on the six-

point scale, the most advanced rating among all Local Governing Entities and Federally Qualified Health Centers in Louisiana. Now that JPHSA is approaching Level 6, the integration goal broadened to include Universal Design. (Universal Design is the creation of an environment that can be accessed, understood and used by all people regardless of their age, size, ability or disability.)

Additionally, JPHSA added Adolescent Community Reinforcement Approach (A-CRA) to its vast array of evidence-based practices during FY2016. A-CRA is a behavioral intervention for alcohol and substance use treatment that seeks to replace the environmental contingencies supporting alcohol or drug use with pro-social activities and behaviors supporting recovery. It is an evidence-based practice. This outpatient program targets youth 12-22 years of age with cannabis, alcohol and/or other substance use disorders. Treatment may include three types of sessions: adolescents alone; parents/caregivers alone; and, adolescents and parents/caregivers together. The goal is to improve life satisfaction and eliminate alcohol and substance use problems by developing problem-solving skills, communication skills, and participation in pro-social activities.

All strategies identified in the current Strategic Plan are utilized with ongoing emphasis on continuous performance and quality improvement for both service delivery and business processes.

1. To what do you attribute this success?
   JPHSA attributes this success to the following: a supportive and knowledgeable Board of Directors; a committed and forward thinking Executive Management Team; a solid strategic management framework; good infrastructure; focus on staff development and consistent positive supervision; an engaged staff; ongoing interaction with key stakeholders; ongoing compliance with Council On Accreditation Standards; a deep commitment to continuous performance and quality improvement; consistent and ongoing utilization management; integrated and holistic service delivery; a focus on “customer” service; and data-based decision-making.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?
   Progress is **not** the result of a one-time gain; rather, it is an ongoing process. Continuous Performance and Quality Improvement is embedded in JPHSA’s culture. JPHSA utilizes division-specific annual business plans and annual Performance & Quality Improvement Initiatives (PQI) as well as targeted PQI work groups to support the Strategic Plan and ensure progress. Support from the Board of Directors is essential and ongoing as well.

- **Where are you experiencing a significant lack of progress?**
  None.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☐ Yes. If so, what adjustments have been made and how will they address the situation?
  ☒ No. If not, why not?
  The JPHSA Board of Directors revised the Mission Statement to reflect integrated services during FY2015.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**

  Jefferson Parish Human Services Authority (JPHSA), a Local Governing Entity, adheres to the Carver Policy Governance Model. The Board of Directors establishes the Mission and Priorities, and selects an Executive Director to provide ongoing leadership and operational management of the Authority. The Executive Director presents the members of the Board with regular monitoring reports as required by Board policy and with activity updates at each Board meeting. She prepares an Ends Policy Monitoring Report detailing progress toward achieving Strategic Plan Goals and Objectives on an annual basis.

  JPHSA monitors, reports, and implements corrective action and/or performance and quality improvement activities with regard to Strategic Plan Goals, Objectives, and Performance Indicators. A broad range of venues are utilized: individual supervision; group supervision; work groups; division staff meetings; all staff meetings; the employee electronic newsletter; the employee website; and, standardized data reports.

  Each Division Director is required to develop and implement an annual division-specific business plan in support of the JPHSA Strategic Plan. Directors provide detailed written reports on progress to the Executive Director on a quarterly basis.

  Additionally, the JPHSA Performance & Quality Improvement Committee develops, adopts, and implements annual cross-divisional Performance & Quality Improvement Initiatives to further support Mission and Priorities and achievement of the Strategic Plan. Quarterly progress reports are delivered during committee meetings and reported in the employee electronic newsletter.

  JPHSA uses its employee electronic newsletter – *Have You Heard* – as a key tool for communicating with staff members about: Strategic Plan Goals, Objectives, and Performance Indicators; policies and procedures; employee recognition, and Authority operations. *Have You Heard* is published a minimum of one time each week via the JPHSA email system with special editions provided on an ongoing basis.

Division Directors involve staff in data collection, analysis, and reporting of Performance Indicator outcomes and in work groups formed to enhance performance and quality. The Executive Director schedules two all-staff meetings each Fiscal Year. Performance and quality improvement is a routine part of the interactive agenda.

Bi-weekly Executive Management Team meetings are used as group supervision and as forums for discussion of progress on meeting/exceeding goals and for collaborative development of corrective action and/or performance and quality improvement plans. The Executive Director holds the Executive Management Team accountable on both an individual and group basis for successful implementation of the JPHSA Strategic Plan, Annual Division Business Plans, and the Annual Performance and Quality Improvement Initiatives. The Executive Director focuses a significant portion of the Executive Management Team members' performance reviews on their contributions to the Strategic Plan and Performance & Quality Improvement Initiatives as well as on their degree of success in accomplishing their Annual Business Plan objectives.

Each JPHSA employee has job-specific performance factors and expectations in support of Authority goals included in his/her annual planning document. Supervisors are required to meet with their subordinates as outlined in JPHSA's Staff Development & Supervision Guidelines. The supervision meetings are documented and used to review and discuss progress toward meeting expectations. Active participation and open discussion are encouraged.

JPHSA leadership approaches the Strategic Plan as ongoing performance and quality improvement involving all Divisions and all staff members, i.e. horizontal and vertical integration. Monitoring and reporting are integral to the process as well.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?

Jefferson Parish Human Services Authority (JPHSA), as a budget unit within the Louisiana Department of Health, continues to be impacted by budget constraints.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   No. However, it certainly has made it more difficult and requires extensive and firmly held controls. The budget for each JPHSA division is closely monitored and managed by both the Division Director and Fiscal Services Department staff; filling vacated positions requires extensive justification and approval by both the Chief Financial Officer and Executive Director; and, the revenue cycle is managed aggressively.

3. What organizational unit in the department is experiencing the problem or issue?
   Budget constraints are always focused on administrative functions rather than services. However, all divisions within JPHSA are impacted by budget adjustments.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Staff members are affected by reductions in State General Fund. Contractors are also affected with concerns over contract reductions that may impact their own operations.

5. How long has the problem or issue existed?
   Concerns regarding State General Funds have persisted over the course of several years.

6. What are the causes of the problem or issue? How do you know?
   N/A.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   Without resolution, this may have an impact on services for individuals with serious mental illness, addiction and/or developmental disabilities.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

   ☒ No. If not, skip questions 2-5 below.
   ☐ Yes. If so, complete questions 2-5 below.

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
JPHSA's Management Services Division provides ongoing monitoring of clinical, service delivery, business, and administrative functions as well as staff development and supervision activities. Audit tools with identified criteria and standards are utilized; results are reported; and, appropriate performance and quality improvement and/or corrective actions are implemented. Further, the Management Services Division audits Authority performance using benchmarks set forth in Council on Accreditation standards. Improvement and/or corrective action plans are developed and executed as needed. The Division monitors progress on plan implementation as well. Each JPHSA Division establishes an annual business plan containing measurable outcomes in support of the Authority's Strategic Plan. Outcomes are tracked and reported on a quarterly basis with performance and quality improvement and/or corrective action initiated as needed. JPHSA's Fiscal Services Department provides ongoing monitoring of agency resources using standard accounting practices. Further, a fiscal monitor is assigned to each Division for ongoing monitoring of both budgets as well as grants and contracts, using standard accounting practices, and in the case of grants and contracts, the scope of work and deliverables as well as budgets. On site monitoring of contractors is standard operating procedure with improvement or corrective action initiated as a need is identified.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
JPHSA is audited on an annual basis through the Office of the Legislative Auditor. The Authority's FY2016 audit produced **no** findings or any recommendations (e.g. management letter), i.e. the audit was clean. The Louisiana Department of Health's Office for Behavioral Health and Office for Citizens with Developmental Disabilities audits JPHSA as set forth in the Accountability Implementation Plan, i.e. ongoing data reporting, annual peer review, and annual on-site audit. Neither the annual on-site audit nor the annual peer review produced any findings or recommendations.

☒ **Policy, research, planning, and/or quality assurance functions in-house**
JPHSA's Management Services Division has overall accountability for policy development and management as well as for the Authority's quality assurance functions. With regard to policy development and update, the Management Services Division Director consults with the in-house counsel on an as-needed basis. The Executive Management Team, headed by the Executive Director, is responsible for short- and long-term planning. She informs and seeks consultation from the JPHSA Board of Directors as appropriate according to Board policy and the Carver Policy Governance Model. The Executive Director provides the Board with monitoring reports as specified in Board policy. The

Performance & Quality Improvement (PQI) Committee, a chartered committee chaired by the Management Services Division Director, is responsible for the review and update of JPHSA's PQI Plan and for the collaborative development and ongoing monitoring of annual Authority-wide PQI Initiatives. All staff complete annual PQI training; and, each division is required to tackle a division-specific PQI initiative annually. Further, in compliance with Council on Accreditation standards, JPHSA has a plethora of time-limited work groups in place at all times.

☐ **Policy, research, planning, and/or quality assurance functions by contract**
JPHSA has **no** contracts for policy, research, planning, and/or quality assurance functions.

☒ **Program evaluation by in-house staff**
Program performance is monitored on an ongoing basis utilizing the JPHSA Strategic Plan, Operational Plan, Division-Specific Annual Business Plans, Annual Performance & Quality Improvement Initiatives, Utilization Management Plan, Staff Development & Supervision Guidelines, and position-specific expectations. All have clearly stated goals/objectives and performance targets and/or outcome measures. Additionally, the Maintenance of Accreditation Committee (a chartered committee representing all facets of JPHSA) helps ensure adherence to accreditation program and service standards through ongoing monitoring on the division level. And, the Utilization Management Committee helps ensure best use of program resources, i.e. the right services at the right time in the right quantity. Each of the three service area Divisions has a program-specific Utilization Management Plan in place. During FY2016, the time-limited Health and Wellness Integration Work Group initiated the process of critically assessing and evaluating the screening and intake process across all program areas to ensure the inclusion of screening and appropriate assessment of health and wellness across all direct services as well as to encourage further service integration. Phase two of this work group's objectives will carry into FY2017. The Executive Director, Executive Management Team, Supervisory Staff, and the Management Services Division share responsibility for monitoring and technical assistance. The Executive Director is also required to submit ongoing monitoring reports to the JPHSA Board of Directors as defined by Board policy.

☐ **Program evaluation by contract**
JPHSA has **no** contracts for program evaluation.

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
JPHSA collects data, performs statistical analysis, and reports outcomes/outputs into LaPAS on a quarterly basis. Notes of explanation are provided for positive and negative variances of 5% or more from quarterly Performance Indicator targets. Each note outlines any needed corrective action or process improvement activities. JPHSA also provides data or makes data available to

the Louisiana Department of Health (LDH), Office for Citizens with Developmental Disabilities (OCDD), and the Office of Behavioral Health (OBH) on an ongoing basis and as required by contractual agreement. JPHSA is compliant with the LDH Human Services Accountability and Implementation Plan, which contains an extensive array of outcome/output measures, many of which OCDD and OBH utilize in compiling data for their own LaPAS reports.

☒ **In-house performance accountability system or process**
JPHSA utilizes the following to model its performance accountability process: Council On Accreditation Standards and Rating System; JPHSA Staff Development & Supervision Guidelines in conjunction with the Louisiana Department of State Civil Service Performance Evaluation System; JPHSA's Performance & Quality Improvement monitors in conjunction with Performance & Quality Improvement Initiatives; ongoing internal monitoring with appropriate follow-up activity; and, ongoing data collection, mining, and analysis for decision support. The JPHSA Executive Management Team meets bi-weekly with other members of the internal Performance & Quality Improvement Committee to discuss progress and any need for performance and quality improvement and/or correction action. The JeffCare, due to this division's size and complexity, has a program-specific Performance & Quality Improvement Committee chaired by JPHSA's Medical Director. Further, the Executive Director meets one-on-one with each member of the Executive Management Team on a quarterly basis for reporting on annual plan progress and any need for performance and quality improvement and/or corrective action. And, to underscore accountability at the individual employee level, the Executive Director and Human Resources Director initiated a "third level" review, i.e. random audit, of rating and planning documents to ensure linkage to job descriptions (SF-3) and ongoing documented supervision and coaching.

☒ **Benchmarking for Best Management Practices**
During FY2016, JPHSA fully implemented Greenway Success EHS as its sole electronic health record for behavioral health and primary care services. (Plans are underway for developmental disability service integration during FY2017.) To enhance data collection and analysis, JPHSA also implemented Business Objects, a database reporting tool. At the close of the Fiscal Year, the Authority was seeking grant funding to support acquisition of a population health data tool, i2i, to further enrich data mining. Developmental disability services data is obtained through the Office for Citizens with Developmental Disabilities software. Comparative studies are enabled through other Local Governing Entities reporting into the LaPAS system as well as through benchmarking against national standards for Evidence-based and Best Practices and through Uniform Data System reporting through the Health Resources Services Administration of the U.S. Department of Health and Human Services. JPHSA's Financial System, Microsoft Dynamics GP, is a highly sophisticated system that allows detailed budget reporting, enabling the measurement of performance against quarterly targets and annual goals as well as identification

of trends.

☒ **Performance-based contracting (including contract monitoring)**
All JPHSA contracts are required by policy to have explicit and detailed performance requirements, i.e. Statements of Work with all deliverables, programmatic requirements, performance/outcome measures, required administrative oversight, and reporting mandates clearly spelled out. Further, mandated monitoring plans all include reporting timeframes, metrics, and assigned clinical/service and financial monitors. JPHSA provides technical assistance to contractors as needed per findings from clinical/service and/or financial monitoring; and, corrective action plans, including timelines, are required for deficiencies that are considered significant or potentially leading to trends. Monitoring occurs both remotely and on-site.

☒ **Peer review**
The JPHSA Medical Director facilitates on going peer reviews among prescribers (physicians and advanced practice registered nurses) as a routine part of practice. Additionally, he leads comprehensive multi-disciplinary peer review in cases of a service recipient suicide or death not associated with a physical disease or chronic condition. JPHSA participates in the Office of Behavioral Health's annual peer review with a sister Local Governing Entity. These reviews alternate focus on program and administrative functions. The peer review for FY2016 focused on program functions. The Office of Behavioral Health and Office for Citizens with Developmental Disabilities also conduct annual on-site reviews with peers from other Local Governing Entities as participants.

☒ **Accreditation review**
During FY2016, the Council on Accreditation awarded JPHSA a second four-year full organization accreditation, the maximum allowable. Additionally, **no** findings or recommendations were noted. The Authority received high praise for meeting or exceeding all standards with particular recognition given for supporting a culture of ongoing performance and quality improvement.

☒ **Customer/stakeholder feedback**
JPHSA participates in annual satisfaction surveys sponsored by the Office of Behavioral Health and the Office for Citizens with Developmental Disabilities. Additionally, JPHSA fields a proprietary survey within its Health Centers on a semi-annual basis in order to identify opportunities for improvement. Comment boxes are available in all Health Centers; and, JPHSA invites confidential feedback on its internet site. JPHSA requires contractors delivering community-based behavioral health services to field satisfaction surveys with their service recipients and to share results with JPHSA. Employees have access to comment boxes in all break rooms, and may also provide the employee-led committee, Esprit de Corps, with suggestions for improvement. The Esprit de Corps Chairperson has direct access to the Executive Director and Executive

Management Team. During FY2016, the Council on Accreditation, as part of the re-accreditation process, conducted surveys with service recipients, contractors, front line employees, supervisors and managers, and Board members. Aggregate results were shared with JPHSA and are being used for performance and quality improvement initiatives. The members of the Board of Directors, per the Policy Governance Model, actively engage in "community linkages" and report the outcomes of these community stakeholder interactions during each Board meeting. Additional feedback is obtained through active participation in the monthly Jefferson Parish Behavioral Health Task Force meetings and in the quarterly Regional Advisory Committee meetings for Behavioral Health and Developmental Disabilities. JPHSA also participates on the Child and Youth Planning Board and Jefferson Parish Alliance for Concerned Citizens. The Executive Director and the Chief Administrative Assistant make regular calls on local and state elected officials as well as community partners.

☐ Other (please specify): NOT APPLICABLE

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☐ Yes. Proceed to Section C below.
☒ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
301 Florida Parishes Human Services Authority

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Richard Kramer**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
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F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: FPHSA implemented a new electronic health record for Behavioral Health Services

A. What was achieved?

In June, 2015, FPHSA implemented a new electronic health record for Behavioral Health services with a more accessible/robust reporting system that will afford the agency more reliable data to use for decision making. By October 2015, the electronic record was being fully utilized for all of FPHSA's behavioral health services.

B. Why is this significant?

FPHSA is working closely with the electronic behavioral health records (EBHR) vendor to customize the record to the agency's workflow and reporting needs. This accomplishment contributes to FPHSA's goal of improving the quality and effectiveness of services and/or treatment through the implementation of best practices and the use of data-based decision-making.

C. Who benefits and how?

Clients of FPHSA benefit through the improvement of coordination and communication among providers through the use of an EBHR. Taxpayers of Louisiana benefit from greater efficiency in providing services.

D. How was the accomplishment achieved?

This accomplishment was achieved by contracting with a vendor to provide a suitable EBHR and modifying practices to use this new tool for improved client care and more efficient operation.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes, this accomplishment helps significantly with data based decision making which is a part of goal 2 below.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes, using electronic health records is considered a best practice and there has been a great movement towards their use across LDH agencies.

Accomplishment #2: FPHSA continues to merge Mental Health and Addictive Disorders Services into Behavioral Health Services

A. What was achieved?

FPHSA has continued towards the merging of services into behavioral health services in accordance with the change in licensure.

B. Why is this significant?

FPHSA has restructured and streamlined screening and assessments for clients to and

educated and trained staff to take a more holistic approach to behavioral health treatment services.

C. Who benefits and how?

Clients of FPHSA benefit by being able to receive services for commonly co-occurring conditions at the same location at time. Additionally, research indicates that treatment outcomes are better for clients using this contemporary approach. Taxpayers of Louisiana benefit from greater efficiency in providing services.

D. How was the accomplishment achieved?

This accomplishment was achieved by modifying the organization of services to comply with the requirements of the new Behavioral Health license.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes, Goals 1 and 2 below are directly impacted in that this change helps assure quality treatment using best practices.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes, combining mental health and substance use services is a best practice and has been an effort that many LDH agencies have been undertaking.

Accomplishment #3: FPHSA expanded the use of Nurse Practitioners and Medical Psychologists

A. What was achieved?

FPHSA has hired more nurse practitioners and medical psychologists to work within their licensed capacity to provide medical psychiatric and substance us care. This change is particularly necessary in light of the national shortage of psychiatrists.

B. Why is this significant?

This change allows for FPHSA to provide services to more individuals for less cost to the budget.

C. Who benefits and how?

FPHSA clients benefit as there is increased capacity to provide needed behavioral health services resulting in better care and shorter waits for services. Citizens of Louisiana benefit

as earlier appropriate care results in decreased costs across the healthcare spectrum. Also, nurse practitioners and medical psychiatrists can provide many of the same level of services as a psychiatrist at a greatly reduced cost to the agency.

D. How was the accomplishment achieved?

This was achieved by embracing the opportunity to use different levels of prescriber as appropriate in Louisiana regulations.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes, this accomplishment allows the agency to better assure comprehensive services are available to improve the quality of life of our clients and their families.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

This does represent a best practice as it allows for increased services to those who need them and uses limited resources efficiently.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

Goal 1: To assure comprehensive services and supports which improve the quality of life and community participation for persons with serious and persistent addictive disorders, developmental disabilities, and/or mental illness, while providing effective limited intervention to individuals with less severe needs.

FPHSA has continued to strive to assure comprehensive services and supports to improve the quality of life of those individuals served. Progress has been made for individuals served through Developmental Disabilities Waiver Supports and Services. In FY 16, 1381 individuals were served through waiver supports and services compared to 1365 in FY 15. The transition to a behavioral health license will allow for individuals with co-occurring substance use and mental health needs to be served in a more comprehensive way. Budget constraints have limited expansion of services and programs but innovative agreements and programs continue to be explored to provide services to those most in need. The agency continues to provide direct clinical services and coordinates an array of services designed to provide treatment on an outpatient basis as well as an ASAM III.5 residential treatment program for addictive disorders.

Goal 2: To improve the quality and effectiveness of services and/or treatment through the implementation of best practices and the use of data-based decision

making.

FPHSA has made progress toward implementation of data-based decision making. Progress has been impeded over the last few years due to the limited ability to pull valid data and information from Clinical Advisor. Area Supervisors (Behavioral Health Services and Developmental Disabilities Services) met regularly with the Executive Director to discuss services and client data. In June, 2015, FPHSA implemented a new electronic health record for Behavioral Health services with a more accessible/robust reporting system that will afford the agency more reliable data to use for decision making. FPHSA is working closely with the EBHR vendor to customize the record to the agency's workflow and reporting needs.

FPHSA has restructured and streamlined screening and assessments for clients and educated and trained staff to take a more holistic approach to behavioral health treatment services.

Goal 3: To promote healthy and safe lifestyles for people by providing leadership in educating the community on the importance of prevention, early detection and intervention, and by facilitating coalition building to address the localized community problems.

FPHSA is meeting this goal in several ways. Major educational initiatives include the Addictive Disorders Services Prevention program. FPHSA provides funding and contracts with providers to teach LifeSkills training and Kid's Don't Gamble in the schools located in the agency's catchment area. FPHSA Prevention Services promotes healthier lifestyles throughout the community by supporting participation in healthy initiatives such as *Red Ribbon Week, Wellness Week, Recovery Month, Alcohol Awareness, Suicide Prevention Awareness, Family Day*, etc. Prevention Services also bring training to the communities to empower individuals and groups to learn about the issues in the community (driven by data) and develop strategic plans to address those issues to promote healthier communities. Such training includes *ASIST* (Applied Suicide Intervention Skills Training); *safeTALK* (a suicide awareness program); *Strategic Planning Framework* (training in a process to strategically assess and address community issues); *Cultural Diversity*; *Preventing Mental, Emotional, and Behavioral Disorders in Young People*; *Ethics; Facilitation* and *Coalition Building;* etc.

FPHSA staff participate in numerous community led efforts across the agency's five-parish service area including *St. Helena Human Services Coalition, Tangipahoa Social Services Coalition, St. Tammany Commission on Families, Washington Parish Commission on Human Services, TRACC* (Tangipahoa Reshaping Attitudes for Community Change), *Livingston Youth and Family Together, LACES* (Louisiana Alliance Creating Economic Success), etc. In addition, FPHSA staff participate in the *Regional Child Mortality Death Review,* and advise, collaborate, and monitor two Drug Free Community grantees (*ADAPT in Washington* and *TRACC in Tangipahoa Parishes*). Staff are advising the *LYFT Prevention Taskforce* who are funded as a designated High Needs Community by the Louisiana Partnership for Success in

Livingston Parish (LYFT). FPHSA staff also participate in numerous health and wellness resource fairs throughout the five-parish service area.

Objective 1: Florida Parishes Human Services Authority/Addictive Disorders Services (ADS) will provide quality treatment services to individuals with addictive disorders and prevention services in a cost effective manner.

FPHSA met this objective in FY 16 in a couple of areas. The average cost per individual served in outpatient addictive disorders services decreased from $2918.62 in FY 15 to $2,587.21 in FY 16. Also, the average cost per registered enrollee in evidence-based educational (prevention) programs decreased from $60.36 in FY 15 to $51.85 in FY 16.

Objective 2: Each year through June 30, 2019, Florida Parishes Human Services Authority/Developmental Disabilities Services (DDS) will provide services that emphasize person-centered individual and family supports to people with developmental disabilities. Delivery of services will result in an increased percentage of people within the FPHSA catchment area that remain in the community rather than being institutionalized.

FPHSA continues to have success towards this objective. The percentage of individuals receiving Flexible Family Funds/Cash Subsidy who remain in the community versus being institutionalized was one hundred percent (100%) again in FY 16. The total number of individuals served through waiver supports and services increased from 1365 in FY 15 to 1381 in FY 16.

Objective 3: Each year through June 30, 2019, Florida Parishes Human Services Authority/Executive Administration will increase the efficiency of the operation and management of public, community-based services related to addictive disorders, developmental disabilities, mental health, and permanent supportive housing in the parishes of Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington.

FPHSA continuously works to increase the efficiency of operations and services.
In June 2015, FPHSA implemented a new electronic health record (EBHR). With the implementation and the ongoing work to customize the EBHR, the agency has been able to increase the efficiency of some operations. FPHSA is continuing to work closely with the EBHR vendor to customize the record to the agency's workflow and reporting needs.

- **Where are you making significant progress?**

FPHSA has continued to make significant progress by expanding Behavioral Health outreach services in the community which has increased access to care more locally for

the clients we serve.

- **Where are you experiencing a significant lack of progress?**

  Expansion of services, both in current locations and in underserved areas, has been difficult due to budget difficulties over the past several years. FPHSA has not been able to establish full time clinics in each of the parishes served or increase capacity in the existing sites. There continues to be unmet needs in the communities and resources to reach them are thin. However, innovative programming (such as walk in appointments) and use of resources has allowed for some progress to be made.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☒ Yes. If so, what adjustments have been made and how will they address the situation?
  ☐ No. If not, why not?

  FPHSA's strategic plan was updated in June 2016. The agency's working business plan continues to evolve with the ever changing demands of the behavioral health and developmental disabilities fields. The agency continues to address the changes brought forth through the managed care, System Transformation, requirements of an electronic health record, required self-generation of revenue, electronic billing, accreditation compliance, healthcare reform, and provide more effective and efficient access to person-centered services.

How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?

FPHSA has monthly meetings with its Board of Directors and conducts routine Executive Management Team meetings. The managers of each service area hold regular meetings with their staff at which information related to the agency's overall plan and strategies are discussed.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

Morale among the workforce has impeded operations to some extent. Due to budget

constraints, over the past year furlough days were necessary in addition to holding positions vacant. This required an already taxed workforce to accomplish more work with less staff. As the push to increase self-generated funding continued this put additional pressure on those same staff members to produce. However, due to new opportunities related to Medicaid expansion and agreements with other organizations there may be innovative opportunities to improve efficiencies and operations to get the most out of the available resources.

Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

   ☒ No. If not, skip questions 2-5 below.
   ☐ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
      - How much progress has been made and how much additional progress is needed?
   b. If not:
      - Why has no action been taken regarding this recommendation?
      - What are the obstacles preventing or delaying corrective actions?
      - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

   ☐ No. If not, please explain.
   ☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
      a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
      b. How much has been expended so far?
      c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
      d. Will additional personnel or funds be required to implement the

recommended actions? If so:

- Provide specific figures, including proposed means of financing for any additional funds.
- Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

- ☐ Internal audit
- ☒ External audits (Office of Risk Management; Louisiana Department of State Civil Service, Office of the Legislative Auditor, Department of Health and Hospitals Accountability and Implementation Plan (AIP), etc.)
- ☒ Policy, research, planning, and/or quality assurance functions in-house
- ☐ Policy, research, planning, and/or quality assurance functions by contract
- ☒ Program evaluation by in-house staff
- ☐ Program evaluation by contract
- ☒ Performance Progress Reports (Louisiana Performance Accountability System)
- ☐ In-house performance accountability system or process
- ☐ Benchmarking for Best Management Practices
- ☒ Performance-based contracting (including contract monitoring)
- ☒ Peer review
- ☐ Accreditation review
- ☒ Customer/stakeholder feedback: ADS Public Forum
- ☒ Other (please specify): Annual Financial Reports

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

- ☒ Yes. Proceed to Section C below.
- ☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
    a. Office of Risk Management Audit
    b. Louisiana Department of State Civil Service
    c. Office of the Legislative Auditor
    d. Louisiana Performance Accountability System (LaPAS)
    e. Contract Monitoring
    f. LDH-The Human Services Accountability and Implementation Plan (AIP) Annual On-site Monitoring Final Report

g. ADS Peer Review
h. LDH—Office of Aging and Adult Services

2. Date completed
   a. February 10, 2016
   b. April 14, 2016
   c. September 7, 2016
   d. October 2016
   e. Quarterly
   f. April 28, 2016
   g. June 7, 2016
   h. June 16, 2016

3. Subject or purpose and reason for initiation of the analysis or evaluation
   a. FPHSA Risk Management Policy and Procedure (ORM Requirement)
   b. Compliance to State Civil Service requirements
   c. Accountability over public funds as required by State law
   d. Compliance to LaPAS requirement
   e. FPHSA Contract Regulations and Procedures
   f. Compliance with MOU with LDH
   g. Block Grant requirement
   h. LDH Permanent Supportive Housing Program contract requirements

4. Methodology used for analysis or evaluation
   a. Audit completed by Sedgwick for ORM
   b. Civil Services policies and rules
   c. Audit completed by the Louisiana Legislative Auditor
   d. DOA-required methodology; performance indicators developed by FPHSA and approved by DOA
   e. FPHSA Contract Regulations Policies and Procedures
   f. Accountability and Implementation Plan (AIP)
   g. Peer Review
   h. Monitoring by LDH PSH Program Project Coordinator

5. Cost (allocation of in-house resources or purchase price)
   a. Not calculated
   b. Not calculated
   c. $23,414
   d. Not calculated
   e. Not calculated
   f. Not calculated
   g. Not calculated
   h. Not calculated

6. Major Findings and Conclusions

a. None
b. None
c. None
d. None
e. None
f. LDH Findings for AIP (OCDD):
    a. A Corrective Action Plan (CAP) should be developed to ensure that updates for the entry data for 458 participants whose data was not recorded, the completion system entry process for 30 participants whose system entry data files were currently open, and the update system entry data for 153 participants with expired Statement of Approvals.
    b. Ensure that supervisor follows up with the findings indicated on the monitoring forms.
    c. Ensure that the latest data system report is updated and accurate.
    d. Ensure that staff verifies waiver status when an application has waiver services marked.
    e. Ensure that case record entry narratives include all case activities.
    f. Ensure that Individual Education Plan (IEP) contain signatures.
    g. Ensure that the universal screening instrument is completed in its entirety.
    h. Performance Indicator (MOU Waiver) – was not met. Ensure that all waiver positions are filled.
g. None
h. LDH Findings for PSH Monitoring:
    a. 1 file contained an assessment that was not dated or signed.
    b. 1 file contained documents that were not properly filed in the chart.
    c. 1 file contained a disaster plan that was found incomplete, missing a signature, and/or missing substantial required information.
    d. 1 file laced a current and/or consistent crisis plan.

7. Major Recommendations
    a. None
    b. None
    c. None
    d. None
    e. None
    f. LDH Recommendations for AIP (OBH):
        a. Updated existing admissions policy to require admission of IV drug users.
        b. A policy be developed that addresses compliance with the SAPT Block Grant requirement as outlined in 96.126(d) related to IVDU clients and the waiting list.

c. Staff use a standardized tobacco screening tool.
d. FPHSA is to include more education on substance abuse treatment in the continuing education made available to employees.
e. With regards to the fiscal requirements and compliance with the SAPT, policy/procedure and/or protocols will be established to provide clear guidance to staff to ensure the expectations are being met for SAPT Block Grant §96.135 (a) (2); §96.135(a) (6); §96.135 (b) (2); §96.135 (a) (5); §96.135 (a) (4); §96.135 (a) (3); and §96.137 (a).

g. Peer Review recommendations:
a. Ensure follow up on missed Medical History appointments.
b. Review charts for initial and updated treatment plans to ensure completed in the appropriate timelines designated for the level of care.
c. Have counselors document support groups and social activities at each group contact.
d. Have providers document referrals upon discharge or, if none, document no referrals at discharge and why.

h. None

8. Action taken in response to the report or evaluation
a. None
b. None
c. None
d. None
e. None
f. Corrective action plans were completed for each performance standard not met. A committee meets quarterly to review progress towards meeting the steps in the plans and to determine if revision or additional steps are required to meet the standard. FPHSA has taken action to fill the vacant Medical Certification Specialist which will allow FPHSA to be in compliance with the contract as outlined. FPHSA will be developing a process to review information, trend data, and identify areas where corrective action may be needed.

Also, for the OBH section, FPHSA will include a unique patient identifier for each injecting drug user seeking treatment and revise the log to indicate where interim services will be provided while the person is waiting for admission. FPHSA will update the job description of the admissions coordinator at the residential treatment facility to include the responsibility of development and implementation of an outreach program per SAPT Block Grant requirements. FPHSA will implement a tobacco cessation program at all facilities and train staff on how to document the interventions in the electronic health record. A custom button has been added to the assessment in the electronic health record that is completed at the time of admission that will include the gambling screening for each admission. TB and HIV custom buttons will be

added to the electronic health record a statement indicating that this type of counseling was provided and retrain staff on this for documentation purposed.

g. FPHSA's workflow includes administrative staff to notify clinicians if one of their clients misses a scheduled medical assessment, and the clinicians are to follow up with the client. Supervisors are instructed to monitor charts for compliance. FPHSA's electronic health record has an alert to notify clinicians when treatment plans are due. FPHSA has instructed clinicians on the importance of documenting all activities related to the client's recovery program in the electronic chart. Managers and supervisors have been instructed to discuss the importance of documenting referrals throughout treatment in their meetings. FPHSA plans on adding referrals to its discharge summary in the electronic record.

h. FPHSA created a new assessment template for clients funded through Community Development Block Grant funds which contain a designated signature and date line. Administrative support staff were trained and assigned to PSH to provide support to keep records in order. A form was created with a designated signature line, date line, and area to indicate acknowledgement of participation in what type of plan, i.e., Crisis Plan, Disaster/Hurricane Plan, or Treatment Plan acknowledgement. FPHSA found the missing crisis plan and uploaded it into the electronic file.

9. Availability (hard copy, electronic file, website)

a. Hard copy
b. Hardy copy
c. http://app1.lla.state.la.us/PublicReports.nsfHard copy
d. www.doa.louisiana.gov/opb/lapas/lapas.htm
e. Hard copy
f. Hardy copy
g. Hard copy
h. Hard copy
i. Hard copy

10. Contact person for more information, including

Name:	Richard Kramer
Title:	Executive Director
Agency & Program:	Florida Parishes Human Services Authority
Telephone:	(985) 543-4333
E-mail:	Richard.Kramer@fphsa.org

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
302 Capital Area Human Services District

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Jan Kasofsky, PhD**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Capital Area Human Services District Received Grant to Continue THP Services

A. What was achieved? Capital Area Human Services District (CAHSD) received a one-year, $118,000 grant from the Humana Foundation to continue two important aspects of our former integrated Total Health Program (THP).

B. Why is this significant? Funding through the Substance Abuse and Mental Health Services Administration (SAMHSA) for THP ended, but CAHSD, through in-house staff, has continued to provide important services that include nutrition education, tobacco cessation, and care coordination with primary care providers.
C. Who benefits and how? The grant will help continue the peer-led whole health groups held at both the Center for Adult Behavioral Health and the Margaret Dumas Mental Health Center.
D. How was this accomplishment achieved? CAHSD will continue its instructor-led fitness classes, and help fund two Peer Support Specialists who lead the Whole Health Action Management (WHAM) groups.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, the goal of integrated primary and behavioral health care is to improve the physical health of CAHSD clients who have or who are at risk for medical conditions including obesity, diabetes, hypertension, and dyslipidemia -- major risk factors for heart disease.
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? No.

Accomplishment #2: Capital Area Human Services District Awards "Mini Grants" for Student-Produced PSAs

A. What was achieved? The CAHSD Prevention Program provided $1,000 "mini-grants" to parish high schools in return for their production of public service announcements (PSAs).
B. Why is this significant? These PSAs will inform and build awareness about the risks and impacts of suicide, bullying, underage alcohol and tobacco use, prescription drug misuse, and violence.
C. Who benefits and how? High school students from three area schools recently debuted video public service announcements that they produced about suicide and alcohol use prevention as part of a CAHSD campaign to reach high school students and the general public.
D. How was this accomplishment achieved? The PSAs were funded through mini grants that were awarded several weeks ago to Scotlandville Magnet High School, McKinley High School, and East Ascension High School. The mini grants were the first of their kind from CAHSD to foster student-designed media that could be circulated through social media channels.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes.

Accomplishment #3: Capital Area Human Services District Justice Involved Outpatient Therapy Program Launched

A. What was achieved? CAHSD launched its Justice Involved Intensive Outpatient Program (JIOP) in January as part of its comprehensive work to help individuals who are in or who have recently been involved in the judicial system.
B. Why is this success significant? In the JIOP, CAHSD clinicians and peers identify persons with co-occurring disorders (mental health and substance abuse) and refer them to services that help ensure a seamless transition for continuity of care. After completing the JIOP, participants are referred for participation in the 12-week Continuing Care Program that emphasizes their continued recovery such as relapse prevention, triggers, life skills, and support system development and maintenance.
C. Who benefits and how? The participants benefit. JIOP participants meet three days a week, three hours each day for a total of 10 weeks. The sessions focus on substance abuse and anger management, primarily designed to provide individuals with the skills needed to manage and control their anger outside of the prison or jail setting. The program is open, allowing participants to enter anytime during the 10-week period.
D. How was this accomplishment achieved? CAHSD Peer Specialists work closely with individuals to provide case management services, such as assistance with housing, transportation, and employment, which pose significant barriers to accessing treatment services and achieving successful reentry.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes.
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes.

Accomplishment #4: Capital Area Human Services District Awarded $80,000 for Work at EBR Prison

A. What was achieved? The Huey and Angelina Wilson Foundation awarded CAHSD a one-year, $80,000 grant to further the agency's work in helping inmates prepare for life outside jail. Those found at risk are paired with a peer mentor who helps develop treatment plans for their jail terms and for at least six months after release.
B. Why is this success significant? The CAHSD award was part of $1 million granted to other area agencies as part of the foundation's Prison Reentry Initiative investments for 2016.
C. Who benefits and how? Louisiana's communities and persons with mental illness and co-occurring substance abuse benefit. The Foundation funds efforts in the areas of Human Services, Healthcare, Education and Prison Reentry, which positively impacts and strengthens the organizations and institutions that address the underlying causes of problems rather than treating symptoms.
D. How was this accomplishment achieved? CAHSD has been working with the East Baton Rouge Parish Prison to ensure that persons with mental illness and co-occurring substance abuse are identified and assessed upon entering the facility.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section

II below.) Yes. The Huey and Angelina Wilson Foundation's mission is to enhance Louisiana's communities, and in particular the greater Baton Rouge area, by supporting philanthropic initiatives and programs that improve the lives of its citizens.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes.

Accomplishment #5: Suicides Prevented, Expulsions Avoided, and Truancy Down in 32 Area Schools

A. What was achieved? CAHSD' School Based Therapy Program achieved significant results over the past five years and has garnered high praise from school leaders, parents, and many others, according to a new report.
B. Why is this success significant? The School Based program has operated for 25 years and is now in 32 schools in seven parishes: Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana. The CAHSD School Based "Progress Report, released in February 2016," tracked the program's results between 2009 and 2014, and found that: 209 suicides were prevented; 131 school expulsions were avoided through mediation; Truancy and discipline referrals decreased by 40%; 396 students "graduated" from the program; 26,160 students attended mental health workshops; and, 45,721 students, parents, and faculty were served through the SB program.
C. Who benefits and how? The community, students, school leaders and parents.
D. How was this accomplishment achieved? School officials, teachers, and parents credit CAHSD for helping students improve their grades and stay in school by effectively addressing problematic behaviors, absenteeism, suspensions and expulsions.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes.
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

The District operates under two separate five-year strategic plans. We, as part of the

Louisiana Department of Health, participate in the state-wide LaPAS Performance Based Budgeting and Planning process which establishes common goals and objectives by specific programmatic disabilities with pre-set performance standards used to establish funding needs and efficient use of allocated resources. The District is on target with the expected accomplishments set forth in this plan.

The District's Internal Strategic Plan is a daily operations guide that establishes internal goals that are aimed at improving the quality of life for our clients and improving operational efficiencies. This plan has three major goals and the District has made significant progress on accomplishing many of the objectives covered under these goals. Progress on meeting our annual goals is reported semi-annually to the CAHSD Board.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
    - Other? Please specify.
    -
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

LDH Plan: Over the past several years, the CAHSD has refined its goals and objectives in the strategic plan to reflect actual expectations of performance within funding limitations. As a result of innovative and creative leadership and staff who are dedicated to community service, we have been successful in consistently attaining our performance targets with minimal variance.

CAHSD Plan: The District continues to make great strides toward meeting its goal of implementing a fully functional and DHHS-HIT approved electronic health record and has successfully reformed its internal clinical and billing practices to that of a Practice Management model.

CAHSD Executive and Senior Management staff monitor progress of all programs, evaluate policies and procedures, and implement changes that enhance performance and provide greater success on a continuous basis.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

  None

  1. To what do you attribute this lack of progress? For example:
     - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
     - Is the lack of progress due to budget or other constraint?
     - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
     - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☒ Yes. If so, what adjustments have been made and how will they address the situation?
  ☐ No. If not, why not?

  The plan was developed as a living document that evolves to meet the ever changing demands of the behavioral health field as we address the changes brought forth through the move to a SMO system and requirements for an electronic health record, electronic billing, Commission on Accreditation of Rehabilitation Facilities (CARF) compliance, Healthcare Reform and to reduce or eliminate wait time for clinic access.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

  The strategic planning process is managed by the Executive Management Team under the direction of the Executive Director. This team monitors the implementation and success of the plan on an on-going basis through monthly meetings, bi-monthly meetings with senior management staff and supervisor weekly meetings with staff.

  The CAHSD Executive Board requires semi-annual and year end progress reports to

ensure progress is made for selected services and initiatives.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   5. How long has the problem or issue existed?
   6. What are the causes of the problem or issue? How do you know?
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

No significant departmental, management, or operational problems/issues have been identified.

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☒ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

4. Are corrective actions underway?
    a. If so:
        - What is the expected time frame for corrective actions to be implemented and improvements to occur?
        - How much progress has been made and how much additional progress is needed?
    b. If not:
        - Why has no action been taken regarding this recommendation?
        - What are the obstacles preventing or delaying corrective actions?
        - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

    ☐ No. If not, please explain.
    ☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
        a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
        b. How much has been expended so far?
        c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
        d. Will additional personnel or funds be required to implement the recommended actions? If so:
            - Provide specific figures, including proposed means of financing for any additional funds.
            - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ Internal audit
☒ External audits (Example: audits by the Office of the Legislative Auditor)
☒ Policy, research, planning, and/or quality assurance functions in-house
☐ Policy, research, planning, and/or quality assurance functions by contract
☒ Program evaluation by in-house staff
☐ Program evaluation by contract

- ☒ Performance Progress Reports (Louisiana Performance Accountability System)
- ☒ In-house performance accountability system or process
- ☒ Benchmarking for Best Management Practices
- ☒ Performance-based contracting (including contract monitoring)
- ☒ Peer review
- ☒ Accreditation review: Magellan annual certification/review and CARF accreditation annual reporting and recertification conducted September 2015
- ☒ Customer/stakeholder feedback
- ☒ Other (please specify): State Licensure (BHS and Public Health-Department of Health and Hospitals)

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☒ Yes. Proceed to Section C below.
☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
   Louisiana Performance Accountability System (LaPAS)
2. Date completed
   Quarterly July 01, 2015 through June 30, 2016
3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Legislative requirement
4. Methodology used for analysis or evaluation
   LaPAS: Standard methodology required by the DOA; actual performance indicators developed in conjunction with program offices and approved by the DOA
5. Cost (allocation of in-house resources or purchase price)
   LaPAS: Cost uncalculated
6. Major Findings and Conclusions
   LaPAS: None
7. Major Recommendations
   LaPAS: None
8. Action taken in response to the report or evaluation
   LaPAS: None
9. Availability (hard copy, electronic file, website)
   LaPAS: www.louisiana.gov/opb/lapas/lapas.htm
10. Contact person for more information, including

    Name: Jan Kasofsky, PhD
    Title: Executive Director

Agency & Program: Capital Area Human Services District
Telephone: 225-922-2700
E-mail: Jan.Kasofsky@la.gov

Name: Charlene Caulfield
Title: Accountant Administrator
Agency & Program: Capital Area Human Services District
Telephone: 225-922-2708
E-mail: chcaulfield@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
304 Metropolitan Human Services District

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Rochelle Head-Dunham, MD**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Care Management/Administration

A. What was achieved?
An independent financial audit of Metropolitan Human Services District (MHSD) financial statements was conducted for FY2016 with the resulting opinion being that there were no instances of noncompliance under Government Auditing Standards and that MHSD achieved compliance, in all material respects, with requirements related to major federal program.

B. Why is this success significant?
The results of such an audit are significant because they demonstrate fiscal responsibility and provide MHSD's Board and other stakeholders with confidence in MHSD's oversight of fiscal processes and procedures within the agency.

C. Who benefits and how?
MHSD benefits from this accomplishment because it validates good financial stewardship of the resources available to its constituents. Additionally, good financial stewardship allows for improved service provision which can result in benefits to persons served.

D. How was the accomplishment achieved?
MHSD's executive management and fiscal division achieved this accomplishment through the preparation and fair presentation of financial statements in accordance with accounting principles generally accepted in the United States of America; this included the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of financial statements that are free from material misstatement.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
This accomplishment contributes to the success of your strategic plan because it aligns with the MHSD strategic plan goal of maintaining a balanced budget while responsibly managing resources and other assets equitably and sustainably.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No, this accomplishment does not represent a Best Management Practice.

Accomplishment #2: Care Management/Administration

A. What was achieved?
Major technology upgrades were successfully completed at four different MHSD clinics in FY16.

B. Why is this success significant?
This accomplishment supports accessibility to services and supports the maintenance of the District's data systems infrastructure.

C. Who benefits and how?
The agency, its employees and by extension persons served, benefited from having updated technological systems. The technology upgrades contribute to work efficiencies and information security.

D. How was the accomplishment achieved?
The accomplishment was achieved through collaboration among MHSD Information

Technology (IT) division, Leadership team, and clinical staff. In the spring of 2016, a review of MHSD's existing technology systems was performed by MHSD's IT Division to determine the state of the MHSD's IT systems. This assessment was then shared and disseminated to MHSD Leadership and led to the development of MHSD's 2016 technology plan. The 2016 technology plan recommended the acquisition of updated hardware, while remaining fiscally responsible. Leadership agreed to implement the recommendations. The technology updates were addressed in a least disruptive manner to the work of MHSD staff, and oftentimes occurred after-hours.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
This accomplishment contributes to the strategic plan by increasing accessibility to services and supporting the District's data systems infrastructure.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No, this accomplishment does not represent a Best Management Practice.

Accomplishment #3: Care Management/Administration

A. What was achieved?
MHSD replaced contracted legal services with an in-house attorney that has experience in governmental affairs, contracting and the civil service system.

B. Why is this success significant?
This is significant given MHSD's number of contracted services, number of civil service employees, and requirements as a political subdivision of the State, and the numerous federal, state and jurisdictional regulations and laws which impact operations and decision making.

C. Who benefits and how?
The district and the persons served benefits from having in-house council available to research and advise on important and pressing legal and regulatory matters. Having in-house council is not only cost efficient compared to contracted legal services, but helps in developing an infrastructure of corporate compliance and adherence to personnel and civil service guidelines.

D. How was the accomplishment achieved?
This accomplishment was achieved through Board approval and a rigorous search and interview process conducted by executive management.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
This accomplishment contributes to success on our strategic plan objective related actively engaging in needs based recruitment of highly qualified professionals when

agency gaps are identified.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No, this accomplishment does not represent a Best Management Practice.

Accomplishment #4: Children's Behavioral Health Services

A. What was achieved?
The MHSD Prevention program continued implementation of the Louisiana's High Needs Communities (HNC) Prevention grant in Plaquemines Parish, which lead to the development of a strategic framework action plan and budget for the newly formed anti-drug coalition.

B. Why is this success significant?
The coalition's objectives are to reduce underage drinking and the misuse of prescription drugs.

C. Who benefits and how?
Individuals in the community with interest in forming a coalition around targeted issues to reduce underage drinking and the misuse of prescription drugs benefit.

D. How was the accomplishment achieved?
The formation of the coalition was achieved by the grassroots efforts of individuals in the community with interest in forming a coalition around targeted issues.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
This accomplishment relates to the success of the strategic plan by contributing to the enhancement of prevention programming as part of MHSD's integrated system of care and services delivery.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No, this accomplishment does not represent a Best Management Practice.

Accomplishment #5: Children's Behavioral Health Services

A. What was achieved?
The MHSD Child and Youth Division's Family Support program instituted well-received monthly advocacy and education workshops for parents raising behaviorally and emotionally challenged youth. These workshops are held at various sites in the community with expert facilitators in such areas as self-care skills, benefits planning for transition age youth, rights and parental participation in IEP's, etc.

B. Why is this success significant?
The significance of this activity is that it supports the guiding principles of ACT 378 by providing supports to families as they care for their developmental or emotionally disabled children at home.

C. Who benefits and how?
Parents and by extension, children and youth with severe emotional and behavioral disturbances, benefit from receiving educational and advocacy training regarding supports and services for their child.

D. How was the accomplishment achieved?
This achievement was accomplished by ongoing surveying of parents and caregivers of children and youth receiving behavioral health services in MHSD clinics, as well as recipients of consumer care and/or flexible family funds, as to the types of supports they would find most beneficial in their efforts at raising challenging youth.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
This accomplishment is significant in achieving the MHSD strategic plan goals of building community capacity through designated partnerships and increasing accessibility to services for those residing in the tri-parish area.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No, this accomplishment does not represent a Best Management Practice.

Accomplishment #6: Children's Behavioral Health Services

A. What was achieved?
The MHSD Child and Youth Division's Youth Support program expanded its services to include alternative high school settings in Plaquemines and St. Bernard parishes while maintaining ongoing services to two alternative high schools in Orleans parish.

B. Why is this success significant?
These services are designed to address behaviorally challenged youth with afterschool programming in the visual arts, career exploration, and soft skills development for the workforce.

C. Who benefits and how?
The identified students at these alternative schools benefited from exposure to less traditional and emphasized learning modalities.

D. How was this accomplishment achieved?
To achieve this accomplishment it required program designs for the two new schools, new agreements with teams of teachers, and MOUs with two school boards.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
The accomplishment of expanding these out-of-school-time services to youth is significant in achieving the MHSD strategic plan goals of building community capacity through designated partnerships and increasing accessibility to services for those residing in the tri-parish area.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No, this accomplishment does not represent a Best Management Practice.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

  MHSD has made significant progress towards the accomplishment of the goals outlined in its five-year (2015 – 2019) strategic plan. Strategies, as measured by performance indicators, have generally been shown to be effective. Performance measurement, data analysis and other information indicate a positive ROI (Return on Investment) when monitoring the linkage between performance and district budgeting.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

  1. To what do you attribute this success? For example:
     - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
     - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
     - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?

- Other? Please specify.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

   Significant progress was made in ensuring MHSD's electronic health record system to allowed for compliance with essential State reporting. This was due to the cooperative and collaborative efforts of data management staff at OBH and MHSD. Progress is consistent with the MHSD Strategic Plan Care Management Goal 2, Objective IV of complying with essential reporting and disseminating District information to state/federal agencies, as well as continuing the development of our data system infrastructure.

   Significant progress was made in planning and development of expanded addictive disorder services provided by MHSD. Research, environmental scans and gap analyses gave direction to this initiative and fueled the decision to reallocate resources for expansion. MHSD also submitted its first SAMHSA grant that would underwrite medication assisted treatment services for prescription opioid abusers in the community as a collaborative effort with OBH. Significant progress in the implementation of addictive disorder services is anticipated, and these efforts align with the Strategic Plan Goal 1, Objective I of Adult Behavioral Health Activities (i.e., broadening the array of evidenced-based services via outpatient individual, group, and family therapy).

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

  None. With new Executive Leadership, firmly in place, MHSD is not currently experiencing a lack of progress.

  1. To what do you attribute this lack of progress? For example:
     - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
     - Is the lack of progress due to budget or other constraint?
     - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
     - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

☒ Yes. If so, what adjustments have been made and how will they address the situation?
☐ No. If not, why not?

Adjustments were made in terms of re-framing certain goals and objectives by obtaining more input and data from a range of stakeholders (e.g., board members, Leadership Team, MHSD employees, persons served, community partners). The impetus for these adjustments was the consensus on the part of leadership that MHSD should strive to be a center of excellence for behavioral health and intellectual/developmental disabilities, and the understanding that data driven decision making is a key measure of excellence.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

MHSD's Executive Leadership and Management team conducts weekly staff meetings where roundtable discussions are held on current projects and timelines. During these meetings, leaders from respective areas within the organization are able to provide input, communicate road blocks and determine execution of various initiatives. The Executive Director also meets individually on a weekly basis with Division Directors from Fiscal, Legal/Compliance, Quality, Adult, Children's and I/DD to obtain status reports. On a quarterly basis, Division Directors give presentations on strategic plan indicators for which their divisions are responsible, and monthly the Executive Director meets with the Board of Directors and provides a status report on key performance indicators for the organization.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   5. How long has the problem or issue existed?
   6. What are the causes of the problem or issue? How do you know?
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

   No significant departmental, management, or operational problems/issues have been identified. MHSD continues to work toward its goal of providing quality behavioral health care.

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☒ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   4. Are corrective actions underway?
      a. If so:
         - What is the expected time frame for corrective actions to be implemented and improvements to occur?
         - How much progress has been made and how much additional progress is needed?
      b. If not:
         - Why has no action been taken regarding this recommendation?
         - What are the obstacles preventing or delaying corrective actions?
         - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

   5. Do corrective actions carry a cost?

      ☐ No. If not, please explain.
      ☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
b. How much has been expended so far?
c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
d. Will additional personnel or funds be required to implement the recommended actions? If so:
    - Provide specific figures, including proposed means of financing for any additional funds.
    - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

- ☒ Internal audit
- ☒ External audits (Example: audits by the Office of the Legislative Auditor)
- ☐ Policy, research, planning, and/or quality assurance functions in-house
- ☒ Policy, research, planning, and/or quality assurance functions by contract
- ☐ Program evaluation by in-house staff
- ☐ Program evaluation by contract
- ☒ Performance Progress Reports (Louisiana Performance Accountability System)
- ☐ In-house performance accountability system or process
- ☒ Benchmarking for Best Management Practices
- ☐ Performance-based contracting (including contract monitoring)
- ☒ Peer review
- ☒ Accreditation review
- ☒ Customer/stakeholder feedback
- ☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

- ☒ Yes. Proceed to Section C below.
- ☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation

2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

1. Title of Report: **AIP/Accountability & Implementation Plan**
2. Date Complete: 12/10/2015
3. Subject/Purpose: To guide the delivery of addictive disorders (AD), Developmental Disabilities (DD), and Mental Health (MH) services funded by appropriations from the state.
4. Methodology: Site monitoring consisted of a joint OBH and OCDD Review team to include data reviews, chart audits, and interviews with staff.
5. Cost: Allocation of committed staff time to the process for the day.
6. Major Findings: none
7. Major Recommendations: none
8. Action taken: MHSD responded as needed in writing with a Plan of Correction (POC) to any major findings.
9. Availability: AIP is available in hardcopy and electronic file; report file will be available in same format.

1. Title of Report: **Independent Financial Audit**
2. Date Completed: June 30, 2016 (for FY16)
3. Subject/Purpose: Full independent audit of MHSD as an independent fiscal entity
4. Methodology: External audit firm selected by LLA and used standard audit approach including A-133 single audit
5. Cost: None
6. Major Findings: No findings – unqualified audit
7. Major Recommendations: No recommendations for MHSD
8. Action: MHSD has shared report with its Board and Leadership staff.
9. Availability: hardcopy and electronic format

1. Title of Report or Program Evaluation: **MHSD Operations Risk Management Audit**
2. Date completed March 30, 2016

3. Subject or purpose and reason for initiation of the analysis or evaluation Annual Audit
4. Methodology used for analysis or evaluation Full site visits with auditor, sit down meeting with auditor to review required records, and a self-audit annually.
5. Cost (allocation of in-house resources or purchase price) N/A
6. Major Findings and Conclusions scored: Pass 99.74%
7. Major Recommendations: None
8. Action taken in response to the report or evaluation: Maintenance of Efforts
9. Availability (hard copy, electronic file, website): Hard copy, and electronic file.

Contact person for more information, including
Name: Rochelle Head-Dunham, M.D.
Title: Executive Director/Medical Director
Agency & Program: 09-304 Metropolitan Human Services District (MHSD)
Telephone: 504-535-2909
E-mail: Rochelle.Dunham2@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
303 Developmental Disabilities Council

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Sandee Winchell**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment: Increased Awareness of the need for Community-Based Services

A. What was achieved?

The Council provided leadership in advocacy, capacity building and systemic change activities that contributed to increased awareness of the need for community-based services for individuals with developmental disabilities and the impact of educational policies and practices on students with disabilities.

Educational policies influenced by the advocacy efforts of LaTEACH and the Council leadership include changes in rule and guidance to count high school diplomas earned by students tested on the alternate assessment level one (LAA-1) in school performance scores; BESE restricted dissemination of a report by LDOE with inaccurate information on costs and outcomes of the scholarship program; LDOE was required to report data on special education indicators; LDOE established an advisory task force on student discipline and behavior; and charter schools are prohibited from collecting medical information from prospective students prior to enrollment.

Significant policy and practice changes influenced by LaCAN and Council advocacy related to community-based services include the Louisiana Department of Health (LDH) agreed that Act 378 funds must be used exclusively for services to individuals with developmental disabilities and their families, not civil service salaries or other administrative costs; $500,000 appropriated for EarlySteps was moved to provide Individual and Family Supports and Services; LDH reversed/corrected a policy decision that had previously indicated Flexible Family Funds were taxable income; a moratorium was placed on new licenses for Pediatric Day Health Care Centers; and, advocacy efforts were successful with increasing Legislators' awareness and support to restore funding for waiver slots for people with developmental disabilities, the Individual and Family Support Program, Families Helping Families Centers, and Human Services Districts and Authorities.

B. Why is this success significant?**

The achievements resulting from Council actions advance our State in providing services supporting individuals with developmental disabilities to live in their own homes, be free from abuse, earn high school diplomas, access the same educational environments, settings and programs, and work in integrated environments,

C. Who benefits and how?

More individuals with developmental disabilities have greater access to the supports and services needed, students with disabilities have additional oversight on the use of restraint and seclusion practices, more students with disabilities were able to exit school with a high school diploma and compete in the workforce, and more people are actively engaged in advocacy related to policy and practices for people with developmental disabilities.

D. How was the accomplishment achieved?

Through the Council's technical assistance provided to two grassroots advocacy networks, Louisiana Citizens for Action Now (LaCAN) and Louisiana Together Educating All Children (LaTEACH), numerous policies were changed to improve and/or increase community services. In addition, multiple training events were held and meetings with key leadership of various agencies collectively resulted in achievement of the accomplishments.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes. The accomplishments directly contribute to the success of the Council's five-year

goals and annual objectives/activities.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Some of the strategies used do represent Best Management Practices regarding stakeholder input to create a consumer-directed, consumer-driven service delivery system. These strategies have been shared to build the capacity of other agencies to improve services.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

The Council creates a five-year plan with targeted initiatives and objectives identified through annual activities and advocacy agenda items. Overall the Council has become recognized as a valued source of information and vision for policy makers to allocate resources and develop consumer-driven systems of support and services for people with developmental disabilities. Our strategies with providing the necessary information and support to individuals with developmental disabilities, their family members, and policy makers and forging relationships between these entities have proven invaluable and incredibly effective with ensuring policy-makers have first-hand perspectives of the impact of their decisions on the citizens they represent.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If

so, how do you gauge your department's contribution to the joint success?
- Other? Please specify.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

While many of the successes in policy and practice changes were a result of collaborations with other agencies, the successes realized are a direct result of targeted educational campaigns to policy makers, advocates and the general public conducted by the Council. The vast majority if not all of these changes would not have occurred without the specific actions taken by the Council. The Council has expanded its repertoire of strategies and tools to connect with the public and policy makers and has plans to continue to build its capacity to utilize social media networks and tools to conduct education campaigns and provide timely information to constituents.

This progress is due to the Council having developed and supported large grassroots advocacy networks and family support agencies over the past twenty years. It is expected that there will continue to be an increase in the influence the Council, self-advocates, and family members of individuals with developmental disabilities have on decisions by policy makers. The Council's capacity to educate the general public and policy makers about needed changes to existing policies and/or the impact of pending decisions is well established and growing.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

  1. To what do you attribute this lack of progress? For example:
     - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
     - Is the lack of progress due to budget or other constraint?
     - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
     - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

  We are not experiencing any significant lack of progress.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

☒ Yes. If so, what adjustments have been made and how will they address the situation?
☐ No. If not, why not?

The Council just developed its next five-year plan and an action plan for the first year to address specific areas of emphasis to target and objectives for each goal area.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

The Council works closely with staff of the Department's Planning and Budget Section to review, update and report progress on the Strategic Plan. The Council's Deputy Director supervises the Strategic Plan, and directly coordinates with the Department's Planning staff to ensure the plan is effective and efficiently implemented.

A task matrix is utilized to ensure the responsibilities of each staff position are performed according to specified timelines. The matrix also allows the coordination of specific tasks for responsibilities shared across staff members. Specific protocols provide detailed steps to achieve each critical task to ensure timely completion regardless of the availability of the responsible staff member. Staff time allocation studies are conducted annually and aligned with any changes to the Council plan. Determinations are made regarding degree of responsibility and timing of tasks to distribute the workload appropriately across staff members.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)

3. What organizational unit in the department is experiencing the problem or issue?
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
5. How long has the problem or issue existed?
6. What are the causes of the problem or issue? How do you know?

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

All Council activities are dependent on federal and state appropriations. The Council consistently takes all actions possible to ensure continued allocations. One significant issue is the economy in general and Louisiana's capacity to maintain the contributions to supporting necessary programs in the future.

B. Corrective Actions
1. Does the problem or issue identified above require a corrective action by your department?

☒ No. If not, skip questions 2-5 below.
☐ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
      - How much progress has been made and how much additional progress is needed?
   b. If not:
      - Why has no action been taken regarding this recommendation?
      - What are the obstacles preventing or delaying corrective actions?
      - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific

regarding types and amounts of costs.

b. How much has been expended so far?
c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
d. Will additional personnel or funds be required to implement the recommended actions? If so:
    - Provide specific figures, including proposed means of financing for any additional funds.
    - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

- ☐ Internal audit
- ☐ External audits (Example: audits by the Office of the Legislative Auditor)
- ☒ Policy, research, planning, and/or quality assurance functions in-house
- ☐ Policy, research, planning, and/or quality assurance functions by contract
- ☒ Program evaluation by in-house staff
- ☐ Program evaluation by contract
- ☒ Performance Progress Reports (Louisiana Performance Accountability System)
- ☐ In-house performance accountability system or process
- ☐ Benchmarking for Best Management Practices
- ☒ Performance-based contracting (including contract monitoring)
- ☐ Peer review
- ☐ Accreditation review
- ☒ Customer/stakeholder feedback
- ☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

- ☒ Yes. Proceed to Section C below.
- ☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation

4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

As required by federal law, the Council submitted a Program Performance Report (PPR) to the federal Department of Health and Human Services, Administration on Developmental Disabilities in December 2015 on its performance in compliance with the federal Developmental Disabilities Assistance and Bill of Rights Act.

This report is based on the federal fiscal year – October 1 to September 30, and therefore covered the first quarter of state fiscal year 2015-2016. A report covering the remainder of the state fiscal year will be submitted to the federal government in December 2017.

This report is required by the federal DD Act, and it is used by the Administration on Developmental Disabilities to determine the Council's compliance with the requirements of the Act, and the Council's effectiveness. The report is done in-house by Council staff and approved by the staff of the Administration on Developmental Disabilities (ADD).

The report is available on the Department of Health and Human Services, Administration on Developmental Disabilities' website.

For more information contact:
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Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
305 Medical Vendor Administration and
306 Medical Vendor Payments

Department Head: **Rebekah E. Gee MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Assistant Secretary: **Jen Steele**
Medicaid Director

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Medicaid Expansion

A. What was achieved?

On January 12, 2016, Governor John Bel Edwards signed executive order JBE 16-01 to expand Medicaid coverage to low income adults in Louisiana beginning July 1, 2016. The move made Louisiana the 31st State in the Union to expand Medicaid based on provisions of the 2010 Affordable Care Act (ACA) thus affording several hundred thousand Louisiana

adults, who previously did not qualify, full Medicaid coverage. The goal was and continues to be to fill in historical gaps in Medicaid eligibility for adults.

B. Why is this success significant?

The Louisiana Department of Health's mission is to protect and promote health and ensure access to medical services for all residents of the State of Louisiana. Success is significant because expansion allows previously uninsured adults access to quality medical care thereby improving the health outcomes for our residents overall. These are benefits that they may not have been able to get previously, that were not offered to them through their employers, or that they did not qualify for through Medicaid.

C. Who benefits and how?

As a result of the successful launch of the Medicaid Expansion program, 186,799 adults have access to quality healthcare that they were not categorically eligible for prior to July 1, 2016. Through Healthy Louisiana, brand name for our Managed Care Organizations (MCOs), these individuals have coverage comparable to that of the private sector, with noted wrap around services of dental and optical coverage.

D. How was the accomplishment achieved?

Louisiana set a high standard of having cards in the hands of Expansion eligible adults on July 1, 2016. Due to Louisiana's budgetary limitations, thinking out-of-the-box was necessary. When additional staffing resources were not available, new and innovative methods had to be developed or enhanced. Some examples include:

- Designed and implemented automated processes to enroll existing Medicaid recipients with limited coverage in the **State's Medicaid expansion program, augmenting the benefits of 186,799**[1] state residents with no effort on their part.

- Conceived, received CMS approval for, and implemented a **process**[2] to enroll state residents with **active Supplemental Nutrition Assistance Program (SNAP) benefits into the Medicaid expansion program based partially on data provided to and verified by the Louisiana Department of Health's sister agency, the Department of Children and Family Services (DCFS).**

- Through partnership with DCFS and collaboration with the Centers for Medicare and Medicaid Services (CMS), Louisiana has sought to streamline enrollment for SNAP recipients. Beginning in the month of May 2016, residents with active SNAP benefits who met criteria were allowed an abbreviated application process, involving no reduplication of Medicaid determination work and facilitating expedited enrollment of other public assistance populations as a cost-effective strategy. Louisiana will

[1] http://dhh.louisiana.gov/index.cfm/newsroom/detail/3840
[2] http://dhh.louisiana.gov/index.cfm/newsroom/detail/3838

continue this process, and will work in conjunction with DCFS and CMS to further streamline the application process.

- Coordinated grassroots outreach events involving Medicaid Application Centers (MACs), Medicaid providers, LDH staff, and other partners such as the Louisiana Hospital Association (LHA). These events were held across the state to educate our partners and to spread the news of this wonderful new opportunity for access to care.

To further improve health outcomes for Louisiana residents, LDH continues to partner with the Louisiana Department of Corrections (DOC) to reduce the rate of recidivism for justice-involved individuals by enrolling these individuals in Medicaid so that they have access to necessary treatment and medications upon release.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes. One objective of the strategic plan is to provide Medicaid eligibility determinations and administer the program within federal regulations, by processing applications timely through ongoing process improvement in order to streamline our business processes and eliminate duplicated effort. By finding new and more efficient ways to get Medicaid eligible individuals enrolled, we are continuously working towards that objective.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. The Department has found the methods used to accomplish launching Medicaid Expansion to be highly effective. Stakeholder input, readiness reviews to determine preparedness, and regular/periodic/frequent status reports from the department heads are crucial.

Accomplishment #2: Outstation Sites

A. What was achieved?

To further assist with Medicaid Expansion enrollment efforts, Medicaid contracted with medical providers across the state to participate in the Onsite Medicaid Worker Program. The purpose of this agreement is to build a partnership with the community through the host sites. The benefits to the host are that their applications would be given priority by the on-site eligibility analyst and the analyst would serve as a source to assist with Medicaid questions. The benefit to LDH is that this arrangement helped us to comply with Medicaid regulation regarding outstationing. We put Medicaid workers at more locations and reduced our need for office space. This costs saving action was achieved by the outstation site (host location) which provides LDH a payment which equals the state's share of administrative costs (25%). Statewide at the end of FY2016 there were 26 provider

locations and Medicaid staff participating in this project. The provider referred to as, the Host, reimburses the direct costs not to exceed an annual cost of $20,000 associated with the Medicaid Analyst(s) operating out of their site on a quarterly, retrospective basis.

At a minimum, direct costs could include:

- Salary of the on-site eligibility worker
- Related benefits for the on-site eligibility worker
- Prorated share of:
    - Outreach activities
    - Outstation support staff and related benefits

B. Why is this success significant?

As with Medicaid Expansion, success is significant because it allows previously uninsured adults access to quality medical care thereby improving the health outcomes for our citizens overall. These are benefits that they may not have been able to afford previously, that were not offered to them through their employers, or that they did not qualify for through Medicaid**.** Outpatient sites provide cost savings to the state, reducing the need for additional office space and at the same time making Medicaid more visible by putting eligibility workers back in the community at more locations, which improves customer service and access to information. The host site benefited by having Medicaid resources staff available to answer questions and give priority processing to host patients and on-site application processing in real time.

C. Who benefits and how?

This is a win-win situation for Louisiana residents, Medicaid Providers, Louisiana Medicaid as well as the Louisiana economy.

- Louisiana residents benefit as they are provided:
    - Enrollment options that are accessible at provider locations via the Medicaid Application Centers (MACs), allowing ease of access to health care and eligibility services in one location.
    - Improved levels of service
    - On-site assistance to determine if new applications are required or if streamlined, time-saving process may be used

- Medicaid Providers benefit by having an experienced Medicaid eligibility worker on-site and available to:
    - Coordinate with the on-site Medicaid Application Centers (MACs) to assist with enrollment efforts.
    - Provide on–site, real time eligibility decisions. With the analyst's help provider reimbursement becomes a swifter process. The patient can walk out of the hospital with eligibility on file which is essential in follow-up care and access to pharmacy for prescriptions.
    - Give priority to making decisions on applications from host's patients and getting the Medicaid decision input into the system.

- Assist with Medicaid eligibility questions

- The Louisiana economy benefits by having healthier, more focused employees return to work sooner after having their healthcare needs met.

- Louisiana Medicaid benefits by:
  - Providing Hospital Presumptive Eligibility (HPE) applications that offer limited scope of coverage and allows applicants to obtain near real-time decisions on applications for full benefits.
  - Helping to comply with federal regulations requiring eligibility outstationing
  - Providing improved customer service and access to information.
  - Reducing the need for additional office space thus saving the State additional money
  - Reducing the State's share of salaries and benefits for Medicaid Eligibility workers
  - Preserving and increasing eligibility capacity within Louisiana Medicaid

D. How was the accomplishment achieved?

While the Outstation Program is made available to states by the Centers for Medicaid and Medicare Services (CMS), Louisiana was 2nd in the nation to successfully implement this program. LDH staff used grassroots techniques to reach out and engage provider partners to participate in this program.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes. Our strategic plan included goals toward providing a quality workforce with options for outstation to create a more favorable work environment which results in higher levels of service to the residents we serve. The strategies are:

- Strategic alignment of staffing to obtain maximum efficiencies and expedite the processing of applications
- Increase enrollment and retention by removing barriers

Our goal towards increasing enrollment and retention was also achieved through this effort by removing barriers to apply and simplifying the application process by providing on-site eligibility workers at host locations. Through our partnership with the host we take full advantage of data-sharing with agency partners to increase access and maximize resources to identify and enroll potentially eligible individuals. Additionally, we are able to expedite the processing of applications.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

The creative strategy of on-site eligibility workers helped to positively build the Healthy Louisiana brand, and restore public confidence in Louisiana government. This initiative demonstrates that Louisiana is taking a progressive approach toward improving processes and providing access to care for our residents despite extraordinary challenges.

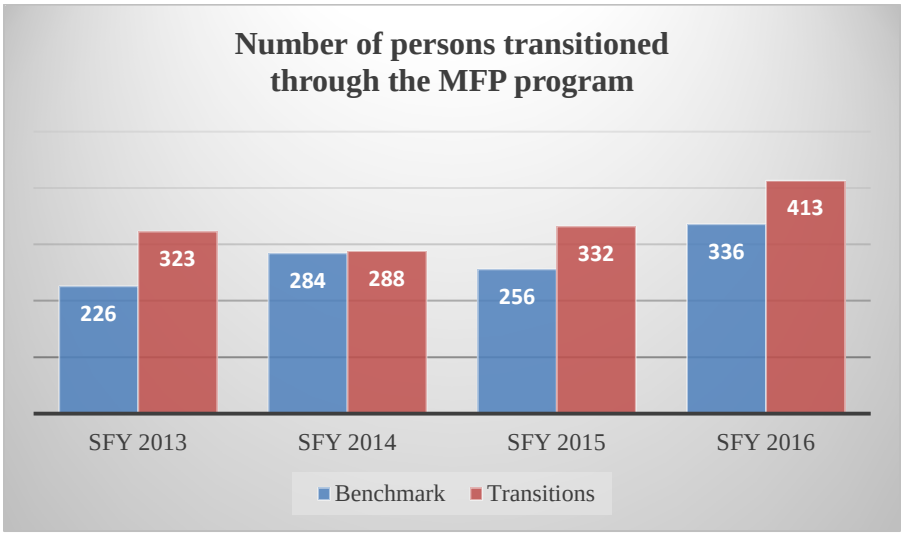
Accomplishment #3: Money Follows the Person (MFP) Award

A. What was achieved?
In FY16, the State was issued an award for $36,625,042 for continuing the Money Follows the Person program through 9/30/2020.

B. Why is this success significant?
This success is significant because it allows the department to continue to transition hundreds of individuals each year out of institutional settings into community based settings through this grant.

C. Who benefits and how?
The elderly in addition to individuals with physical and developmental disabilities benefit from this program as it allows them them to live in the least restrictive settings and to get the community based services they need to function well in their homes. The department also benefits by serving individuals at a lower costs in the community.

D. How was the accomplishment achieved?
This accomplishment was achieved by several offices including Medicaid Program Supports and Waivers (MPS&W), the Office of Aging and Adult Services (OAAS), and the Office of Citizens with Developmental Disabilities (OCDD) by dedicated MFP staff funded through the grant collaboratively working together to meet all of the many financial and programmatic requirements due on a monthly, quarterly and annual basis. One of the requirements is to achieve a designated level of transitions of individuals out of institutions into the community. Each year the State has exceeded this benchmark. See chart below:



E. Does this accomplishment contribute to the success of your strategic plan?
(See Section II below.)

This accomplishment tremendously contributes to the success of our strategic plan objective of refocusing the system to increase choice and provide more robust living options for those who need long-term supports and services by promoting home and community-based services to meet the existing demand for services and decreasing the reliance on more expensive institutional care.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Not applicable.

Accomplishment #4: Improving Quality of Care through Advancing Health Information Technology

A. What was achieved?

The Medicaid Quality and Benefits Management sections have a large focus on healthcare quality and outcomes and have a dedicated Quality Team led by Medicaid's Chief Medical Officer, Dr. SreyRam Kuy, and the Quality Section Chief, Ms. Piia Hanson. More broadly, our team is composed of physicians, nurses, public health experts, programmers, policy analysts, statisticians, and PhD level researchers. During this fiscal year, we launched a replacement State Level Repository (SLR) for administration of the Medicaid Electronic Health Records (EHR) Incentive Program. The SLR is a web-based portal where providers log-in to apply for an incentive payment. The SLR also captures valuable meaningful use data and clinical quality measures. Another area of significant progress is in the Medicaid Managed Care activity, which aims to increase budget predictability while providing for a service delivery model of high quality, medically necessary health services, and avoiding unnecessary duplication of services.

The Medicaid Managed Care Activity also saw an increase in healthcare utilizations. For FY 2016, the rates for adolescent well-child visits and postpartum care showed an increase that nearly meets and/or exceeds the benchmarks and continues to demonstrate improvement. For Adolescent Well-Care Visits, all health plans continued to exceed the Pre-Bayou Health Baseline (2012) of 25.16%. The average utilization of Adolescent Well-Care Visits increased from 49.73% to 51.51% from 2015 to 2016. The LDH 2016 goal of 40.69% was met by all health plans except Aetna.

For Postpartum Care, the LDH 2016 goal of 63.12% was met only by AmeriHealth Caritas while the remaining health plans were only off ranging from 1.15 to 4.89% off from designated goal. The average of the plans increased from 46.72% to 60.19% from 2015 to 2016.

Additionally, for Breast Cancer Screening, we realized an increase from 53.63% to 55.55% from 2015 to 2016, and the 55.55% plan average exceeded the 2015 National Committee for Quality Assurance (NCQA) Quality Compass South Central – 50th Percentile Benchmark of 53.02%.

The results for Chlamydia Screening continued to show a slight increase from 2015 to 2016. The 2012 Pre-Bayou Health Baseline of 56.88% continued to be exceeded by all plans and the average of Chlamydia Screening for the plans increased from 58.14% to 60.98% from 2015 to 2016, which exceeded the 2015 NCQA Quality Compass South Central—50th Percentile Benchmark of 51.79%. Finally, the Pharmacy program implemented numerous edits at the Point of Sale and has incorporated prior authorization criteria on some prescriptions to assure that prescriptions filled are appropriate and medically necessary. Savings were achieved and rebates, described in detail later in this document, were captured.

Also, during this fiscal year, the Clinical Policy Section was incorporated into the Quality Management Section of Louisiana Medicaid. The Clinical Policy Section is comprised of a team of Registered Nurses that are experts in their field. To develop coverage policies and criteria, the Clinical Policy Section has processes in place to review clinical evidence and other policy considerations in order to make informed decisions. This team has developed numerous policies including cervical cancer screening and breast reconstruction following breast cancer.

Finally, Louisiana Medicaid's Quality Strategy has been recognized nationally, profiled at the National Academy for State Health Policy (NASHP) Conference, found in the link: http://www.nashp.org/bridging-the-gap-between-healthcare-and-health-equity/ and with a State Spotlight Profile in "Mostly Medicaid" found in the link: http://www.mostlymedicaid.com/?p=1813.

B. Why is this success significant?

Louisiana Medicaid leads a quarterly Medicaid Quality Committee, which incorporates in the membership diverse Louisiana healthcare stakeholders, including patient and patient advocate perspectives as well as providers, MCO's, and other members of the healthcare community. By working with various stakeholders, the Medicaid Quality and Benefits Management teams are able to better support providers and consumers.

The previous SLR was developed by Molina Health Care Solutions and launched in May 2013 as a stop gap solution when plans to implement a commercial off-the-shelf SLR product were interrupted due to contract termination. The previous SLR lacked the functional capabilities necessary to effectively administer the EHR Incentive Program through its sunset in 2021. Meaningful use measures, including clinical quality measures (CQMs), were uploaded to the previous SLR by program participants through use of Excel files. This method created inefficiencies in audit and reporting processes, compromised data integrity; and created inconvenience for users.

Additionally, the Clinical Policy Section provides a systematic approach to guiding the decision making of policy redesign and adding new Medicaid benefits. Policy decision making is evidence based and guided by relevant research studies and literature. Services that are experimental, investigational, cosmetic, or non-FDA (Federal Drug Administration) approved are not considered.

With regard to our robust pharmacy program, we have made significant strides during this fiscal year. These include the following:

- The Coordination of Benefits process requires providers to bill other insurance carriers before billing Medicaid. This prevents duplicate payment from multiple payers. Cost avoidance**: $83,409.**

- Prospective Drug Utilization is significant as it creates a system of edits at the Point of Sale and prevents excessive expenditures for early refills, prescription duplications and alerts pharmacists to pregnancy precautions. **In federal fiscal year 15 (FFY 15) $80,058,674 were cost avoided.**

- The Retrospective Drug Utilization Review reviews patterns of prescription utilization and sends prescription profiles on selected clinical criteria to prescribers and pharmacists after prescriptions are dispensed. **Cost avoidance in FFS (Fee for Service) in federal fiscal year 15 (FFY) was $381,446.**

- With regard to the Pharmacy Provider Fee Collections, the Louisiana Department of Health imposes a $0.10 provider fee on all out-patient prescriptions dispensed for Louisiana residents. This fee is applied toward the state general fund match requirements for financing the cost of the Medicaid program. **Pharmacy program collected $8,831,970.80 in principal and $5,399.38 in interest and penalties.**

- The Pharmacy Rebate Program is staffed by University of New Orleans personnel and generates quarterly rebate invoices, reconciles payments and resolves disputes with manufacturers.

Additionally, federal rebates are collected on claims billed in FFS and by the MCOs. Supplemental rebates are captured just on FFS claims. These are noted below:

Rebates Collected (Fiscal Year ending 6/30/16)	
FFS FEDERAL	$66,026,477.31
MCO FEDERAL	$291,895,427.94
FFS SUPPLEMENTAL	$6,794,218.09
TOTAL	**$364,716,123.34**

Finally, with regard to Pharmacy Provider Compliance Audits, improper billing by providers may result in a payment disallowance and/or administrative sanctions by Medicaid and/or the Board of Pharmacy. As such, pharmacy staff works closely with

Program Integrity and the Attorney General's staff on potential fraud cases. **Total Audit Collections were $138,872.26.**

C. Who benefits and how?

The primary beneficiaries of the replacement SLR are Medicaid providers who seek an incentive payment. The replacement SLR allows for a more streamlined application process – as meaningful use data can be entered directly into the SLR – providing for increased efficiency and expediency. Secondary beneficiaries include Medicaid staff, who will experience greater ease in fulfilling reporting requirements and providing data for audit purposes. Medicaid and LaCHIP (Louisiana Children's Health Insurance Program) recipients, Louisiana residents, the MCOs and FI (Fiscal Intermediary) as well as other stakeholders benefit from the development of the Clinical Policy Section as evidence based informed decision making helps to ensure the cost-effectiveness, efficacy, and safety of newly added benefits as well as the improvement in the quality of the healthcare delivered.

Additionally, the pharmacy program has implemented numerous efficiencies in securing cost avoidance while continuing to provide necessary medication to Medicaid recipients. The pharmacy program is highly monitored by State and Federal auditors as many facets of this program are statutorily required and must comply with the Board of Pharmacy rules and regulations. While the Pharmacy program is one of the largest in services and expenditures, pharmacy services improve health status, reduce cost and promote a healthier population by providing drug therapies.

D. How was the accomplishment achieved?

There are currently 37 quality measures that each health plan is contractually obligated to report that include the state-wide health plan incentive measures (9), HEDIS (Healthcare Effectiveness Data and Information Set) Measures (23), Prevention Quality Indicators (PQI) Measures (3), Vital Records Measures (2), and CMS Measures (1). Further measures are in development for the next contract year that will be based upon submission of CQMs (clinical quality measures) through the Medicaid HIT (Health Information Technology) /EHR initiatives and will include Women's and maternal Health, Pediatric Health, Behavioral Health (Pediatric and Adult), Adult Health/Primary Care (encompassing our new expansion population) and STIs (sexually transmitted infections).

With regard to Medicaid's HIT efforts, a Request for Proposals (RFP) was developed, which required approval by CMS and Louisiana's Office of Information Technology. In addition, HITECH (Health Information Technology for Economic and Clinical Health Act) funding was sought and received via a HIT Implementation Advanced Planning Document (IAPD). After nearly a year, the RFP resulted in a contract award to Health Tech Solutions. After six months of development, the replacement SLR was launched in September 2016.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes, this accomplishment supports the vision, mission, and philosophy of Louisiana Medicaid by making informed evidence based decisions to improve health and healthcare of Louisiana recipients thereby improving the health of populations. Current data collection allows for only health plan level quality data. The Clinical Quality Measures (CQM) initiative will allow us to collect clinical level data (such as lab results) at the provider and member levels which will help advance LDH's vision of performance-based, value-based purchasing.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes, this accomplishment is in keeping with LDH's strategic mission and vision as well as CMS' Medicaid Information Technology Architecture (MITA), a national framework to support improved systems development. Louisiana Medicaid's HIT efforts meet MITA standards by increasing automation and efficiency. Best Management Practice is the basis of our clinical policy redesign processes.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

Accomplishment # 3

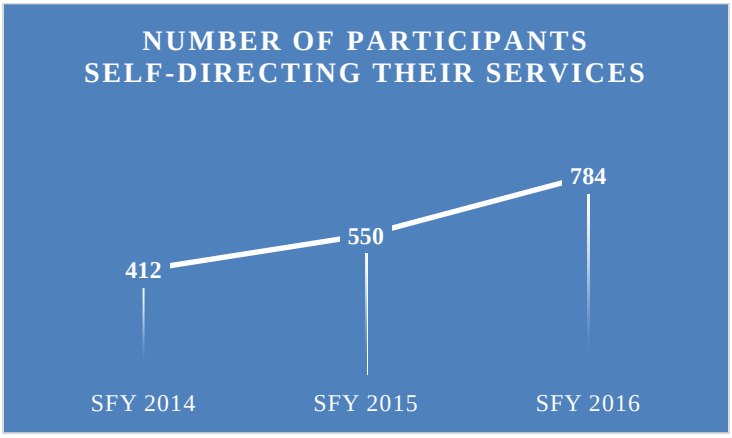
- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

Our Five Year Strategic Plan involved improving the balance of its long term supports and services (LTSS) system to improve health care quality, controlling costs, and enhancing the quality of life for Louisiana citizens while promoting choice among individuals served. Mechanisms to rebalance LTSS, which included continuing the MFP program, took advantage of the funding received through the Balancing Incentives Program in order to increase access to long term supports services.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify

and discuss strategies that are working better than expected. Be specific; discuss the following for each.

In addition to the success of the MFP program as described above, our self-direction program for waiver participants has been a success as well. One of our strategies was to increase choice of self-directed services by exploring the feasibility of removing the enrollment cap. The self-direction option allows participants or their authorized representative to have decision-making authority over their services and take direct responsibility to manage their services. This delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. There is no enrollment cap and individuals have been able to take advantage of this option that promotes personal choice. See below chart that illustrates to continued growth in the program:



. 1. To what do you attribute this success? For example:

- Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?

There is a demand to be a part of this program. The department was able to secure the contract which enables the provision of these services, and avoid severe budget cuts which contribute to the success.

- Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

The demand for this program continues to grow and the department has allowed for resources to be in place to accommodate the growth and continued success.

- Is progress related to the efforts of multiple departments or agencies? If

so, how do you gauge your department's contribution to the joint success?

- Other? Please specify.

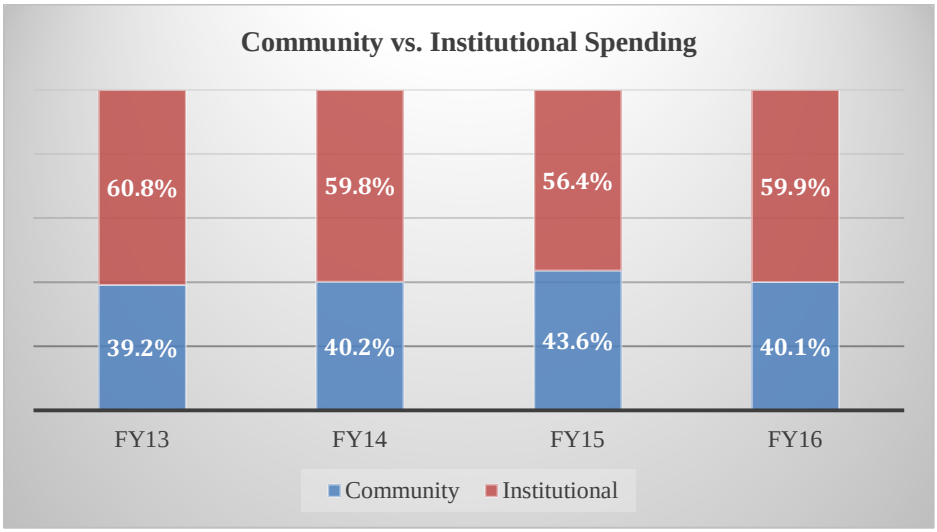
In collaboration with the Office of Citizens with Developmental Disabilities and the Office of Aging and Adult Services, the Medicaid office facilitates the development of the request for proposals and contract for the provision of the services. Without ensuring the contract and funding is in place, enrollment would not continue to occur and the program would not exist.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

The progress is expected to continue at this pace as long as significant budget cuts are not applied to this program.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each.

Another one of the department's strategies to rebalance LTSS was to maximize federal match through the participation in the Balancing Incentive Program (BIP). The State was awarded the grant in 2013 but was suspended from participating in December 2014 due to the State's inability to achieve the minimum of 50 percent of its total LTSS spending on non-institutional (home and community-based) settings no later than September 30, 2015. The suspension letter states, "The state has not progressed towards the statutorily required home and community based target spending percentage, and in fact, non-institutional spending has actually decreased by .6 percent since the state began in the program." See below chart illustrating our community and institutional percentage averaged by SFY:



1. To what do you attribute this lack of progress? For example: (See #2 below)
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
    - Is the lack of progress due to budget or other constraint?
    - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
    - Other? Please specify.

2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

The lack of progress is due to a combination of circumstances: budget crisis, lack of funding to fill waiver slots, consistent institutional spending for nursing homes, services in intermediate care facilities and disproportionate share hospital payments that inhibits the state's ability to achieve this goal. The State also proposed to restructure the delivery of LTSS by placing long term care populations and services in Medicaid managed care to make progress towards achieving this goal; however, this plan was not approved by the legislature. The move to managed care would support rebalancing as it provides incentives to managed care organizations to place people in most cost effective community based settings.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

☐ Yes. If so, what adjustments have been made and how will they address the situation?
☒ No. If not, why not? See below

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully. The department will need direction in addressing the shortfalls discussed as they are related to external factors.

Accomplishment #4

Please provide a brief analysis of the overall status of your strategic progress. What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

The Medicaid Quality and Benefits sections remain on target toward achieving Strategic Plan Goals and Objectives. Strategies outlined in the current Strategic Plan continue to be effective and continue to be strengthened by a strong commitment to continuous Performance and Quality Improvement throughout every program and activity. Our quality strategy includes evidence based quality metrics, which are built around PIPs (performance improvement projects), specified performance measures (primarily HEDIS®), and member satisfaction (Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) ® 5.0H surveys). Also included are compliance monitoring and EQRO (external quality review organization) audits and evaluation for each plan.

Additionally, when the previous five-year strategic plan was developed, focus was solely on increasing adoption and meaningful use of certified electronic health records technology Certified Electronic Health Record Technology (CEHRT) among Medicaid providers. Focus was also on increasing provider participation in LaHIE, Louisiana's state-designated health information exchange.

However, Louisiana Medicaid's vision has moved beyond increasing adoption and meaningful use of CEHRT. LDH leadership has a long-term vision of performance-based, value-based purchasing. In order to achieve the vision, robust adoption and interoperability of CEHRT among all provider types is required. Although efforts are still focused on increasing adoption and HIE (Health Information Exchange) connectivity, primary focus has shifted to enabling the collection and exchange of accurate, reliable patient level clinical data.

The Quality and Financial goals for the agency are updated and made available for public view within our Medicaid Annual Report on our website found at www.makingmedicaidbetter.com. Previous published reports can be found here: Medicaid Annual Reports, which has all our reports from 1996 to present.

- **Where are you making significant progress?**

Louisiana Medicaid received HITECH funding from CMS to administer projects and initiatives through the use of contractors to increase CEHRT adoption and meaningful use and HIE connectivity. Efforts are continuing through the use of contractors.

Additionally, LDH convened a group of stakeholders to form the Louisiana HITECH Advisory Committee. The committee is charged with assisting LDH in developing strategies and making inroads in facilitating the exchange of clinical data. And finally, LDH receives input and guidance from contractors and organizations, such as the National Governors' Association, in helping develop strategy.

- **Where are you experiencing a significant lack of progress?**

No significant lack of progress.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☒ Yes. If so, what adjustments have been made and how will they address the situation?

  LDH administration recognizes role that improved Quality and Benefits Management services play in improving health outcomes and lowering health care costs through performance-based, value-based purchasing. Increased involvement has led to a focus beyond CEHRT adoption to interoperability and the exchange of clinical data. The five-year strategic plan is being revised to reflect the expanded focus.

  ☐ No. If not, why not?

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

  On a Department-wide level, Performance Based Budgeting activities (including, but not limited to, strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. Recommendations are made directly to the Assistant Secretaries or the Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

  Within Medicaid, the Medicaid Quality and Benefits Management team monitors, reports, and implements performance and quality improvement activities with regard to Strategic Plan Goals, Objectives, and Performance Indicators. Current performance improvement projects for the health plans include ADHD (Attention Deficit Hyperactivity Disorder), Prematurity, and HIV (Human Immunodeficiency Virus). The plans are given latitude on exactly how their Performance Improvement Project (PIP) is organized and functions, but receive direction, guidance and assistance from Medicaid when/where needed. A broad range of venues are utilized including individual supervision, work groups, division staff meetings, all staff meetings, newsletters, and standardized data reports. Each staff member is required to develop and implement an annual performance plan with LDH's vision and mission. Additionally, the Medicaid Medical Director reports progress to LDH leadership on a regular basis.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Accomplishment # 3

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description

1. What is the nature of the problem or issue?

The nature of the problem is that Home and Community Based Services have not been funded to the extent necessary to significantly increase the proportion of spending as compared to institutional spending. Institutional spending mandates also exist in the State of Louisiana which creates barriers to significantly increase the proportion of spending.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)

Yes

3. What organizational unit in the department is experiencing the problem or issue?

The Office for Citizens with Developmental Disabilities, Office of Aging and Adult Services, and Medicaid.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)

The approximately 40,000 people on the Medicaid Request for Services Registry awaiting Home and Community Based waiver services and their families.

5. How long has the problem or issue existed?

As described in, "Framing the Future Together: Long Term Care Financing" Report to the House of Representatives in 2013, historically, Louisiana has relied almost

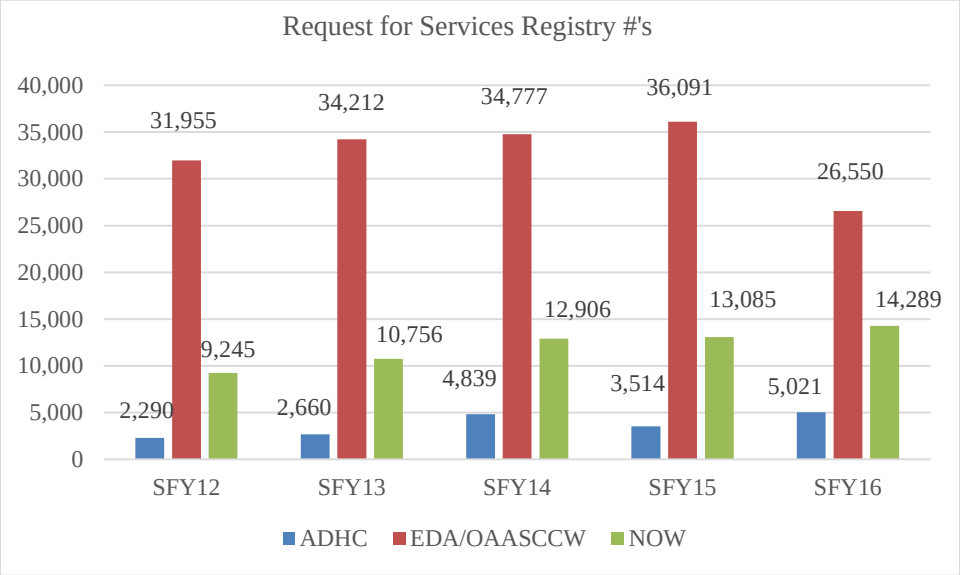
exclusively on institutional care and was one of the most heavily institutionalized states in the nation. It wasn't until the U.S Supreme Court ruled in 2000 in the Olmstead case that states must provide alternatives to institutional care for persons with disabilities, based on the Americans with Disabilities Act. The Advocacy Center filed a follow-up suit in Louisiana, the Barthelemy case, which paved the way for the growth in the number of waiver slots or persons served. Progress has been made in shifting resources and services from institutional to community based care, but progress has been at a standstill in recent years.

6. What are the causes of the problem or issue? How do you know?

The causes are external factors such as fiscal condition of the state and state legislation, rules and mandates.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

Surveys show that most people prefer to receive long term care at home or in a community based setting, and the demand for services continues to grow as shown by the number of persons on the waiting lists to receive services.



*2016 decrease due to registry list clean-up (deaths and non-response to validation of the registry)

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

☒ No. If not, skip questions 2-5 below.
☐ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
    a. If so:
        - What is the expected time frame for corrective actions to be implemented and improvements to occur?
        - How much progress has been made and how much additional progress is needed?
    b. If not:
        - Why has no action been taken regarding this recommendation?
        - What are the obstacles preventing or delaying corrective actions?
        - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

    ☐ No. If not, please explain.
    ☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
        a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
        b. How much has been expended so far?
        c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
        d. Will additional personnel or funds be required to implement the recommended actions? If so:
            - Provide specific figures, including proposed means of financing for any additional funds.
            - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
The Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste & abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

Internal Audit also provides management with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

Within Louisiana Medicaid, the agency contracts with the audit firm Myers and Stauffer to conduct post-payment reviews of incentive payments.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The Louisiana Department of Health (LDH) has a designated Audit Coordinator for financial audits. The LDH Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal ~~c~~communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

Within Medicaid, the Electric Health Records (HER) Incentive Program is subject to external audit by the U.S. Department of Health and Human Services and Louisiana Legislative Auditor – both of which have conducted audit or review of the program since its launch in 2011. Findings were used to strengthen controls.

☒ **Policy, research, planning, and/or quality assurance functions in-house**
☒ **Policy, research, planning, and/or quality assurance functions by contract**
☒ **Program evaluation by in-house staff**
☐ **Program evaluation by contract**

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory Notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

Within Medicaid, programs report on several LaPAS (Louisiana Performance Accountability System) measures on a quarterly basis.

☐ In-house performance accountability system or process
☐ Benchmarking for Best Management Practices

☒ **Performance-based contracting (including contract monitoring)**
In most cases, contractors are compensated through use of performance-based payment models – which helps to ensure the receipt of deliverables.

☐ Peer review
☐ Accreditation review
☒ **Customer/stakeholder feedback**

☒ **Other (please specify):**
Federal regulations require the state conducts an environmental scan to assess the state's HIT landscape. A previous scan was conducted in 2010. A repeat scan will be conducted during the upcoming fiscal year.

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☐ Yes. Proceed to Section C below.
☒ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:
1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
307 Office of the Secretary

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment # 1: Louisiana Bureau of Minority Health Access Received $1 Million Federal Grant

A. What was achieved?

The Bureau of Minority Health Access (BMHA) received a five-year, $1 million grant (disbursing $200,000 per year) to address overall health and health disparities as it relates to obesity among minority and underserved populations. This project is supported by the United States Department of Health and Human Services' Office of Minority Health.

B. Why is this success significant?

This grant award will have a large impact on the lives of many Louisianans. The Bureau of Minority Health Access does wonderful work in addressing health disparities and bridging the gaps in access to both health care and service delivery among minorities in Louisiana, but the state still struggles with minority health disparities.

C. Who benefits and how?

This grant targets areas that BMHA can improve, and will provide the Louisiana Department of Health (LDH) with the funds needed to pursue that improvement.

This project aims to educate racial/ethnic minority groups and underserved populations on:

- making better food choices,
- adopting physically active lifestyles,
- being properly screened for diseases associated with being overweight and obese, and
- understanding peer-to-peer and professional care to prevent onset of mental illness.

D. How was the accomplishment achieved?

The Louisiana Partnership Grant to Address Minority Health Disparities is a collaborative project among the BMHA; Southeast Louisiana Area Health Education Center (SELAHEC); NM2C, LLC; IAM Wellness Solutions (which targets mental illness); and other community partners.

The Louisiana Division of Administration's Office of Resource Management and Assistance provided guidance in conjunction with SELAHEC and NM2C, LLC for this request for funds application. Pennington Biomedical Research Center's Evaluation Center will provide evaluation services. The project offers a continuation of LDH's Own Your Own Health Initiative, community-level projects and mini grants in LDH Regions 1 (Orleans Parish and surrounding areas), 8 (Ouachita Parish and surrounding areas) and 9 (Tangipahoa Parish and surrounding parishes).

Starting in year two of the project, LDH will work with IAM Wellness Solutions and NM2C, LLC to implement worksite wellness initiatives addressing mental health, nutrition, physical activity and obesity among first responders.

According to the "U.S. Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity," caloric intake, physical activity/inactivity, metabolism, culture, environment, education, socioeconomic status and genetics also play a role in overall weight and are the greatest areas for prevention and treatment actions.

Scientific research shows that when weight increases to reach levels of overweight and obesity, the risks for chronic disease conditions also increase. Those diseases include diabetes, heart disease and stroke. Individuals also increase the risk of developing other conditions, such as liver and gall bladder diseases, osteoarthritis, sleep apnea and respiratory problems.

The Bureau of Minority Health Access will select up to 10 communities in areas of high need for chronic disease prevention and control approaches to receive grant funding for physical activity, nutrition and mental health projects.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes, this accomplishment does contribute to the success of our strategic plan. BMHA works with local, state and national communities and organizations to develop and implement comprehensive and effective policies to support healthy body weight, physical fitness and healthy eating among minority communities. This accomplishment is directly in line with the Department's mission to "to protect and promote health and to ensure access to medical, preventive and rehabilitative services for all citizens of the State of Louisiana."

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes, this accomplishment represents a Best Management Practice that should be shared with other executive branch departments or agencies. Wellness and healthy living are keys to better overall well-being, and BMHA targeted areas across the state to improve those metrics by increasing access and eliminating health disparities among racial and ethnic minority groups.

For more information on the Bureau of Minority Health Access, visit www.dhh.la.gov/oyoh.

Accomplishment # 2: LDH Partnership Created to Improve ADHD Assessment and Treatment – State agencies bring national "Teacher to Teacher" program to Louisiana public schools

A. What was achieved?

Broadening its response to both the human and financial costs of attention deficit hyperactivity disorder (ADHD), the Louisiana Department of Health (LDH) announced a partnership with the Louisiana Department of Education (LDOE), and Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) -- the national resource on ADHD. The partnership will train more Louisiana teachers to recognize classroom behaviors caused by ADHD and to use appropriate and effective techniques to address them.

B. Why is this success significant?

Louisiana has one of the highest rates of ADHD prescription drug use in the country. While ADHD is a neurological condition affecting children in all communities, the rate of ADHD prescriptions is especially high in boys, with 17 percent of all Louisiana boys enrolled in Medicaid taking ADHD medication. LDH formed the ADHD Task Force in August 2014 to research and promote best practices regarding the proper diagnosis, medication and treatment of ADHD. This new partnership is an expansion of the Task Force's efforts to help ensure that

teachers throughout Louisiana have the best possible information and training when instructing children they suspect or know to have ADHD.

C. Who Benefits and how?

By working with CHADD and LDOE, LDH will help more Louisiana teachers identify and accommodate the learning needs of children with ADHD in their classrooms. The better prepared our teachers are, the more students will have the opportunities to succeed. This partnership will also help reduce the number of children without a genuine ADHD diagnosis from being misidentified based on classroom behavior.

D. How was this accomplishment achieved?

Members of the ADHD Task Force, including the State's Department of Health in conjunction with the Department of Education met with representatives of CHADD. This coalition of local and national resources discussed an approach to assist Louisiana's teachers in recognizing when classroom behaviors are caused by ADHD and appropriate techniques to effectively address them. An implementation plan is currently being crafted that will be centered on CHADD's 'Teacher to Teacher' Program.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes, this accomplishment does contribute to the success of our strategic plan. LDH wants to give our students every advantage to succeed in the classroom. LDH is excited about this partnership and this pilot program because it provides our educators with the tools necessary to support these students and give them every advantage possible.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. The “Teacher to Teacher: Best Practice Intervention Strategies to Ensure School Success” is a day-long workshop that helps educators identify common ADHD-related learning problems and proven classroom techniques, interventions, and the latest research to enhance school success for students with ADHD. This interactive training allows classroom teachers to discuss solutions to common academic and behavioral problems in a case-based format.

CHADD is absolutely delighted to work with the State of Louisiana in order to improve the lives of children affected by ADHD. This is a first of its kind initiative whereby students, parents, teachers and health care providers will all potentially be affected due to the unique ability of the Departments of Health and Education to collaborate in assessment and problem-solving. CHADD will ensure that the State has access to the best evidence-based practices available.

Accomplishment # 3: Health Standards Section acquired the CNA Registry

A. What was achieved?

In January 2016 the Health Standards Section (HSS) acquired the Certified Nursing Aide Registry (CNA) and all of its processes including the oversight of over 60,000 CNAs. The IT platform for this registry was extremely old and outdated and previous budget concerns have not allowed any updates to this system. In October 2016, Health Standards Section brought the backlog up to date.

B. Why is this success significant?

When the workload was obtained from the Louisiana Board of Examiners of Nursing Facility Administrators (LABENFA), there was an enormous backlog of registry items that had not been addressed. All 50 states, plus the District of Columbia, have a Nurse Aide Registry. This list includes addresses and phone numbers for all of them as well as links to online registries if available.

C. Who benefits and how?

This work that is being done will continue to be addressed during FY 17. The platform for the registry will be updated to make an electronic process that will greatly the paperwork burden on the state survey agency.

D. How was the accomplishment achieved?

This was a budget neutral transfer with no acquisition of staff. HSS made needed staffing adjustments to fully address this workload.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes, this accomplishment contributes to the success of our strategic plan, as it directly relates to Goal 4 of the LDH strategic plan, "To utilize available resources in the most effective manner." Staff adjustments are made daily to efficiently address the critical needs/issues and scheduling using a tier priority system. All of the additional workload is time driven and there is continuous assessment and review to ensure that timelines are met.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

No, this does not represent a best management practice. However, the Health Standards Section has made staffing adjustments to fully address the additional workload.

Accomplishment # 4: Health Standards Section and the Louisiana Dementia Partnership

A. What was achieved?

The Health Standards Section (HSS) in conjunction with the Louisiana Dementia Partnership has been extremely active with the nursing home industry to address, educate, monitor, and follow up with the use of antipsychotic medications in the long term care setting. There continues to be a steady decrease in this usage as a direct result of this laborious effort.

B. Why is this success significant?

Since the initiation of the partnership, the Centers for Medicare and Medicaid Services (CMS) has continued to monitor the progress of each state in their efforts to reduce the use of antipsychotic medications among nursing home residents. Louisiana has dropped from 29.7% use in 2014 to 19.09% use in July 2016. Louisiana no longer remains last in the nation in the use of these medications. The initial focus of the partnership was and remains on reducing the use of antipsychotic medications. The partnerships larger mission is to enhance the use of non-pharmacologic approaches and person-centered dementia care practices.

C. Who benefits and how?

The Health Standards Section remains a very active member of the Louisiana Dementia Partnership and the Louisiana Culture Change Coalition regarding the quality and care of services provided to residents of long term care facilities. Additional shifting of workload within the HSS has allowed for the ability to begin scheduling full licensure surveys for adult residential care facilities.

D. How was the accomplishment achieved?

In early 2012, CMS established the National Partnership to Improve Dementia Care in Nursing Homes in response to an Office of the Inspector General (OIG) report underscoring the high use of atypical antipsychotic medication for "off-label" indications among nursing home residents. This initiative is being supported by nursing home advocates, provider associations, and other stakeholders.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes, this accomplishment contributes to the success of our strategic plan and is in line with the mission of the Department, “To protect and promote health and to ensure access to medical, preventive and rehabilitative services for all citizens of the State of Louisiana.” The National Partnership set forth the mission of the initiative to deliver health care that is person-centered, comprehensive, and interdisciplinary. A specific focus has been set on protecting residents from being prescribed antipsychotic medications unless there is valid clinical indications for such in association with a systematic process to evaluate each individual’s needs.

High level scrutiny of internal quality improvement processes continue to ensure the integrity, quality, and "defendability" of all written survey reports. Also, as a result of legislation passed during the 2016 session, the HSS has revised its reporting processes and documentation regarding immediate jeopardy situations in all provider entities. This ensures that each facility is fully aware of the immediacy of this matter, the components of the situation, and their need to immediately address a plan of removal.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. CMS and HSS will continue to track the progress being made by each individual nursing facility utilizing those national reports received. The expectation is that nursing facilities will put systems in place to address the use of antipsychotic medications within their homes.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

  Strategic Plan: Yes, the strategic plan for the Department is on time for accomplishment. Our 5-Year Strategic Plan, which was revised in July 2016, provides: (1) a general picture of intended performance across the agency, (2) a general discussion of strategies and resources the agency will use to achieve its goals, and (3) general confidence and reliability that agency performance information will be credible.

  The Department's strategic planning efforts continue to improve over the previous fiscal years. The Office of the Secretary has also recognized and identified the need for improved performance information. Without increased management attention to setting priorities and developing overall goals that can be used to assess its performance, the Department would be limited in its ability to make significant progress.

  Our priorities as an agency center on three themes: Building Foundational Change for Better Health Outcomes, Promoting Independence through Community-Based Care, and Managing Smarter for Better Performance. As we present the next iteration of our planning process, we continue to use these themes to guide our efforts to improve the way we manage our programs and services for a healthier Louisiana.

- **Where are you experiencing a significant lack of progress?**

  Health Standards Section: The ability to meet the demands of the licensed only program workload which is funded by state general funds is becoming more difficult to

achieve. Over the years, the Health Standards Section (HSS) has routinely never had enough state general fund resources. HSS in 2016 achieved 92.98% of its budgeted licensed only workload for that SFY; however, this accomplishment did exceed our state funding. HSS has never had the funding needed to accomplish 100% of the workload required for completion of state licensed; only workload which includes both full surveys and complaint surveys. Lack of funding (dollars) and resources (staff) hampers the ability to routinely schedule these onsite inspections to assess the health, safety, and welfare of the citizens served in these populations. HSS always schedules the complaint surveys to be done; however, the shortfall routinely occurs with the routine 'every 3 year' full licensing inspections. HSS operates with a tier priority workload system for both federal and state workload. Over the years, HSS has had transferred to them programs from DCFS (waivers, ADHC, adult residential care, and from OAAS APS, and PDHCs all of which were budget neutral transfers with no TO and no dollars. That is approximately an additional 800 providers.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☒ Yes. If so, what adjustments have been made and how will they address the situation?

  Adjustments within each office/section are made on a continuous basis to efficiently address critical needs/issues of each office. The scheduling uses a tier priority system varying between onsite inspections versus desk reviews.

  ☐ No. If not, why not?

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**

  On a Department-wide level, Performance Based Budgeting activities (including, but not limited to, strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. Recommendations are made directly to the Assistant Secretaries or the Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

No significant department management or operational problems exist.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   5. How long has the problem or issue existed?
   6. What are the causes of the problem or issue? How do you know?
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☐ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   4. Are corrective actions underway?
      a. If so:
         - What is the expected time frame for corrective actions to be implemented and improvements to occur?
         - How much progress has been made and how much additional progress is needed?
      b. If not:
         - Why has no action been taken regarding this recommendation?
         - What are the obstacles preventing or delaying corrective actions?
         - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of financing for any additional funds.
      - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
The Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste & abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

Internal Audit also provides management with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The Louisiana Department of Health (LDH) has a designated Audit Coordinator for financial audits. The LDH Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of

LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

☐ Policy, research, planning, and/or quality assurance functions in-house
☐ Policy, research, planning, and/or quality assurance functions by contract
☐ Program evaluation by in-house staff
☐ Program evaluation by contract

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory Notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

☒ **In-house performance accountability system or process**
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies and programs review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, as well as agency and program management department-wide.

☒ **Benchmarking for Best Management Practices**
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

☒ **Performance-based contracting (including contract monitoring)**
Contracts are required to contain a description of the work to be performed

including goals and objectives, deliverables, performance measures and a monitoring plan.

☐ Peer review
☐ Accreditation review
☐ Customer/stakeholder feedback

☒ **Other (please specify):**
The Health Standards Section (HSS) addresses the status of programs via performance indicator review; feedback through the Informal Dispute Resolution process afforded to all providers and complainants; through continuous quality improvement process and guidelines established for review of survey activity; and through the Centers for Medicare & Medicaid Services (CMS) State Performance Standards Review process for certification, survey, and Clinical Laboratory Improvement Amendments (CLIA).

Louisiana has passed all state performance standards so no corrective action plan was required. The same is true for adherence to state performance standards. The informal dispute process is one that is not programmatic in nature but is survey specific, and any identified matters are addressed on a case by case basis.

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☐ Yes. Proceed to Section C below.
☒ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
309 South Central Louisiana Human Services Authority

Department Head: **Rebecca E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Lisa Schilling**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment: Expanded Billing Capabilities

A. What was achieved?

With the expansion of Medicaid and the influx of new billing capabilities brought about with the Healthy Louisiana plans, the South Central Louisiana Human Services Authority (SCLHSA) chose to expand its billing capabilities by hiring a Practice Manager position to oversee the agency's clinical documentation and fiscal coding/billing efforts. This individual is responsible for designing, implementing and enforcing policies and procedures, as well as streamlining effective billing processes across multiple markets. The primary purpose of this position is to assist in the day-to-day accounting functions of

the facility in accordance with current acceptable accounting and cost reimbursement principles relating to health care and in specific for behavioral health and primary care operations in SCLHSA's outpatient clinic settings.

B. Why is this success significant?

Medical billing is a central pillar of any health care practice. Although care is the top priority, our practice is still a business. To make sure we actually getting paid for the services we provide, it was essential to hire a knowledgeable, focused and reliable individual to oversee our billing. From coding and processing claims to dealing with insurance companies and chasing down unpaid patient accounts, an agency billing department needs to be on the ball. It is crucial to stay on top of the ever-changing regulatory framework and new policies to be successful in any type of medical practice. SCLHSA opted to keep its billing in-house because it was easily manageable and gave us more control over the process. But, with the expansion of our services in the Medicaid, Medicare and private insurance markets, the billing process soon became more time-consuming and complex. We soon realized we needed someone with experience both in the clinical and fiscal fields to bridge that communication gap between what is needed in documentation and coding to assist us in being successful in the billing process. Our objectives were to increase our collection rate, reduce rejections and denials, and to provide an analysis of our accounts receivables. The overall goal was to have one individual responsible for overseeing our revenue cycle management to yield the highest reimbursement rates for the integrated services that we provide in our outpatient clinic sites.

C. Who benefits and how?

The entire SCLHSA organization benefits from the Practice Management process. The staff receive validation for the agency's exceptional work product and the quality service delivery provided to our clients on a daily basis in the form of revenue generated. The SCLHSA clients benefit by receiving information on their patient account through the electronic health record through a mechanism called the patient portal. Patient portals are an online website that is connected to our electronic health record, centrally focused on patient access to health data. These tools give patients a look into various data points, including lab results, physician notes, their health histories, discharge summaries, and immunizations. SCLHSA's patient portal has features such as direct secure messaging, online appointment scheduling, online bill payments, prescription refill requests, and even data update capabilities. Our billing staff can field phone calls and address patient questions as well. Our goal is to offer our patients the capability to directly access and pay off their account. Giving the patient the ability to review their treatment information as well as manage invoices and bills securely and confidentially helps to increase the patient ability to take control for their care.

D. How was the accomplishment achieved?

Health practices need to build a strong foundation to ensure their success. A strong foundation starts with a clear strategy and a plan to execute it. SCLHSA also needed to consider the best structure and model to use as well as determine decision making within the billing/accounting departments of the agency. Important to this area as well was the need to consider issues like developing a growth strategy, coping with increased regulation and competition, pricing, marketing and client relationship management, what services to offer and which clients to serve, and building a firm culture. Listed below are some of the steps that were taken to bring these practices into focus for SCLHSA:

1. Administrative staff are informed of issues through a bi-weekly billing meeting with the executive director, the deputy director, billing services, fiscal services, clinical services, and compliance in attendance.
2. Cross training was conducted for all billing staff in credentialing, denial management, payments postings, and patient statements.
3. Communication between the billing and clinical staff was enhanced through the following measures:
    - The billing manager attends the clinical managers meetings each week with notes of any upcoming changes, areas of concern, or patterns or trends that may need to be addressed.
    - A billing liaison was assigned to each clinic location as a contact person for questions regarding insurance benefits and eligibility, online access, authorizations, patient statements, CPT coding, and denied claims.
    - The billing liaison is on site at each clinic location weekly to work alongside clinical staff to observe processes and answer any concerns.
    - A monthly videoconference was established between the administrative billing staff and the clinical billing staff for training.
4. New policies were developed and implemented in reference to clear practice guidelines for clinical staff in regards to fees for services to non-covered services and delinquent premium payments.
5. Timely billing processes and guidelines were implemented to include:
    - Run claims for each clinic location every three days
    - Review the clearing house rejected claims list weekly and make corrections as needed.
    - Review the denied claims list weekly and makes corrections as needed.
    - All write offs are reviewed, addressed and documented weekly.
6. A monthly recoupment payment process and report was developed to ensure that all revenue is captured appropriately.
7. The denial management report is reviewed each day from the electronic health record to reversal of payments is logged. Each reversed payment is coded and documented along with the revenue collected each month.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

SCLHSA chose to pursue this process because it not only fits into our Strategic Plan through our goals, but also in one of our core values. Stewardship is one of SCLHSA's core values in our governing principles and it simply means to effectively manage the resources bestowed upon our organization in an ethical and sustainable manner. Practice management helps to achieve this core value by overseeing the day to day fiscal operations. The second short term goal listed in our Strategic Plan is to increase staff accountability and fiscal integrity of the agency. This goal is accomplished through developing and implementing staff productivity benchmarks to increase efficiency and effectiveness and to maximize time management principles in the workplace.

Additionally we strive to increase the percentage of collections for all forms of payment by focusing on educating staff on new processes and reaffirming existing formats; establishing agency wide benchmarks for the self-pay collection process and implementing a new credit/debit card function at all treatment sites to increase revenue capability. The last objective for this particular goal in our strategic plan focuses on establishing a minimum fee for all services rendered and follow through process with collections where payment is overdue by expanding agency policies that do not obligate us to render services "free" unless crisis situation exists and to enhance collection of administrative fees for processing pharmaceutical forms and dispensing process.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes - to help improve the management and operational efficiency of an agency, practice management is intended to help those managing practices to address opportunities and challenges; improve their competitiveness, profitability, and sustainability; enhance their expertise, competence, and efficiency; create an environment conducive to the provision of high-quality services; and showcase global best practices and latest practice management techniques. Practice management covers a wide array of topics, both operational and strategic, to do with running a successful accounting practice. Topics include marketing, networking, pricing, human resource management, practice development, merging or purchasing a practice, succession planning, compensation strategies, recruiting and retention, billing and collection, administration, leadership, information technology and more. Not surprisingly, the theories, techniques, approaches, and tools of practice management share much in common with those in managing a business. Effective management is essential to the success of any organization, accountancy practices included. In large part, it is about recognizing opportunities and taking advantage of them to the benefit of the organization. For a practice to succeed in today's competitive marketplace, it has to cope with and manage these issues. Health practices such as SCLHSA's are continually evolving, and their practice management needs are constantly changing. Best Management Practices demonstrated through practice management include conformance to internationally accepted standards; improved communication with persons served; person-focused standards that emphasize an integrated and individualized approach to services and

outcomes; accountability to funding sources, referral agencies, and the community; management techniques that are efficient, cost-effective, and based on outcomes and consumer satisfaction; evidence to federal, state, provincial, and local governments of commitment to quality of programs and services that receive government funding; and guidance for responsible management and professional growth of personnel.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

Overall, South Central Louisiana Human Services Authority remained on target with progress toward achieving our Strategic Plan Goals and Objectives. The Authority consistently utilized all strategies outlined in its Strategic Plan to effectively demonstrate performance and quality improvement on a continuous basis. In addition to Strategic Plan Goals and Objectives, implementation of efficiency strategies also produced positive results in the areas of client engagement, documentation of clinical treatment, client satisfaction (internal satisfaction survey results improved over previous survey and showed high marks for all clinicians, all support staff, and perceived positive outcomes), and staff retention.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
    - Other? Please specify.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

During FY 2015-2016, South Central Louisiana Human Services Authority has made huge strides in demonstrating compliance with its Strategic Goals which were created with input from the SCLHSA Board of Directors, Local Providers and SCLHSA staff. The four following goals represent the community's perspective on where our agency needs to continue to concentrate its efforts:

Goal 1: Improve service outcomes by partnering with stakeholders to expand integrated service programs in the community.

Goal 2: Increase staff accountability and fiscal integrity of the agency.

Goal 3: Provide the infrastructure, information, and systems to help employees successfully complete their jobs.

Goal 4: Maintain Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation by comitting to quality improvement, focusing on the unique needs of each person we serve, and monitoring the results of services we provide.

The South Central Louisiana Human Services Authority will continue to utilize all Strategic Plan strategies with a concentrated focus on utilization management, monitoring and related follow-up activities, client engagement, and positive outcomes to achieve the Authority's goals and objectives. The South Central Louisiana Human Services Authority strives for continued progress toward achieving Strategic Goals and Objectives in support of its Mission: To increase public awareness of and to provide access for individuals with behavioral health and developmental disabilities to integrated community based services while promoting wellness, recovery and independence through education and the choice of a broad range of programmatic and community resources

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

We are not experiencing any significant lack of progress.

1. To what do you attribute this lack of progress? For example:
   - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
   - Is the lack of progress due to budget or other constraint?
   - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
   - Other? Please specify.

2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

☒ Yes. If so, what adjustments have been made and how will they address the situation?
☐ No. If not, why not?

South Central Louisiana Human Services Authority's implemented additional Strategies specific to: expansion of eligibility criteria, strengthened collaboration with community partners/stakeholders; intensified focus on evidence-based and best practices for treatment/services delivery; increased access to social support systems; increased monitoring; increased technical assistance to contractors; and, pervasive performance and quality improvement activities. All strategies were geared to assure sustainability, increase capacity, and continue the delivery of high quality effective services and supports. The Authority also honed performance Indicators, retaining some trending data with the bulk of the attention focused on the development of true and meaningful outcome measures.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

The South Central Louisiana Human Services Authority, a Local Governing Entity, adheres to the Carver Policy Governance Model. The Board of Directors establishes the Authority's Mission, Vision, and Priorities, and selects an Executive Director to provide ongoing administration and operational management of the Authority. The Executive Director presents the Board of Directors with monthly updates and an annual Ends Policy Monitoring Report detailing progress toward the organization's Strategic Plan Goals and Objectives.

As an organization that has adopted and actively practices both Accountable Care and Performance and Performance Improvement models/philosophies, South Central Louisiana Human Services Authority continuously communicates, monitors, reports, and implements corrective action/process improvement activities with regard to Strategic Plan Goals, Objectives, and Performance Indicators via a broad range of venues (from individual supervision to performance reporting available to staff).

Each Service Director assists the Authority developing an annual organizational specific business plan in support of the South Central Louisiana Human Services Authority Strategic Plan. Each Director is also required to provide monthly Progress reports to the Executive Director and other members of the Executive Administrative Team. Additionally, the Executive Management Team develops, adopts, and implements cross-divisional annual Performance Improvement Initiatives (PI) to further insure South Central Louisiana Human Services Authority will meet

and/or exceed Strategic Plan Goals and Objectives and to support the successful sustainability of the Authority. As with the business plan, quarterly progress reports are delivered in this case by the full Executive Management Team to the Board.

South Central Louisiana Human Services Authority informs employees about Strategic Plan Goals, Objectives, and Performance Indicators via monthly Manager Meetings and, Directors involve staff in data collection, analysis, and reporting of Performance Indicator outcomes. Clinic Managers lead discussion about the Performance Improvement Plan during staff meetings (held weekly), reporting progress, obtaining staff input, and emphasizing accountability for reaching goals and objectives.

The Executive Director schedules quarterly All-Staff Videoconference meetings each year with the entire agency. Performance improvement is a routine part of the agenda. Further, the Executive Director bases a significant portion of the Division Directors' annual performance reviews on their contributions to the South Central Louisiana Human Services Authority Strategic Plan and Performance Improvement Initiatives as well as on their degree of success in accomplishing organizational goals and objectives.

Monthly Executive Management Team (EMT) meetings and occasional planning retreats are used as both group supervision and as forums for discussion of progress on meeting/exceeding Goals and for development of corrective action and/or performance improvement plans. The Executive Director holds the Executive Management Team accountable on both an individual and group basis for the successful implementation of the South Central Louisiana Human Services Authority Strategic Plan, Division-specific Plans, and Performance Improvement Initiatives.

Each South Central Louisiana Human Services Authority staff member has job-specific performance factors and expectations included in his/her annual planning document to support Authority Goals. Managers and Supervisors are expected to meet with individual staff members reporting to them as outlined in South Central Louisiana Human Services Authority's Staff Development and Supervision Guidelines (weekly for new employees, monthly for established employees, and as needed for employees in need of performance improvement) to review and discuss progress toward meeting expectations. Continued and open discussion is encouraged.

South Central Louisiana Human Services Authority leadership approaches implementation of the Authority Strategic Plan as comprehensive and ongoing performance improvement that involves all Divisions (horizontal integration) and all staff members (vertical integration). Monitoring and reporting are integral parts of the process as are compliance and process improvement activities.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure,

resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

There are no significant department management or operational problems to report.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external
   5. How long has the problem or issue existed?
   6. What are the causes of the problem or issue? How do you know?
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☒ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

   4. Are corrective actions underway?
      a. If so:
         - What is the expected time frame for corrective actions to be implemented and improvements to occur?
         - How much progress has been made and how much additional progress is needed?
      b. If not:

- Why has no action been taken regarding this recommendation?
- What are the obstacles preventing or delaying corrective actions?
- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of financing for any additional funds.
      - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**

South Central Louisiana Human Services Authority's Administrative Services Division provides ongoing monitoring of clinical and administrative functions. Audit tools, with identified criteria and targets are utilized; results are reported; and, appropriate process improvement and/or corrective actions are executed. Further, South Central Louisiana Human Services Authority developed process improvement and fiscal functions to audit Authority performance using benchmarks set forth in the Council on Accreditation of Rehabilitation Facilities (CARF) standards and to implement process improvement and/or corrective action as needed. A member of the Administrative Services Division oversees each of these areas to assure there is no duplication of effort.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
South Central Louisiana Human Services Authority is audited on an annual basis through the Office of the Legislative Auditor as well as by the Department of Health & Hospitals Office of Behavioral Health Licensing Standards and the Louisiana Department of State Civil Service.

☒ **Policy, research, planning, and/or quality assurance functions in-house**
The South Central Louisiana Human Services Authority's Executive Management Team provides these functions with oversight from the SCLHSA Deputy Director.

☒ **Policy, research, planning, and/or quality assurance functions by contract**
The South Central Louisiana Human Services Authority Adult, Child and Prevention Services Contract Monitors meet monthly with all contracted services for review of contract objectives and to gather service data information. The contract agency or individual has the opportunity to share any issues with service provision or funding at that time.

☒ **Program evaluation by in-house staff**
Performance is monitored on an ongoing basis utilizing the South Central Louisiana Human Services Authority's Strategic Plan, Operational Plan, Performance Improvement Plan, Risk Management Plan, and position-specific performance expectations. All have clearly stated expectations and performance targets. The Executive Director, Executive Management Team, and the Supervisory Staff share responsibility for oversight of these functions. Outcomes are reported on no less than a quarterly basis.

☒ **Program evaluation by contract**
The South Central Louisiana Human Services Authority Management Team meets on a quarterly basis for review of contract objectives, service data information and financial projections for the fiscal year. The Contract Monitors have the opportunity to share any issues with service provision or funding at that time. Additionally, each contractor is given the results of the quarterly meetings should there be any identified needs for improvement. SCLHSA also requires that its contractors fill out a survey on the previous service year and offer comments on ways to improve the contractual relationship. Suggestions are reviewed and changes may be implemented to the contract process for performance improvement purposes.

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The South Central Louisiana Human Services Authority meets with its contracted services on a quarterly basis for review of contract objectives and service data information. The contract agency has the opportunity to share any issues with service provision or funding at that time. Additionally, each contractor with SCLHSA is required to fill out a survey on the previous service year and offer comments on ways to improve the contractual relationship which

is reviewed and changes may be implemented to the contract process for performance improvement.

☒ **In-house performance accountability system or process**

South Central Louisiana Human Services Authority utilizes: the Louisiana Department of Health Accountability and Implementation Plan, the Commission on Accreditation of Rehabilitation Facilities (CARF), Performance Improvement model, Staff Development and Supervision Guidelines in conjunction with the Louisiana Department of Civil Service Performance Planning and Review system; ongoing internal monitoring and auditing mechanisms including corrective action and/or process improvement action plans with assigned accountability.

☒ **Benchmarking for Best Management Practices**

South Central Louisiana Human Services Authority has an active and robust decision-support function supported by the availability of live data from its electronic health record, state and other internal data warehouses. Data analysis includes comparative studies to benchmark against national statistics and internally set goals/targets. Studies range from individual service provider productivity to billing denial rates. South Central Louisiana Human Services Authority also utilizes benchmarks set forth in the Accountability Implementation Plan and Council on Accreditation of Rehabilitation Facilities (CARF) for ongoing performance and quality improvement initiatives.

☒ **Performance-based contracting (including contract monitoring)**

All South Central Louisiana Human Services Authority contracts have explicit performance requirements and include mandatory reporting and development of corrective action and/or process improvement plans if the need is indicated

☒ **Peer review**

South Central Louisiana Human Services Authority's Performance Improvement Program uses peer review as part of the ongoing performance and quality improvement initiative. The Authority's Medical Director leads comprehensive multi-disciplinary peer review in cases. The Authority has initiated an ongoing peer review process to be conducted annually as part of the compliance standards implemented for the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation process.

☒ **Accreditation** review

South Central Louisiana Human Services Authority is implementing an Authority-wide plan for re-accreditation readiness with the Commission on Accreditation of Rehabilitation Facilities (CARF). Communication between the Authority and Commission on Accreditation of Rehabilitation Facilities (CARF) is ongoing and formal application was filed. As stated previously, South Central Louisiana Human Services Authority has active process improvement functions that focus on meeting and/or exceeding requirements set

forth in the Commission on Accreditation of Rehabilitation Facilities (CARF) Standards, the Healthy Louisiana Plans and the Louisiana Department of Health.

☒ **Customer/stakeholder feedback**

South Central Louisiana Human Services Authority participates in satisfaction surveys sponsored by the Office of Behavioral Health and the Office of Citizens with Developmental Disabilities. Additionally, South Central Louisiana Human Services Authority fields a proprietary survey within its Behavioral Health Clinics on a quarterly basis to gain additional information for the identification of opportunities for improvement. The Authority has initiated satisfaction surveys for all contractors as part of standard contractual requirements. South Central Louisiana Human Services Authority also partners with the Office of Behavioral Health to hold an annual community forum for the residents of our seven parishes. The members of the Board of Directors, per the Carver Policy Governance Model, actively engage in "community linkages" and report the results of these interactions with community stakeholders during monthly Board meetings.

☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☐ Yes. Proceed to Section C below.
☒ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

The South Central Louisiana Human Services Authority monitors and evaluates its operations and programs on an ongoing basis as described throughout this report and has a well-developed decision-support function in place. Data is analyzed (including trending and projecting future performance) and discussions are held during Executive Management Team meetings. Findings are shared during individual and group supervision and at all-staff meetings, as appropriate. Corrective action and/or process improvement plans are developed and executed as needed, and are monitored by the Administrative Team on a routine basis and by the Executive Director as necessary.

Information concerning South Central Louisiana Human Services Authority's internal reports may be obtained by contacting:

Lisa Schilling
Executive Director
South Central Louisiana Human Services Authority (SCLHSA)
985-858-2931
lisa.schilling@la.gov

Kristin Bonner
Deputy Director
South Central Louisiana Human Services Authority (SCLHSA)
985-858-2931
kristin.bonner@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
310 Northeast Delta Human Service Authority

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Monteic Sizer, Ph.D.**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

In FY 2015-16, Northeast Delta Human Service Authority (NEDHSA) realized several outstanding accomplishments, defined by its Strategic Plan and its overarching Mission & Vision. NEDHSA implemented its work using the three tenets it established that guide the agency's professional conduct and action: greater access to services, excellent customer service, and quality competent care. Much of the work in FY 2015-16 focused on deepening the established breadth of work the agency has initiated over the past three fiscal years.

Accomplishment #1: Conducted Summit Entitled, "Delta Solutions Rural Health Summit: Moving from Theory to Practice."

A. **What was achieved?**

NEDHSA planned and conducted a summit entitled "Delta Solutions Rural Health Summit: Moving from Theory to Practice." This summit addressed rural healthcare access, support services, prevention and recovery issues unique to northeast Louisiana.

B. **Why is this success significant?**

The Summit program featured solution-based discussions including: How a rural community can identify its individual capacities, abilities and assets to identify resources and create a plan to help solve its problems; How to address and deepen the understanding of diversity, cultural norms and stigma in rural behavioral healthcare settings; The importance of support services and integrated healthcare to improve recovery, sustainability and the continuum of care.

C. **Who benefits and how?**

The Summit goal was to further improve regional health outcomes for citizens as they relate to behavioral healthcare and developmental disabilities services. NEDHSA always strives to find innovative ways to ensure that our citizens have access to the best care and realize the healthiest lives possible.

D. **How was the accomplishment achieved?**

NEDHSA was awarded a 2015 Seed Grant by Magellan of Louisiana to implement the Delta Solutions Summit. This seed grant was intended to advance critical services and increase linkages among various health and human services sectors.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**

Yes.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**

Yes. This Summit represents how a seed grant can be used productively to bring regional agencies together and work innovatively toward the betterment of its citizens.

Accomplishment #2: Faith-Based Mental Health Summits

A. **What was achieved?**

NEDHSA hosted three Faith-Based Mental Health Summits in FY 2015-16. The summits included clergy and mental health expert-led panel discussions about: mental health prevention programs and techniques through faith-based organizations, how mental illness affects children and families, clergy and mental health issues, how to avoid Pastoral and congregational burn-out and disengagement and faith-based community support resources.

B. **Why is this success significant?**

These summits were significant because studies show that more communication is needed to bridge the gap between formal mental health care providers and citizens in rural communities.

C. **Who benefits and how?**

Clergy, who can help strengthen this linkage, benefitted by learning more about recognizing mental illness in their communities. Along with reaching citizens through faith-based approaches, these summits helped clergy leaders better understand their own challenges.

D. **How was the accomplishment achieved?**

NEDHSA defined the parameters for these summits, then formed a regional coalition to implement them. These faith-based summits addressed many facets that comprise communities, including family, business, government, education into the topic of faith-based mental health.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**

Yes.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**

Yes. These summits can be replicated by other agencies and organizations.

Accomplishment #3: Winner of Inaugural Health Care Delivery Innovation Competition

A. **What was achieved?**

NEDHSA was selected by the Abdul Latif Jameel Poverty Action Lab (J-PAL) North America, a research center at the Massachusetts Institute of Technology, as a winner of its inaugural Health Care Delivery Innovation Competition.

B. **Why is this success significant?**

This success is significant because NEDHSA's Integrated Services Model was identified as having innovative programs with the potential to serve as a national model and support the development of a large-scale randomized controlled trial to evaluate these programs' impact. Being selected for this award is also a testament to our Board and staff's commitment to our vision and mission.

C. **Who benefits and how?**

Empirical test findings around NEDHSA's innovative service delivery model could change the way primary and behavioral healthcare is delivered for vulnerable populations with complex needs in Louisiana and across the country. We hope this work will help develop meaningful data and best practices for improved health outcomes in northeast Louisiana and beyond.

D. **How was the accomplishment achieved?**

NEDHSA wrote a letter of interest to enter this Health Care Delivery Innovation Competition.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**

Yes.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**

Yes. Results could serve as a model for delivering integrated behavioral and primary healthcare to populations with complex needs.

Accomplishment #4: Established the Phoenix Clinic

A. **What was achieved?**

Developmental Disabilities (DD) services along with Office of Behavioral Health (OBH) services for NEDHSA established the Phoenix Clinic. The Phoenix Clinic is an integrated clinic that serves people with developmental disabilities who also have mental health diagnosis and\or addictive disorders. This clinic also seeks to assist recipients and their caregivers in locating a medical home by connecting them to resources and other agency partners throughout the region.

B. **Why is this success significant?**

The establishment of the Phoenix Clinic provides the direct service delivery to a person with a developmental disability along with a mental health and\or addictive disorder in a setting traditionally unavailable. This clinic allows for the collaboration of multiple aspects of care for a recipient providing a more cohesive and holistic plan of support. The availability to receive these services within the clinic also allows more exposure and education between those with behavioral health and developmental disability training to further develop the understanding of serving people with multiple needs. As we learn from one another, we strengthen the capacity and improve the support we provide to our customers.

C. **Who benefits and how?**

People with developmental disabilities benefit from the Phoenix Clinic by receiving services they need. Those involved in the clinic benefit from learning more about serving people with multiple needs.

D. **How was the accomplishment achieved?**

NEDHSA recognized the need for all of these accomplishments and established goals and timelines to develop the processes and logistics to make them happen. Multiple discussions\meetings with various involved organizations, advocates and self-advocates were held to get input regarding the outcomes we expected with each accomplishment. We worked to identify barriers and then develop strategies to overcome those barriers and make these goals happen. NEDHSA has an ongoing desire to see advancement in service delivery to all of the people we serve.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**

Yes.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**

Yes, we believe that our approaches are in line with best practices and in keeping with person centered service delivery.

Accomplishment #5: Providing Services to People with Developmental Disabilities

A. **What was achieved?**

NEDHSA Developmental Disabilities (DD) services continues to partner with a local provider agency to provide direct support professional training to staff serving DD recipients receiving state funded services. The goal of the Personal Care Assistant (PCA) Competency Program is to assure that staff are screened and trained in service delivery to people with DD, thus improving safety and the quality of services.

B. **Why is this success significant?**

A mandatory curriculum of training of direct support professionals improves the skills of those employed to work with people with developmental disabilities. The staff becomes more invested in their work understanding the responsibilities and respect of their job. The recipients are safer in having a level of screening and training for their needs to be met by those that provide support.

C. **Who benefits and how?**

People with DD have the opportunity to receive competent, quality care through the PCA Competency Training Program. This allows for outcomes to be met.

D. **How was the accomplishment achieved?**

NEDHSA recognized the need for all of these accomplishments and established goals and timelines to develop the processes and logistics to make them happen. Multiple discussions\meetings with various involved organizations advocates and self-advocates were held to get input regarding the outcomes we expected with each accomplishment. We worked to identify barriers and then develop strategies to overcome those barriers and make these goals happen. NEDHSA has an ongoing desire to see advancement in service delivery to all of the people we serve.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**

Yes.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**

Yes, we believe that our approaches are in line with best practices and in keeping with person centered service delivery.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

  NEDHSA strategic plan goals are being implemented in our general operations. Continued progress is being tracked, documented and reported. Expansion of services and quality of care are strong indicators of our achievement in meeting the performance standards. Overall, improvements have been reported in AD treatment services, addiction completion rates and self-reported data on health statuses.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

  Our agency is tracking above average on many indicators, but not significantly higher than anticipated. We consider this a measure of stability in our ability to project with increased accuracy and managing the expectations of meeting our goals.

  1. To what do you attribute this success?

     We consider this a measure of stability in our ability to project with increased accuracy and managing the expectations of meeting our goals.

     - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
     - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
     - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
     - Other? Please specify.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

  None; our agency is meeting the prescribed benchmarks.

  1. To what do you attribute this lack of progress? For example:
     - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
     - Is the lack of progress due to budget or other constraint?
     - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
     - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☐ Yes. If so, what adjustments have been made and how will they address the situation?

  ☒ No. If not, why not? NEDHSA implemented the first year of our strategic plan during FY 2015-16.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**

  Our strategic plan is centrally located on the agency's intranet for all employees to view. A large percentage of the performance indicators are also reported in LaPAS and our AIP. Each department of our agency has quarterly performance improvement committee meetings to discuss the performance indicators and strategies to enhance our delivery of services. As leadership makes data driven decisions about management and funding, we consider the performance indicators to help us determine how to streamline our funds and processes for improved outcomes.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

None

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   5. How long has the problem or issue existed?
   6. What are the causes of the problem or issue? How do you know?
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☐ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   4. Are corrective actions underway?
      a. If so:
         - What is the expected time frame for corrective actions to be

implemented and improvements to occur?
- How much progress has been made and how much additional progress is needed?

b. If not:
- Why has no action been taken regarding this recommendation?
- What are the obstacles preventing or delaying corrective actions?
- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of financing for any additional funds.
      - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
Corporate Compliance performs audits of each department within NEDHSA

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
Audits by SMO, ORM, Office of Legislative Auditor, etc.

☐ Policy, research, planning, and/or quality assurance functions in-house
☐ Policy, research, planning, and/or quality assurance functions by contract

☒ **Program evaluation by in-house staff**
Evaluations of clinical services by Corporate Compliance staff using Treatment Record Review, Review of Consumer Complaints, Critical Incident Analysis, and TeleSage Outcomes Measurement System (TOMS)

☒ **Program evaluation by contract**
Substance abuse block grant report, mental health block grant report, Accountability Implementation Plan (AIP) for Behavioral Health and Developmental Disabilities

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
Corporate Compliance reports performance data in LaPAS

☒ **In-house performance accountability system or process**
Performance Improvement Committee and HSAIP Review Committee

☐ Benchmarking for Best Management Practices

☒ **Performance-based contracting (including contract monitoring**)
Contract monitoring and technical direction of contracts

☒ **Peer review**
Substance Abuse, Prevention, and Treatment (SAPT) Block Grant Annual Peer Reviews

☒ **Accreditation review**
Commission on Accreditation of Rehabilitation Facilities (CARF)

☒ **Customer/stakeholder feedback**
Consumer Satisfaction Surveys/C'est Bon

☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☐ Yes. Proceed to Section C below.
☒ No Skip Section C below.

B. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation

4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
320 Office of Aging and Adult Services

Department Head: **Rebekah E. Gee MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Assistant Secretary: **Tara A. LeBlanc**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Improvements to Quality, Management, and Accountability in Protective Services

A. What was achieved?

In SFY 2016, Adult Protective Services implemented recommendations made by the Louisiana Legislative Auditor's (LLA) Office related to intake functions and caseload equalization.

B. Why is this success significant?

The immediate implementation of recommendations made by the Louisiana Legislative Auditor's (LLA) Office helped improve quality and consistency of practice in the areas of intake processes and workload distribution (e.g., regional staffing and caseload equalization).

C. Who benefits and how?

Incorporating the recommendations from the LLA helped to improve the quality of service delivered to the public and promotes staffing efficacy.

D. How was the accomplishment achieved?

The Office of Aging and Adult Services (OAAS) has taken the following actions to implement recommendations made by LLA:

- OAAS evaluated current policies and procedures for intake procedures and developed a stand-alone Intake Quality Assurance tool to measure and improve quality. Actions were also taken to incorporate best practice standards and improve staff training.

- APS used data to establish a recommended caseload standard. The standard was used to support decisions related to investigator staffing and workload equalization across the state.

E. Does this accomplishment contribute to the success of your strategic plan?

Yes. This accomplishment contributes to the OAAS Strategic goal "by improving program activities for the timely completion of investigations of abuse, neglect, exploitation, and extortion to vulnerable adults" to ensure that vulnerable adults are protected.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

The assessment and recommendations provided by LLA immediately after the recent unification of the Elderly and Adult Protective Services Program has helped to identify program needs and to support initiatives being taken by OAAS to continue its enhancements to protective services.

Accomplishment # 2: Louisiana's Money Follows the Person Demonstration Program among top ten in the country

A. What was achieved?

In SFY 2016, OAAS Money Follows the Person (MFP) program was able to exceed by 68 its

calendar year benchmark of transitioning 270 nursing facility residents to the community. A total of 338 nursing facility residents were successfully assisted in returning to their desired communities with community-based services.

B. Why is this success significant?

The accomplishment is significant because the Americans with Disabilities Act and the U.S. Supreme Court *Olmstead* decision holds that individuals with disabilities, including frail elders, have the civil right to live in the least restrictive setting of their choice. Louisiana's MFP program is one way of assuring that right. On a per person basis, the program also saves taxpayer dollars: a year of community-based services is on average $20,000 less than nursing facility services. Louisiana's MFP program was rated among the top ten in the country.

C. Who benefits and how?

Elders and people with disabilities living in nursing homes who are able and would prefer to live in their own homes benefit. Taxpayers also benefit from the savings.

D. How was the accomplishment achieved?

The Deficit Reduction Act of 2005 (Section 6071) enacted the Money Follows the Person demonstration, designed to help states move Medicaid-enrolled individuals from institutions back into the community. The demonstration pays an enhanced federal match for the first year of community-based services as well as funding for transition services and staff. Demonstration funds also allow OAAS to build systems and infrastructure that strengthen the community-based services delivery system for all recipients.

MFP staff also began in-person delivery of waiver offers to nursing facility residents, a practice that ensures that assistance and waiver slots are offered only to residents who have not already transitioned on their own. It also improves resident's understanding of what is involved in accepting a waiver offer. This new process has improved timeliness of waiver certification and transitions as well as enrollment in MFP.

E. Does this accomplishment contribute to the success of your strategic plan?

This accomplishment contributes to the OAAS strategic goal, "To promote and develop health and Long Term Supports and Services (LTSS) delivery systems that improve care and outcomes for high risk, high cost populations served by OAAS and achieve LTSS rebalancing consistent with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's decision in *Omlstead v. L.C.*"

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

As one of the 10 most successful MFP programs in the country, Louisiana's program should be emulated by other states, but is not applicable to other state agencies.

Accomplishment #3: Increase in Permanent Supportive Housing units occupied throughout the state

A. What was achieved?

Accelerated leasing of Permanent Supportive Housing (PSH) units.

B. Why is this success significant?

Accelerated leasing means that more individuals and households with disabilities are stably housed more quickly and that participating landlords have their units filled and producing revenue more quickly. Efficient filling of PSH units as they become available is critical to retaining the participation of housing providers in the PSH program. It is also important to how the federal department for Housing and Urban Development (HUD) assesses program success and awards administrative funding.

C. Who benefits and how?

Individuals and households who are housed by the PSH program are the primary beneficiaries, but taxpayers and communities as a whole also benefit. The majority of persons served by PSH were previously homeless or institutionalized. Studies have shown that there's a high cost to homelessness across social service systems including healthcare, homeless services, and the corrections system. Homelessness is also a drag on economic development and quality of life in many communities. Louisiana's PSH program has been shown to significantly reduce hospitalization and use of emergent care.

D. How was the accomplishment achieved?

The Louisiana Permanent Supportive Housing program (PSH) links affordable rental housing with voluntary, flexible, and individualized services to people with severe and complex disabilities, enabling them to live successfully in the community. In September 2015, the LDH PSH office assumed responsibility for leasing S+C (shelter plus care) applicants in Region 1, which is the New Orleans area. This population is homeless, mostly chronically homeless, and the most difficult to serve based on their significant challenges. The office received 183 referrals from the local Continuum of Care. LDH PSH staff were able to house 164 of these referrals, resulting in a 90% successful housing rate, well above national averages for this population. On the project based voucher side of the program, LDH was able, for the first time, to exceed 1,500 vouchers actively being utilized. The 811 PRA (project rental assistance) demonstration program has leased its first 36 households. This is the second highest in the nation for states participating in this demonstration.

E. Does this accomplishment contribute to the success of your strategic plan?

LDH PSH housing program contributes to the OAAS strategic goal, "To promote and develop health and Long Term Supports and Services (LTSS) delivery systems that improve care and outcomes for high risk, high cost populations served by OAAS and achieve LTSS rebalancing consistent with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's decision in *Omlstead v. L.C.*"

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

While not applicable to other state agencies, Louisiana's PSH program has been recognized in SFY 16 alone by the National Governor's Association, the Corporation for Supportive Housing, George Washington University's National Health Policy Forum, and the CMS Innovation Accelerator Program.

Accomplishment #4: Continued Coverage of Permanent Supportive Housing under Medicaid

A. What was achieved?

By the end of State Fiscal Year 2015-2016, sixty-seven percent (67%) of Permanent Supportive Housing (PSH) households were transitioned from the temporary revenue source of Community Development Block Grant (CDBG) funded services to sustainable coverage under Medicaid.

B. Why is this success significant?

The PSH program strives to house individuals with disabilities who, without support services, are not likely to maintain housing. This sustainable funding significantly increases the chances of participants maintaining safe and affordable housing. For many, these services also aid in avoiding institutional settings for their long-term housing solution. PSH has proven to be cost effective for Medicaid. These services coupled with housing reduce both long and short-term hospitalizations, emergency room visits, and long-term institutionalization.

C. Who benefits and how?

Individuals and households who are housed by the PSH program and who will have their supportive services continue under Medicaid are the primary beneficiaries. Taxpayers and communities as a whole also benefit. The majority of persons served by PSH were previously homeless or institutionalized. Studies have shown that there's a high cost to homelessness across social service systems including healthcare, homeless services, and the corrections system. Homelessness is also a drag on economic development and quality of life in many communities. Louisiana's PSH program has been shown to significantly reduce

hospitalization and use of emergent care.

D. How was the accomplishment achieved?

This accomplishment was achieved through the efforts of many partners in the PSH program. OAAS and OCDD both rewrote waivers to include PSH services and facilitated transition of PSH recipients from CDBG funding to waiver participation. For households eligible for behavioral health services under Mental Health Rehabilitation, PSH service providers conducted assessments and worked with the Healthy Louisiana managed care organizations to transition households to these services.

E. Does this accomplishment contribute to the success of your strategic plan?

This accomplishment contributes to the OAAS strategic goal, "To promote and develop health and Long Term Supports and Services (LTSS) delivery systems that improve care and outcomes for high risk, high cost populations served by OAAS and achieve LTSS rebalancing consistent with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's decision in *Omlstead v. L.C.*"

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Though not applicable to other state agencies, Louisiana has been recognized nationally for its innovative and successful PSH program, with recent attention focusing particularly on Medicaid coverage of the services component. Louisiana's PSH program was featured in national presentations this year sponsored by the Centers for Medicaid and Medicare Services Innovation Accelerator Program, the National Governor's Association, and the Corporation for Supportive Housing.

Accomplishment #5: Compliance and Audit Team (CAT) Reduction of Program Spending

A. What was achieved?

Use of data mining and field audits to assure quality and compliance with eligibility and resource allocation rules in the Long Term Personal Care Services (LTPCS) program.

B. Why is this success significant?

Data mining and CAT field audits produced a reduction in program spending by 32% ($75 million) from FY 14 to FY 16 and improved program auditability and accountability, assuring that resources go to those who need them.

C. Who benefits and how?

Louisiana taxpayers and citizens in need of long-term care services are the primary

beneficiaries of this effort. OAAS' goal in this effort is to provide community-based services to citizens who are most in need of LTPCS and to ensure the quality of those services.

D. How was the accomplishment achieved?

In SFY2016, the OAAS Compliance and Audit Team (CAT) continued to conduct audits and targeted assessments designed to assure the quality and accuracy of the Long Term Personal Care Services (LTPCS) assessment, eligibility, and resource allocation processes. In this role, the team is also well positioned to discover potential fraud and abuse. The CAT teams advanced research and investigative work have led to over 361 referrals to both Medicaid Program Integrity and the Attorney General.

CAT is aided by strategic data-mining and analysis performed by the OAAS statistical team which looks for patterns that are used to focus CAT efforts and provides data for more complete profiling of participant and provider performance and behavior. These efforts have led to major improvements in the accuracy of LTPCS eligibility and resource level determinations. CAT also affords the State the opportunity to monitor service delivery, therefore adding another resource to the oversight and delivery of LTPCS.

E. Does this accomplishment contribute to the success of your strategic plan?

It contributes to the OAAS strategic goal, "To promote and develop health and Long Term Supports and Services (LTSS) delivery systems that improve care and outcomes for high risk, high cost populations served by OAAS and achieve LTSS rebalancing consistent with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's decision in *Omlstead v. L.C.*" It does this by assuring the accountability and sustainability of LTPCS as a community-based option.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Potentially, yes. The combination of intelligent data-mining and field monitoring are applicable to any widely used service.

Accomplishment #6: Electronic Visit Verification (EVV) for Adult Day Health Care (ADHC) Implemented

A. What was achieved?

On January 1, 2016, OAAS implemented an Electronic Visit Verification (EVV) system for Adult Day Health Care (ADHC) providers.

B. Why is this success significant?

The EVV system is used to track exact times Adult Day Health Care services are provided and assure that billing corresponds to these times. With this system, OAAS is able to better

identify overlapping services between ADHC providers and providers of other services such as personal care attendants. Individuals and/or agencies who are discovered to be knowingly participating in fraudulent activities are referred to the Attorney General's Medicaid Fraud Control Unit.

C. Who benefits and how?

Louisiana taxpayers and citizens in need of long-term care services are the primary beneficiaries of this effort because it assures that funds pay for services delivered and are not wasted. This contributes to program sustainability. Providers also benefit from the more streamlined approach to billing.

D. How was the accomplishment achieved?

The EVV system is Internet based, which means that it can be accessed from any device that has an Internet connection. ADHC providers are now enabled and required to clock each participant in and out at precisely the time they enter and leave the center, a process that also generates post-authorization for payment. ADHC providers also have the option of electronically tracking transportation to and from the center.

E. Does this accomplishment contribute to the success of your strategic plan?

This accomplishment contributes to the OAAS strategic goal, "To promote and develop health and Long Term Supports and Services (LTSS) delivery systems that improve care and outcomes for high risk, high cost populations served by OAAS and achieve LTSS rebalancing consistent with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's decision in *Omlstead v. L.C.*" It contributes by assuring the accountability and sustainability of Adult Day Health Care as a community-based options.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. This methodology could be replicated in any center-based service, such as child care centers.

Accomplishment #7: Continuation of the Nursing Home Quality Innovations Grants

A. What was achieved?

Over eighty (80) facilities were engaged in initiatives to improve quality of care and quality of life in Louisiana nursing homes.

B. Why is this success significant?

Louisiana nursing homes consistently rank among the worst in the nation for quality. For instance, in the past three years, the United Healthcare Foundation has ranked Louisiana nursing homes 50th, 49th, and 50th in the U.S. for quality. A 2015 issue brief by the Kaiser Family Foundation cited Louisiana as the state with the second highest percentage of one and two star nursing facilities (on a scale where 5 stars indicates highest quality). And Louisiana nursing homes rank 51st and 50th respectively for pressure sores and for use of anti-psychotic medications according to the state Long Term Supports and Services Scorecard published by the Commonwealth Fund, SCAN Foundation, and AARP.

C. Who benefits and how?

Nursing home residents benefit from initiatives that improve quality of care and quality of life, and often nursing facility staff benefit from improved care practices.

D. How was the accomplishment achieved?

Fines collected from nursing homes for federal survey deficiencies are used to fund quality improvement initiatives, some in the form of grants made directly to nursing homes and some funded through cooperative endeavors with third party experts who work with nursing homes on specific areas of quality improvement. The federal Centers for Medicare and Medicaid Services (CMS) must approve each grant made by OAAS. In FY 2016, notable projects included:

- Quality Innovation Grants: Small grants of up to $19,500 were given to eleven (11) nursing facilities for projects that improved resident's bathing experience, food service, activities and therapy programs, and management.
- Music & Memory Program: Seventy-eight (78) nursing facilities participated in building individualized music playlists delivered on iPods and MP3 players for at least 15 residents each. Facilities are reporting improvements in depression, resistance to care, anxiety, and social engagement.
- Antipsychotic Reduction: Regional workshops, limited in-home consultation and physician workshops were provided to educate nursing facilities about antipsychotic reduction. OAAS is seeing improvement in the state's national ranking on this quality measure.

E. Does this accomplishment contribute to the success of your strategic plan?

This accomplishment contributes to the OAAS Strategic goal, "To administer and manage resident care programs at Villa Feliciana Medical Complex in a manner that ensures compliance with applicable standards of care; and to promote policies and practices that improve the quality and cost-effectiveness of privately-owned nursing facilities.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Using survey fines as a dedicated source of funding for quality improvement is a practice that could be emulated for other regulated human services.

Accomplishment #8: Additional Improvements to the Quality Assurance Process and the Environment of Care at Villa Feliciana Medical Center (VFMC)

A. What was achieved?

During FY16, Villa Feliciana Medical Center (VFMC) continued to make significant improvements to the physical plant, therapeutic environment and quality of care of residents. VFMC has also continued to use the Quality Assurance/ Performance Improvement (QAPI) to improve practices that directly affect resident quality of life.

B. Why is this success significant?

Changes in processes, direction and performance improvements meant that VFMC not only successfully passed the annual Health Standards survey, but more importantly VFMC has improved the quality of life for residents.

C. Who benefits and how?

Residents and employees of Villa benefit from this accomplishment.

D. How was the accomplishment achieved?

Major physical plant improvements included:

- Renovations and rehabilitation of two of the three buildings that house residents; including completion of a new HVAC system, roof and drain repairs, fire alarm system upgrades, improved lighting and new ceilings.
- Utilization of Electronic Medical Record modules to improve communication and documentation.
- New paint, sidewalks and furniture for the residents.
- Installation of electronic sliding doors for wheelchair residents and ambulance use on resident care buildings.

The continued use of the QAPI process has led to a new system for tracking resident admissions to the hospital unit, a modernized guard house/communication center, mitigation of trees to ensure fluid distribution of the electrical system, and an aggressive initiative to decrease the use of anti-psychotic medications.

Changes came about in FY16 because the leadership and staff remain vigilant in looking for opportunities to improve resident care and involve all staff and disciplines in the QAPI process.

E. Does this accomplishment contribute to the success of your strategic plan?

The accomplishment contributes to the OAAS Strategic goal, "To administer and manage resident care programs at Villa Feliciana Medical Complex in a manner that ensures compliance with applicable standards of care; and to promote policies and practices that improve the quality and cost-effectiveness of privately-owned nursing facilities."

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

QAPI is a management best practice that is used widely in the private and public sector.

Do these accomplishments contribute to the success of your strategic plan?

Accomplishments #3 and #4 above contribute to the OAAS strategic goal, "To promote and develop health and Long Term Supports and Services (LTSS) delivery systems that improve care and outcomes for high risk, high cost populations served by OAAS and achieve LTSS rebalancing consistent with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's decision in *Omlstead v. L.C.*" Accomplishments #5 and #6 also contribute by assuring the accountability and sustainability of community-based options.

Accomplishment #2 facilitates access to the community-based alternatives developed by OAAS.

Accomplishment #1 contributes to the OAAS Strategic goal, "To timely complete investigations of adult abuse, neglect, exploitation, and extortion in the community." By improving training, quality management, data, and reporting; and by participating in national initiatives, OAAS protective services is better able to fulfill its mission to serve adults with disabilities and enable them to live free from harm due to abuse.

Accomplishments #7 and #8 contribute to the OAAS Strategic goal, "To administer and manage resident care programs at Villa Feliciana Medical Complex in a manner that ensures compliance with applicable standards of care; and to promote policies and practices that improve the quality and cost-effectiveness of privately-owned nursing facilities.

Do these accomplishments or their methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Implementation of the Electronic Visit Verification system is potentially applicable to any center-based service reimbursed through state agencies. As discussed in Accomplishment numbers 2, 3, and 4, Louisiana's Permanent Supportive Housing Program is a nationally recognized program that is being replicated in other states and should be expanded in Louisiana. Louisiana's Money Follows the Person program is part of a national demonstration implemented in over forty states, and Louisiana's program is performing in the top ten of participating states.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

OAAS continues to make progress in many areas related to its strategic goals and objectives.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

OAAS continues to improve the cost-effectiveness of its home and community-based programs compared to nursing facility services. The office has also implemented effective controls to address fraud, abuse, or waste in these programs. The Money Follows the Person Demonstration (MFP) continues to exceed benchmarks for transitioning individuals from nursing homes to the community. The Permanent Supportive Housing program has become the keystone to a multi-faceted housing strategy. OAAS continues to work closely with the Healthy Louisiana plans and their provider networks to improve timely access to community-based behavioral health services for individuals with mental illness seeking to return to the community from nursing homes.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

  1. To what do you attribute this success? For example:
     - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
     - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
     - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
     - Other? Please specify.
  2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

None.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

    1. To what do you attribute this lack of progress? For example:
        - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
        - Is the lack of progress due to budget or other constraint?
        - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
        - Other? Please specify.
    2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

Budget constraints have resulted in decreased access to community-based waiver services and program waiting lists remained in the range of 26,000 people waiting for services in FY 2016. Though nursing facility utilization has remained flat for several years, Medicaid spending for nursing facility care continues to rise. Furthermore, delivery of long term services and supports alone is not sufficient to address the significant chronic care needs of the population served by OAAS.

There is less than expected progress with respect to information technology issues that impact the program goal of "improving access, quality and outcomes for populations receiving or at risk of needing long-term supports and services." OAAS has been working to develop a web-based assessment and care planning system which would make the process of accessing and enrolling in community-based services more efficient and improve the ability to conduct real-time monitoring of participant plans of care. Implementation of this system was delayed by an LDH decision to make it the pilot case for a new software platform.

- **Has your department revised its strategic plan/business plan to build on your successes and address shortfalls?**

    ☒ Yes. If so, what adjustments have been made and how will they address the situation?
    ☐ No. If not, why not?

OAAS has modified its strategic plan to explore options in addition to Managed Long Term Supports and Services.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**

On a Department-wide level, Performance Based Budgeting activities (including, but not limited to, strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. Recommendations are made directly to the Assistant Secretaries or the Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

OAAS's vision for increasing access to home and community-based services as a sustainable, cost-effective alternative to nursing home care, in addition to improving access, efficiency, and quality in all OAAS programs, is key to integration of the OAAS strategic plan in other departmental processes such as budget and business plan development. Whether it takes the form of AMPAR reporting, LAPAS performance indicators, "transformative" business objectives, or budget explanations/justifications, OAAS strategic goals and objectives are clear, consistent over time and administrative changes, and understood by all OAAS staff. OAAS has been fortunate in having access to data that allows management and staff to monitor program outcomes, often against national goals and benchmarks. This allows OAAS to adjust strategies as needed to attain office objectives. Because OAAS administers Medicaid funded programs, OAAS works very closely with that agency and with other offices in LDH to assure strategies and goals are aligned.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

No significant department management or operational problems exist.

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)

5. How long has the problem or issue existed?
6. What are the causes of the problem or issue? How do you know?
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☐ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

   4. Are corrective actions underway?
      a. If so:
         - What is the expected time frame for corrective actions to be implemented and improvements to occur?
         - How much progress has been made and how much additional progress is needed?
      b. If not:
         - Why has no action been taken regarding this recommendation?
         - What are the obstacles preventing or delaying corrective actions?
         - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

   5. Do corrective actions carry a cost?

      ☐ No. If not, please explain.
      ☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
         a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
         b. How much has been expended so far?
         c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
         d. Will additional personnel or funds be required to implement the recommended actions? If so:
            - Provide specific figures, including proposed means of

financing for any additional funds.
- Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
The Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste & abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

Internal Audit also provides management with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The Louisiana Department of Health (LDH) has a designated Audit Coordinator for financial audits. The LDH Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

☒ **Policy, research, planning, and/or quality assurance functions in-house**
OAAS conducts numerous quality assurance functions internally. Some are performed to meet federal requirements for the operation of Medicaid programs, but OAAS performs much additional quality assurance beyond that required to

meet federal assurances. The discovery and analysis phases of quality assurance often lead to policy changes and planned improvements to program operation and delivery. Similarly, research into national best and promising practices drive policy and program improvements. Examples of in-house quality assurance include the APS activities described in I.1. above, CAT activities described in I.5., nursing home quality improvement activities described in I.7, and annual waiver monitoring performed by OAAS Program Operations and Quality Section staff.

☒ **Policy, research, planning, and/or quality assurance functions by contract**
OAAS contracts for Consumer Experience Surveys to be completed via face to face interviews with statistically valid random samples of OAAS program participants. OAAS also contracts for quality assurance projects in nursing facilities as described in I.7. above. Through OAAS' Access Services for Long Term Supports and Services contract, the contractor's Quality Assurance Manager is to oversee implementation of an OAAS-approved Quality Assurance/Quality Improvement plan. This plan includes mechanisms to assure effective performance of all contract deliverables, internal quality performance measures, and a means of initiating and overseeing corrective action when warranted.

☒ **Program evaluation by in-house staff**
The chief program evaluation performed by OAAS is the federally required comprehensive reviews of HCBS waiver programs. Data collection and analysis for these reviews are performed on an ongoing basis, but OAAS is also required to submit a report – referred to as the Evidence Based Report – to CMS every three years. APS has many data mining efforts that reports on a monthly basis to cases are being handled effectively and timely.

☒ **Program evaluation by contract**
As described above, OAAS contracts for consumer surveys.

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory Notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

☐ In-house performance accountability system or process

☒ **Benchmarking for Best Management Practices**
Continued funding for Louisiana's Money Follows the Person program is tied to hitting program benchmarks, which OAAS has exceeded every year since 2009.

Several of the LAPAS measures used by OAAS are nationally benchmarked measures. OAAS also attends closely to national rankings such as the United Health Care Senior Report and the AARP/Commonwealth Fund Long Term Supports and Services Scorecard and seeks to use measures and tools that can be nationally benchmarked. The Consumer Experience Survey is one such tool used by OAAS that is under federal development for benchmarking. OAAS also uses the Minimum Data Set suite of assessment instruments because they are federally mandated for nursing facilities and are used by multiple states for community-based services. These tools allow for cross-state and, in some instances, cross-program comparisons. OAAS also periodically uses claims data to run a limited set of HEDIS measures that can be nationally benchmarked or benchmarked against the Louisiana Medicaid population overall. Louisiana APS staff is a working member of the educational and training committee of the National Association of Adult Protective Services Association to further develop and establish best practices.

☒ **Performance-based contracting (including contract monitoring)**
The major Requests for Proposals and contracts written and monitored by OAAS are all performance-based and include payment incentives for excellent performance and penalties for performance that falls below standards for accuracy, timeliness, etc. A chief example of this is the contract with Xerox for operation of the OAAS single point of access which provides differential payment depending upon the timeliness and accuracy of key tasks such as assessments and appeals. Contract monitoring relies on reports provided by the contractor as per terms of the individual contracts, but OAAS always requires direct access to contractor data and runs independent analyses to verify contractor reports and to look for additional trends or anomalies.

☐ Peer review
☐ Accreditation review

☒ **Customer/stakeholder feedback**
In addition to the Consumer Experience Surveys described above, OAAS has regularly scheduled meetings with providers and advocates that are an ongoing resource for program improvement.

☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☐ Yes. Proceed to Section C below.
☒ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including

    Name: Tara LeBlanc
    Title: Assistant Secretary
    Agency & Program: Office of Aging and Adult Services
    Telephone: (225) 219-0223
    E-mail: tara.leblanc@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
324 Louisiana Emergency Response Network

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Paige Hargrove**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Added Level II Trauma Center

A. What was achieved?

Louisiana Emergency Response Network added an ACS Verified Level II Trauma Center to the state trauma system located at North Oaks Medical Center, Hammond LA.

B. Why is this success significant?

The LERN Board's vision is to establish an ACS verified trauma center in each region of the state. North Oaks lies in LDH Region 9, which previously did not have a trauma center.

C. Who benefits and how?

The citizens of Louisiana, and anyone visiting the state, benefit from expanding the trauma system. In 2011 there were only two trauma centers in the state with only 31% of the state's population having access to a trauma center within a 60 minute drive time or the "Golden Hour." Now, there are five verified trauma centers in the state and 55.4% of the population has access within the Golden Hour. North Oak's trauma center designation means citizens injured in the area no longer have to travel to Baton Rouge or New Orleans to receive care at a trauma center.

D. How was the accomplishment achieved?

This was achieved by working collaboratively with LERN Stakeholders to implement the Board's vision of achieving a trauma center in each region of the state. LERN administration approached the CEO at North Oaks three years ago asking them to consider becoming a verified trauma center. The LERN Trauma Medical Director consulted with the North Oaks team on a monthly basis for almost two years while the center was developed.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes – set a goal and develop a support plan to help achieve the goal.

Accomplishment #2: Consultative Visits with the American College of Surgeons

A. What was achieved?

Two hospitals underwent consultative visits with the American College of Surgeons – Lafayette General Hospital, Level II (Region 4) and Lakeview Regional Medical Center, Level III (Region 9).

B. Why is this success significant?

This is significant because the next step is the verification survey which upon successful review will result in two additional trauma centers in the state for a total of 7 verified centers. Most importantly, it will mean there is a Level II Trauma in LDH Region 4, which currently does not have a center.

C. Who benefits and how?

Same answer as above. When Lafayette General and Lakeview achieve trauma center designation, 67.3% of the population will have access to a trauma center w/in the Golden Hour.

D. How was the accomplishment achieved?

For Lafayette, same as above. LERN administration identified a gap in R4 and approached the CEO/administration with a pitch of why a trauma center is needed and why we thought their hospital was a good fit. Provided consultative visits monthly to move development along. Lakeview is pursuing as part of AHA corporate initiative, but they have been great partners is system development.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes.

Accomplishment #3: Grant from Highway Safety Research Group

A. What was achieved?

AIS coding class for 27 hospital trauma registrars – funded via grant from Highway Safety Research Group.

B. Why is this success significant?

In order to obtain trauma center designation in Louisiana, hospitals must pass the ACS-COT verification survey. In 2015, the ACS began requiring all trauma registrars to complete the AIS coding course. This course is typically only taught out of state and the registration is $750. Travel plus registration would have been very expensive for the hospitals. LERN secured a grant for the course and it was conducted in Louisiana at no cost to the hospitals and helped them meet the new requirement.

C. Who benefits and how?

Hospitals and the state benefits because this will not be a deficiency upon review by the ACS thus strengthening the system and it helps to improve data quality in the state trauma registry.

D. How was the accomplishment achieved?

The LERN Executive Director is a member of the Traffic Records Recording Committee (TRCC). The TRCC is working to link medical data to crash reports in order to better understand the true impact of crashes. Accurate and consistent coding/data reporting across the state fits with the TRCC goals. The Executive Director submitted a grant proposal and $20,000 was awarded.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

No.

Accomplishment #4: Revised the Trauma Destination Protocol

A. What was achieved?

Revised the Trauma Destination Protocol and promulgated via rule making procedures.

B. Why is this success significant?

As the trauma system grows and changes, it is important that the destination protocols are amended as needed. The 2015 change is more in line with the national CDC Field Triage Criteria.

C. Who benefits and how?

All injured people. The protocol directs to the most appropriate hospital. Hospitals also benefit because they are less likely to receive patients that they do not have the resources to adequately care for.

D. How was the accomplishment achieved?

Aligning with the national standard and educating stakeholders.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes – where there are national standards based on science, we should try to align with those when possible.

Accomplishment #5: Trauma/Injury Education Courses Offered Through LERN

A. What was achieved?

Continued trauma/injury education courses offered through Louisiana Emergency Response Network (LERN): Trauma Nurse Core Curriculum (TNCC), Emergency Nurse Pediatric Course (ENPC), Rural Trauma Team Development Course (RTTDC), and MCI education. EKG Training Course expanded to 3 additional LDH Regions.

B. Why is this success significant?

An educated workforce is paramount in the success of the trauma system.

C. Who benefits and how?

Hospitals and EMS agencies employing the recipients of the education benefit from this accomplishment. LERN provides the education at little or zero cost to the students and we provide the education in their community. This reduces time off work. The following number of students completed the courses FY 15-16: EKG Course 11 classes = 368 students, TNCC 19 classes = 219 students, ENPC 16 classes = 165 students, RTTDC 3 classes = 66 students, MCI 6 classes = 279 students.

D. How was the accomplishment achieved?

Identifying needs via gap analysis.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

No.

Accomplishment #6: Recognized at the International Stroke Conference

A. What was achieved?
Louisiana was recognized at the International stroke conference as one of only 12 states to have enacted policies around the recognition of stroke facility designation.

B. Why is this success significant?
Stroke is a time sensitive illness. Two million brain cells die every minute a patient experiences a stroke. Systems that recognize stroke capable hospitals enable EMS and the public to seek care at the most appropriate hospital and have a chance at the best possible outcome.

C. Who benefits and how?
The patients, hospitals and the state benefit. Better outcomes mean more productive lives and lower costs to the healthcare system.

D. How was the accomplishment achieved?
Achieved first by establishing legislation that tasks LERN with stroke system development. Second, by formulating a state stroke workgroup to design the system and promote participation. Third by promulgating rule which defines requirements for stroke center recognition.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #7: Addition of Three Primary Stroke Centers

A. What was achieved?

LERN added three additional Primary Stroke Centers (PSC) in the state: University Health Shreveport, St. Tammany Parish Hospital and North Oaks Medical Center.

B. Why is this success significant?

The most significant addition to the stroke system is University Health Shreveport. Prior to them achieving PSC, we did not have a PSC north of Alexandria. Their achievement has also prompted Willis-Knighton Pierremont to pursue PSC designation. This is significant because certification elevates care. North Oaks in Hammond and St. Tammany Parish Hospital in Covington also obtained PSC.

C. Who benefits and how?

Patients benefit. Hospitals that obtain certification meet standards that support better outcomes for stroke care.

D. How was the accomplishment achieved?

The hospital administration has to make the commitment, but the LERN Stroke Medical Director identified a stroke champion in LDH R7 – Shreveport. This neurology champion joined the Region 7 LERN Commission and worked with hospital administration to identify PSC as a strategic priority. The LERN Stroke Medical Director provided consultation as needed.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

Yes, we are progressing towards meeting the goals and objectives set forth by our strategic priorities. Returns on investment are being met, but without a comprehensive trauma, stroke and STEMI registry it is impossible to demonstrate outcomes.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

1. LERN Mission Sustainability

Strengthen the Sustainability of LERN's Mission, Including State Office Operations and the Development of an Ideal Statewide Network of Designated Trauma Centers

- Lessen or eliminate LERN's reliance on state general fund dollars
- maximize LERN funding from recurring, dedicated source(s)

Status: This is the one area where we have not made significant progress. With the budget deficit across all areas of the state it has been difficult to come forward with legislation for alternative funding to support LERN's mission. We continue to depend on the state general fund. We continue the Low Income Needy Care Collaborative Agreement (LINCCA) for the Communication Center Staffing contract in order to leverage state general fund dollars. We received to grants to help support the trauma and EMS registries.

Anticipated returns on investment are being realized in terms of efficient use of resources. Due to the LERN Call Center routing, secondary transfers have been significantly reduced. Minimizing secondary transfers save money by reducing duplication is services and improves trauma patient outcomes.

2. Statewide Trauma Center Network

Build a consensus among key stakeholders for the development of an ideal statewide network of designated trauma centers in Louisiana.

- Secure two attestations from CEOs for meeting Trauma Program requirements in regions without a trauma center.
- Research and Design a Regional Performance Improvement pilot.
- Meet quarterly with the Trauma Program Managers Group to facilitate information exchange relative to best practices and shared challenges.
- Continue to provide trauma training opportunities to all level providers statewide.

Status:

- Attestation submitted by Lafayette General Hospital in LDH Region 4. Commitment made by Lake Charles Memorial Hospital to pursue Level III Trauma Center designation if Region 5 – no attestation received yet.
- Region 9 has developed Regional Pre-hospital trauma operations group. As this group matures, regional PI will be started.
- Group has met twice this fiscal year via conference call and once at the COT meeting. Communication between centers is improved.
- Very successful as indicated in (I) of this report.

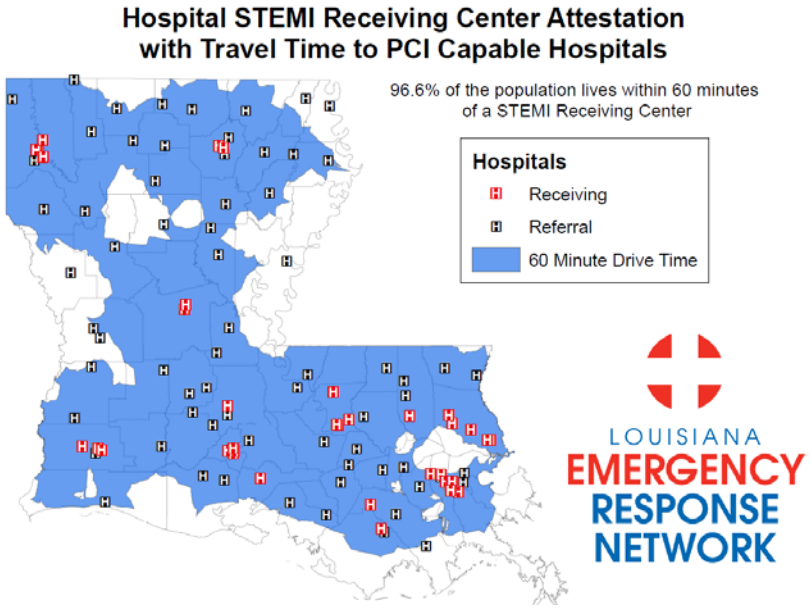
3. STEMI Network

Develop a statewide system of STEMI care to improve outcomes for Louisiana citizens regardless of where they live in the state.

- Continue to map geographic distribution of STEMI resources statewide.
- Educate and inform stakeholders of their role in the STEMI System.
- Provide 12 Lead EKG Interpretation education in each region of the state

- Establish ACTION regional report to drive performance
- Increase participation in ACTION registry and use regional report to assess outcomes of care for STEMI patients.

Status: Map of geographic distribution of STEMI resources updated based on recent attestations. Map indicates that 96.6% of the state's population has access to a STEMI Receiving Center within a 60 minute drive time. Education continues to be provided via the tri-regional coordinators at the regional commissions and via the LERN Newsletter. The ESF-8 portal was updated with statewide STEMI resources and the LCC continues to route patients to definitive STEMI care as needed. 12 Lead EKG education has been provided in Regions 1, 2, 3, 6, 7, 8 and 9. A total of 369 paramedics or nurses have completed the course. We have received 2 state ACTION regional reports that indicate we are meeting or exceeding national benchmarks. We still need more hospitals to participate in the registry and we continue to engage hospitals.



4. Stroke Network

Develop a statewide system of stroke care to improve outcomes for Louisiana citizens regardless of where they live in the state.

- Establish stroke physician champions in each region of the state
- Implement education plan for public and providers.
- Enhance compliance with LERN Stroke Hospital requirements.
- In regions without an existing Primary or Comprehensive stroke center, develop priority prospects and secure commitments from at least 1 level 3 hospital to pursue PSC and one Level 4 to pursue Level 3 status.
- Engage and secure 10 additional level 3 stroke centers to participate in LERN data collection or GWTG.

Status:

- Stroke champions identified in all regions except for region 5.
- 11 part stroke webinar series developed and implemented. It is posted on the

LERN website for future use. Mini NIHSS cards made for EMS to provide education and a reference when transferring patients who received tPA.

- Monitoring is a work in progress. Quarterly feedback reports provided to each Level III Stroke Center who submits data to LERN. Proposal being developed to require action plans for those not meeting benchmarks.
- Met this goal. University Health Shreveport was a Level III center in an area without a PSC. They obtained their PSC and are now a Level II Center. Hood Memorial, Glenwood Medical Center and Winn Hospital all moved from Level IV to Level III Stroke centers.
- We met this target – 9 level III Centers started submitting data to LERN and 1 began using GWTG.
-

4. MCI/Disaster Preparedness

Promote LERN as the "information coordinator" for unfolding events in Louisiana on a 24/7 basis

- Participation in regional activities to integrate LERN into region specific protocols for event management and support
- Serve as the primary coordinating entity for messaging and notifications regarding events and incidents as they occur
- Maximize regional assets by coordinating patient flow/transport

Status:

- Participated in 6 training classes reaching 279 stakeholders
- LERN Call Center (LCC) served as the primary coordinating entity for messaging and notification 131 times in FY15. LCC continues to work with regional partners in drills and disaster planning.
- Record high year for year for volume for LCC – routed 16,651 patients.

Where are you making significant progress? If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?

We have been successful in all areas except funding. Specifically, we have been very successful in the expansion of the trauma system and development of the stroke system. The same results would not have occurred without LERN leadership. Contracting with subject matter experts continues to augment the effectiveness of the LERN staff. LERN continues to collaborate with local, regional and state level stakeholders to continue to build the statewide trauma & time sensitive illness network.

- Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

Yes – Progress is directly related to specific department (LERN) actions. LERN has initiated, supported and implemented every aspect of the Stroke and STEMI system to date. LERN trauma outreach and education has engaged stakeholders across the state and facilitated an educated work force. We have reallocated resources to have a more direct focus on outreach and education for the four tiers of LERNs mission: Trauma, Stroke, STEMI, and All Disasters-Response. Participation in drills across the state has resulted in more efficient and safer management of mass casualties.

- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?

Specific department actions have directly related to the success of LERN. Examples include: Continued support from the Secretary and Under Secretary as it relates to funding, Bureau of Health Informatics continues to provide stroke data as available and Vital Records provides mortality data related to trauma, stroke and STEMI.

- Other? Please specify.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

Progress is not the result of a onetime gain. Building and maintaining systems of care takes time and is a long term commitment. Progress will continue at a steady pace.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

1. To what do you attribute this lack of progress? For example:
   - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
   - Is the lack of progress due to budget or other constraint?
   - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
   - Other? Please specify.

We have made little progress lessening or eliminating LERN's reliance on state general fund

dollars. We have received some grant funds, but we have not been successful in identifying larger grants that fit LERN's mission and strategy. Despite budget constraints, LERN has still made significant progress in the last year. We understand the funding alternatives utilized by other state trauma systems and we understand existing state dedications that could serve as practical alternative sources of recurring funding for LERN. It is not the right time politically to pursue those funding sources.

Data collection/registry development for STEMI and Trauma has been difficult. LERN does not have the authority to mandate data collection. Hospitals have a hard time collecting data due to competing priorities. It cost money to hire a data entry person. To deal with STEMI data collection, LERN has had success getting hospitals that already use ACTION Registry to agree to submit their data to a state report. This does not cost them any money. For trauma, we are focusing our efforts on those facilities working to become trauma centers.

2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

The problem will continue until we are in a position where we can successfully pursue passing legislation to fund the system. Most trauma systems are funded via fees or fines associated with DUI, traffic violations or vehicle registration.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☒ Yes. If so, what adjustments have been made and how will they address the situation?

  The strategic priorities remain the same, but the goals/action plans were adjusted to achieve each of the priorities.

  ☐ No. If not, why not?

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

The Executive Director provides a report to the LERN Board of Directors (BOD) at least quarterly. This report includes progress to goals for each strategic priority. The strategic plan is completely re-evaluated annually by the LERN BOD. The LERN Regional Commissions are informed through the Tri-Regional Nurses and the LERN Administrative & Medical Directors.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure,

resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   5. How long has the problem or issue existed?
   6. What are the causes of the problem or issue? How do you know?
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☒ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   4. Are corrective actions underway?
      a. If so:
         - What is the expected time frame for corrective actions to be implemented and improvements to occur?
         - How much progress has been made and how much additional progress is needed?
      b. If not:
         - Why has no action been taken regarding this recommendation?
         - What are the obstacles preventing or delaying corrective actions?

- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of financing for any additional funds.
      - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
Monthly review and reconciliation of all call center volume/reports.

☐ External audits (Example: audits by the Office of the Legislative Auditor)
☒ **Policy, research, planning, and/or quality assurance functions in-house**

☒ **Policy, research, planning, and/or quality assurance functions by contract**
Review of literature, other best practices, review of other state trauma programs, is performed by LERN staff and consultants, used to guide the implementation and continued development of the LERN Trauma and Time Sensitive Illness Network

☒ **Program evaluation by in-house staff**
Performance Improvement meeting bi-monthly. Led by Dr. Hunt, Dr. Owings, or Dr. Freeman.

☒ **Program evaluation by contract**
Communications Center staffing provided by contract with AMR. Data is input to the Louisiana State owned Image Trend system. This system software provides data on calls, time to definitive care, mechanism of injury and transport time. LaHidd data used to evaluate the stroke program.

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
LERN reports Performance Indicators quarterly through the LaPAS system

☒ **In-house performance accountability system or process**
Monthly audits on Communications Center calls; Error statistics on data base with follow-up with each communicator; Secondary transfer log reviewed weekly by Executive Director.

☒ **Benchmarking for Best Management Practices**
Compare state trauma registry data with NTDB data. STEMI Regional Report compared to national benchmark. Stroke Registry (Level III) centers compared to the aggregate. Benchmarks are based on national standards.

☐ Performance-based contracting (including contract monitoring)

☒ **Peer review**
The LERN Communicators are required to perform peer review audits on two calls per shift.

☐ Accreditation review

☒ **Customer/stakeholder feedback**
Case review process.

☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☒ Yes. Proceed to Section C below.
☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation: LERN Annual Report FY 2104-2015
2. Date completed: March 2016
3. Subject or purpose and reason for initiation of the analysis or evaluation
   Required by LERN Legislation La.R.S.40:2845

4. Methodology used for analysis or evaluation
   Data included in the report is obtained from call center data and from the trauma registry.
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information:

    Name: Paige Hargrove
    Title: Executive Director
    Agency & Program: Louisiana Emergency Response Network
    Telephone: (225)756-3440
    E-mail: Paige.Hargrove@la.gov

a) LERN Annual Report to the Louisiana Legislature and the House and Senate Health and Welfare Committees – submitted in compliance with the 2004 LERN Enabling Legislation

b) Monthly Fiscal Reports submitted to LERN Treasurer, Chairman of the Board and discussed at LERN Board meetings.

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
325 Acadiana Area Human Services District

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Brad Farmer**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Three Year Award from CARF International

A. What was achieved?
Acadiana Area Human Services District (AAHSD) achieved National accreditation – A 3-year award from Commission on Accreditation of Rehabilitation Facilities (CARF), the highest level of accreditation possible, for the second time in a row.

B. Why is this success significant?
First, national accreditation is required by the Statewide Management Organization (SMO) as Louisiana moves toward a managed system of care; secondly it demonstrates

competence and commitment toward internationally recognized standards of practice; and it provides a foundation for AAHSD to operate more effectively and efficiently.

C. Who benefits and how?

Clients benefit as the organization increases the use of 'best practices' and also monitors significant clinical indicators to ensure the effectiveness of services. Additionally, AAHSD has implemented a quality improvement (QI) process and also monitors service access. The community at large and funders of services benefit as AAHSD demonstrates its competence in both administrative and clinical operations, along with the additional accountability of the accreditation review cycle.

D. How was the accomplishment achieved?

The development and implementation of an organizational Policy/Procedure manual and other supporting documentation, staff training, the designation and leadership of an 'Accreditation Team', and an on-site review by a CARF survey team.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes

<u>Accomplishment #2: Pharmacy Generated Over $5.91M in Patient Assistance Program (PAP) Medication</u>

A. What was achieved?

Acadiana Area Human Services District's (AAHSD) pharmacy generated over $5.91M in Patient Assistance Program (PAP) medication for clients last fiscal year (up from $5.32M in FY15 and $5.21M in FY14). AAHSD's SGF expenditures for pharmacy were 4.53% of total pharmacy expenditures for FY15.

B. Why is this success significant?

The PAP program is designed to assist clients in obtaining their medications at little to no cost to the client or AAHSD.

C. Who benefits and how?

Clients benefit from this as they receive needed medications they otherwise may not be able to afford/obtain. Acadiana Area Human Services District is able to utilize resources to provide medications to other clients who otherwise may not be able to afford/obtain medications and may not qualify for PAP medications.

D. How was the accomplishment achieved?
PAP staff works under the supervision of the AAHSD Pharmacy Director. The Pharmacy Director and Medical Director maintain close communication to ensure the success of this program.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes

Accomplishment #3: Staffing the Family Resource Center

A. What was achieved?
Acadiana Area Human Services District (AAHSD) participated in staffing the Family Resource Center established by the Lafayette Consolidated Government in response to the Grand Theater shooting.

B. Why is this success significant?
AAHSD was able to provide licensed mental health professionals on-site during the entire shelter operating timeframe in order to provide counseling to anyone in the community impacted by the shooting.

C. Who benefits and how?
The city of Lafayette, as a whole, benefits due to the benefit of immediate availability of counseling resources to residents, witnesses, family members, first responders, and the community at-large following the shooting incident.

D. How was the accomplishment achieved?
This accomplishment was achieved through coordination with Lafayette Consolidated Government and the Office of Public Health.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes

Accomplishment #4: Implemented the CareLogic Electronic Record System

A. What was achieved?
Acadiana Area Human Services District (AAHSD) implemented the CareLogic electronic record system.

B. Why is this success significant?
This allows for greater accuracy in monitoring quality of treatment services, provides a universal template to house client's treatment records. Electronic healthcare records facilitate centralized information archive and improve AAHSD's ability to secure reimbursement for services provided.

C. Who benefits and how?
Clients benefit from an organized system of care documentation by being exposed to reduced repetition of information collection. The system of care benefits by gathering the required information in a timely and thorough manner, allowing for allocation of remaining time/resources to treatment of additional clients.

D. How was the accomplishment achieved?
This process was driven from the District Executive Management Team and involved selection of a dedicated Implementation Team that included a representative sample of staff from all clinics across the District, fiscal staff, and both management and direct-care staff members. The Implementation Team selected Train-the-Trainers according to discipline specialties and these persons trained line staff in implementation of the system directly. The CareLogic was introduced, designed, and staff were trained in 6 weeks, from project kick-off to go-live implementation.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes

II. Is your department Five-year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

AAHSD submitted our initial five-year Strategic Plan in June 2013. Thus far, our goals and objectives are being met and the plan is on target for successful completion.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

AAHSD is progressing towards accomplishing goals and objectives, such as: developing clear policy objectives; providing behavioral health treatment services as part of the State's continuum of care; improving accessibility; increasing stakeholders' involvement; and, providing quality services and supports. These strategies are effective in ensuring persons served receive the highest quality care.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
    - Other? Please specify.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

    a. AAHSD is on target for making the progress that was projected in the five-year Strategic Plan. Progress is due largely to reorganizing our internal structure, developing new policies and procedures, utilizing the expertise of the Governing Board, conducting staff training, and implementing a team structure and approach to management. We are continually working to improve policies/systems and making necessary changes to become more effective and efficient.

    b. Progress is expected to continue on an 'on-target pace' as we conduct regular ongoing meetings of teams (Accreditation, Health/Safety, Quality Improvement, and Senior Management), participate in ongoing external reviews, and conduct ongoing internal reviews. Our efforts so far have not been 'one-time events' but the building of infrastructure and operating systems to ensure ongoing success.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

  1. To what do you attribute this lack of progress? For example:
     - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
     - Is the lack of progress due to budget or other constraint?
     - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
     - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

  None

- **Has your department revised its strategic plan/business plan to build on your successes and address shortfalls?**

  ☐ Yes. If so, what adjustments have been made and how will they address the situation?

  ☒ No. If not, why not?

  The AAHSD five-year Strategic Plan gave a clear overview of goals and objectives to accomplish. The plan fully encompasses administrative and programmatic issues for ongoing review/improvement.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

  All senior managers gave input into the development of the strategic plan and received a copy of the final version. Senior managers shared this with their departments and staff. This strategic plan, along with the annual management report, is made available to all staff and is included as public information on our website so the community at large and other interested stakeholders can be fully informed as to these plans. The Strategic Plan was also shared with our Governing Board.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   5. How long has the problem or issue existed?
   6. What are the causes of the problem or issue? How do you know?
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

No significant department management or operational problems/issues exist.

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☒ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   4. Are corrective actions underway?
      a. If so:
         - What is the expected time frame for corrective actions to be implemented and improvements to occur?

- How much progress has been made and how much additional progress is needed?

b. If not:
   - Why has no action been taken regarding this recommendation?
   - What are the obstacles preventing or delaying corrective actions?
   - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of financing for any additional funds.
      - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☐ Internal audit

☐ External audits (Example: audits by the Office of the Legislative Auditor)

☒ **Policy, research, planning, and/or quality assurance functions in-house**
QI Team reviews client quarterly

☐ Policy, research, planning, and/or quality assurance functions by contract

☐ Program evaluation by in-house staff

☐ Program evaluation by contract

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
LAPAS Reports

☐ In-house performance accountability system or process
☐ Benchmarking for Best Management Practices

☒ **Performance-based contracting (including contract monitoring)**
Contract Monitoring

☒ **Peer review**
Medical Doctors and OCDD peer review process

☒ **Accreditation review**
CARF Accreditation—AAHSD received a 3-year accreditation

☒ **Customer/stakeholder feedback**
Stakeholder Survey

☒ **Other (please specify):**
Human Services Accountability and Implementation Plan (AIP) monitoring visits by OBH and OCDD

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☒ Yes. Proceed to Section C below.
☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. **Title of Report or Program Evaluation**: AAHSD Management Report
2. **Date completed**: June 2016
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
The AAHSD Management Report is offered as partial fulfillment of the standards set forth by CARF and is designed to summarize the results of the program plans; quality assessment; goals and objectives; the data collected in the areas of effectiveness, efficiency, service access, and consumer satisfaction; and from other operating systems and to provide a synopsis of ‘significant events’.
4. **Methodology used for analysis or evaluation:**
Review of AAHSD systems including: Corporate Compliance, Health and Safety (including Accessibility), Human Resources, Information Management, Outcomes Management System, Quality Improvement, and

Risk Management.

5. **Cost (allocation of in-house resources or purchase price):** In house resources
6. **Major Findings and Conclusions:**
   - AAHSD's 2016/2017 budget has been developed and submitted per Division of Administration (DOA) requirements *(at the time of this report, the 2017/2018 budget has also been submitted).*
   - New AAHSD policies have been approved by State Civil Service.
   - Employees have completed Civil Service PES as required.
   - The AAHSD Human Resource office has successfully completed a Civil Service audit.
   - AAHSD is moving to a new EHR, CareLogic.
   - AAHSD has conducted and/or participated in numerous public events, health fairs, community forums, and other professional forums.
   - AAHSD has supported other organizations in their efforts to provide crisis services to the community – either through education/training opportunities, funding and/or referrals.

   This report was made available to the Governing Board, all staff, and copies were available in all service locations for clients/visitors. A copy was sent to senior DHH officials as well as the entire 'Acadiana Delegation'. Additionally, this report is posted on our website for public view.

7. **Major Recommendations**: None
8. **Action taken in response to the report or evaluation:** None
9. **Availability (hard copy, electronic file, website):**
   Located in the policy and procedure manual and website

10. **Contact person for more information**:
    Name: Brad Farmer
    Title: CEO
    Agency & Program: AAHSD
    Telephone: 337-262-4190
    E-mail: Brad.Farmer@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
326 Office of Public Health

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Assistant Secretary: **Beth Scalco**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: STD/HIV Program Formed a Shreveport Syphilis Response Task Force

A. What was achieved?

STD/HIV (Center for Community and Preventive Health)

In order to address the high rates of syphilis in the Shreveport area, the STD/HIV Program formed a Shreveport Syphilis Response Task Force, which includes community leaders, key stakeholders, OPH staff and Centers for Disease Control (CDC) federal

assignees. The Task Force developed a syphilis action plan, and five Task Force subcommittees (Media/Communications, Outreach, Evaluation, Provider Education, and Youth Advisory) carried out activities outlined in the plan. Successes include increased ability of the parish health unit to effectively serve more clients; reached over 200 medical providers through educational outreach activities; established public/private partnerships to address structural barriers that affected testing and treatment; and encouraged providers to offer services to clients during non-traditional hours. From 2014 through June 2015, early infectious syphilis decreased by 19% in Shreveport.

B. Why is this success significant?

In 2013, Shreveport had both the highest syphilis rate and the highest number of cases in the state. Activities conducted by the Task Force have increased the number of persons tested and treated for syphilis in a timely manner and has led to a decrease in new infections in Shreveport.

C. Who benefits and how?

Individuals living with syphilis and partners at risk have benefited from the Shreveport Task Force activities by getting tested and treated earlier. Untreated syphilis can cause significant long-term complications and can also be passed from mothers to their children, greatly increasing the risk of stillbirth, miscarriage and health issues for the infant.

D. How was the accomplishment achieved?

The project has been successful due to Louisiana's strong and mature HIV surveillance program and a philosophy of using those data for informed public health action. Staff examines surveillance data to identify persons with HIV who are not in medical care and reach out to them in a confidential and compassionate manner, assisting them with a variety of challenges in order to get them established in care.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes. These activities are directly related to the Program's key indicators to: 1) increase the proportion of persons living with HIV who are linked to HIV medical care and who are virally suppressed, and 2) ensure persons with syphilis are treated in a timely manner.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. These activities are directly related to the Program's key indicators to: 1) increase the proportion of persons living with HIV who are linked to HIV medical care and who are virally suppressed, and 2) ensure persons with syphilis are treated in a timely manner.

Accomplishment #2: The STD/HIV Program was awarded $1.8 million

A. What was achieved?

STD/HIV (Center for Community and Preventive Health)

The STD/HIV Program (SHP) was awarded $1.8 million/year for 3 years through the Health and Human Services Secretary's Minority AIDS Initiative Fund for Care and Prevention in the United States (CAPUS) to improve linkage to care, retention in care, and viral suppression rates in the state and to increase the capacity of staff and the program to address HIV related racial disparities in those key outcomes. SHP employed several strategies intended to achieve the CAPUS goals and significant improvements were achieved during the project that ended September 29, 2016. Most notably, the percentage of persons newly diagnosed with HIV in Louisiana who entered HIV-related medical care within 90 days of their diagnosis increased from 81% in 2014, to 82% in 2015, and again to 86% among persons diagnosed with HIV from January to June 2016; and viral suppression among persons living with HIV in Louisiana who were in medical care increased from 70% in 2014 to 79% in 2015. Additionally, the entire SHP staff and the staff of community based organizations contracted to provide other CAPUS services were extensively trained on understanding and addressing institutional racism, homophobia and transphobia as those structural factors present significant barriers to effective STD/HIV prevention, care and treatment.

B. Why is this success significant?

Reducing the amount of time from diagnosis to linkage to HIV care and increasing the proportion of those in HIV care who are virally suppressed are the most significant indicators of progress necessary to reduce the transmission of HIV. Understanding and addressing HIV care and viral suppression barriers related to the effects of racism, homophobia and transphobia on the populations most impacted by HIV is key to preventing transmission.

C. Who benefits and how?

Individuals living with HIV and their sex partners have benefited from the CAPUS project by getting linked to care and achieving viral suppression faster, thereby preventing further transmission of HIV.

D. How was the accomplishment achieved?

The CAPUS project was successful due to SHP's highly experienced programmatic staff as well as the strong and mature HIV surveillance program which allowed for the use of those data for continuous quality improvement of the CAPUS project. Staff examines surveillance data to identify persons with HIV who are not in medical care and reach out to them in a confidential and compassionate manner, assisting them with a variety of challenges in order to get them established in care.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes. These activities are directly related to the Program's key indicators to: 1) increase the proportion of persons living with HI who are linked to HIV medical care and who are virally suppressed, and 2) to reduce HIV health disparities based on race/ethnicity, gender identity and sexual orientation.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. The management and monitoring of the CAPUS project was carried out by a cross-unit collaborative of key staff and this practice could be replicated for addressing other health issues in the state. Several CAPUS strategies are currently being expanded in the state following similar management practices and utilizing new CDC grant funds (PS1506 and PS1509). Making trainings related to understanding and addressing institutional racism, homophobia and transphobia available to staff and requiring their participation is also a management practice that is highly applicable and could be replicated for addressing other health issues in Louisiana.

Accomplishment #3: Bureau of Nutrition Services Action Plan

A. What was achieved?

Nutrition Services WIC Vendor Operations Overhaul
(Bureau of Nutrition Services, Center for Community and preventive Health)

To advance the Louisiana Supplemental Nutrition Program for Women, Infants and Children (WIC) Operations, Bureau of Nutrition Services has solidified a comprehensive action plan to improve program integrity, cost neutrality, cost containment and fair WIC authorized vendor selection criteria. WIC Vendor Operations staffing has been supplemented and increased with both permanent and temporary staff to ensure all goals are met. By the end of SFY16, the following was achieved:

- Revision of the Vendor Application, Vendor Agreement and Vendor Guide
- Reestablishing Vendor Peer Groups
- Updated the Louisiana Administrative Code to reflect all new WIC Vendor Operations changes

B. Why is this success significant?

The successful revamping of WIC Vendor Operations improves WIC program integrity and accountability of United States Department of Agriculture (USDA) funds allocation by implementing an evidence-based cost containment strategy in order to comply with USDA regulations. In addition, the newly hired Program Monitor (Vendor Relations / Communications Liaison) has engaged the WIC vendor stakeholders as the program prepares to implement *eWIC*, an Electronic Benefits Transfer (EBT) solution, which USDA mandates by 2020 as a key component.

C. Who benefits and how?

The benefits realized from the reorganization will be felt by the agency, the program, the vendor stakeholders and the public. This opportunity will allow Nutrition Services to recruit more highly skilled talent to manage WIC's Vendor Operations Unit which must implement a complex evidence-based cost containment strategy in order comply with USDA regulations.

D. How was the accomplishment achieved?

Bureau of Nutrition Services engaged nationally-renown experts from the Altarum Institute to provide professional consultation to overhaul the Program, which included a comprehensive assessment of the Program's structure and staffing. In addition to the Altarum Institute's recommendations, successful completion was largely due to a high level of OPH Administration support. This effort took a great deal of communication and coordination with Civil Service, LDH, OPH and USDA.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Through the reorganization of personnel and their respective activities, it is expected that Nutrition Services will increase its efficiencies and compliance of WIC Vendor Operations in order to provide the highest level of service to ensure robust cost containment and effective vendor management. By improving the program's level of capability to serve the needs of the industry and the public, this reorganization supports the goals of the OPH Strategic Plan through Improved Financial Stability priority — Goal 1: Increase financial stability and revenue through more efficient utilization of resources.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes, through the utilization of subject matter experts who provided professional consultation to complete a through program assessment and evaluation and the unit reorganization of staff to change employee roles, increase program compliance and efficiencies.

Accomplishment #4: Bacterial Testing of Drinking Water

A. What was achieved?

OPH Laboratory (Center for Community Preparedness and Health Protection)

OPH improved customer service for bacterial testing of drinking water by leveraging technology and restructuring specimen delivery and results reporting. By re-opening the Shreveport laboratory for only bacterial drinking water testing, within the Caddo Parish Health Unit, we were able to bring a much desired service back to the northern part of the state at low cost to OPH. This testing requires that the sample testing begin within

30 hours of collection. This project decreased turn-around-time for results reporting by having a laboratory in the proximity and removing the need for samples to be transported to the southern part of the state, which in turn reduced the number of samples that were rejected due to the "collection to analysis" time being exceeded. In addition, the laboratory implemented a new laboratory information management system (LIMS) for environmental testing, which allows results to be reported much quicker through electronic notification, as well as the system provides the capability for both the laboratory and the environmental programs to monitor and analyze data much more efficiently. A $386,533 annualized efficiency gain was created (this was not included as a FY 2016 budget reduction as per OPH Budget Director).

B. Why is this success significant?

This project resulted in a 19% reduction in total process time. The lab reduced courier costs by eliminating multiple routes to transport samples from the northern part of the state to the southern part of the state. In addition, reducing the time of transporting samples decreased the amount of rejections and thus reduced the need for samples to be recollected by water systems. Because samples are getting to the laboratories earlier, we decreased the amount of compensatory (K) time the laboratory staff was accruing, which has both increased morale among the staff and resulted in a decreased cost to the lab. The LIMS also reduced the time required to report lab results by converting to an electronic system that emails reports, as well as provides data analytics for oversight and management. All of these improvements increased customer satisfaction. With the state's budgetary constraints, every financial gain is important.

C. Who benefits and how?

The OPH Safe Drinking Water Program benefits by receiving lab reports electronically in real time, which reduces the time needed to respond to water safety issues. The operators of public and private water systems benefit by reduced time and cost of a "boil water advisory," having a reduced number of samples being recollected and by receiving laboratory results more rapidly. This often means the public has a decreased inconvenience of being on a "boil water advisory" and does not have to boil their water for as long while repeated results are analyzed. The lab staff benefit by no longer having to work extra hours to accomplish the testing, and the lab benefits by not having staff accrue as much K-time. Lab management is able to balance workloads and make adjustments for further efficiencies.

D. How was the accomplishment achieved?

This was accomplished using the Lean Six Sigma (LSS) methodology to evaluate the current system and evaluate process data. The LSS team determined improvements, managed the project to completion and measured the benefits. The data collected provided the insight for leadership to approve the changes. It required the coordinated efforts of OPH Executive Leadership, OPH Lab Leadership and staff, Parish leadership and staff, and the LSS team.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes, it reduces the overall cost of laboratory operations and improves customer services at the same time. The financial efficiency gain helps reduce the cost to the programs and yields more funding for mission critical activities.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes, it highlights the benefits of using Lean Six Sigma method to address customer complaints and program deficiencies (in this case, increased numbers of rejected water samples). This allowed the root problems to be identified and addressed, which improved service and lowered the cost of operations. Using data to drive decisions and measure gains is critical to progress in reducing costs and increasing customer satisfaction. The "voice of the customer" exercise is a useful tool in ensuring that changes will delight the customer.

Accomplishment #5: Maintained a 100% Inventory Inspection Frequency

A. What was achieved?

Bureau of Sanitarian Services
(Center for Community Preparedness and Health Protection)

For the Fiscal Year 2015-2016 the Field Staff Sanitarians successfully maintained a 100% inventory inspection frequency. In other words, all inspections were completed on time per the recommendation of the Food & Drug Administration.

B. Why is this success significant?

This success is significant because all LDH-permitted retail food establishments and facilities are monitored and provided oversight to ensure food safety and decrease imminent health risks. By completing inspections as recommended by the Food & Drug Administration using the frequency guidance for each risk category, the risk to the public for food borne illnesses is minimized.

C. Who benefits and how?

The 24 million citizens and visitors to the State benefit from this oversight and monitoring. The routine and frequent inspections are expected to decrease the number of critical food safety violations in a food preparation establishment that can cause foodborne illness and death.

D. How was the accomplishment achieved?

This was accomplished using an electronic scheduler that was developed to assist inspectors by automatically scheduling the next inspection as the frequency is dictated by the risk category assigned to the establishment. The scheduler ensures that the Field

Sanitarian is targeting the highest priority work, according to the risk and frequency guidelines built into the system.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes. The Retail Food Program prevents and minimizes food-borne disease outbreaks through consulting, monitoring, issuance of permits and regulation of food establishments and the standardization of licensed sanitarians. OPH has two special priorities and three goals this accomplishment addresses: Health Information, Technology, Infrastructure, Integration, and Utilization Priority.

Goal 1: Adopt and maintain a modern IT infrastructure to ensure a well-equipped workforce that has the tools to meet or exceed performance standards and funding requirements.

Goal 2: Leverage health information technology to maximize use and integration of data to drive decision making.

Improved Workforce Development Priority

Goal 1: OPH attracts and retains a competent and diverse staff throughout our workforce to maximize productivity, deliver high quality service, and improve outcomes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. Lean management is a best practice and ensures that the right work is being prioritized and monitored for completion. In the event the work lags, the management team is able to quickly adjust resources or reprioritize to ensure the mission of the organization is met. This real time action is dependent on real time data and performance expectations being clearly defined. The scheduler acts as an objective communication tool to ensure the field sanitarians, doing the work, and the state and regional directors, managing the work, are informed and aligned.

Accomplishment #6: Reinstatement of Sanitation Training Program

A. What was achieved?

Bureau of Sanitarian Services
(Center for Community Preparedness and Health Protection)

Reinstatement of the Sanitation Training Program

B. Why is this success significant?

In 1999, a standardized training program was established in Sanitarian Services to provide education, training, experience and mentoring to produce a well-qualified, competent and confident inspector. By 2008, the program had been slowly dismantled

through budget cuts and attrition. As of July 2015, the program no longer existed.

Since 2008 the program has been experiencing the negative ramifications of the demise of the training program. The negative consequences of a sanitarian that is not fully equipped and knowledgeable include higher risk of not citing a critical violation, over citing violations, complaints from the establishments, business owners, and legislators concerning customer service, and lack of work management skills to ensure work is performed timely and accurately. Sanitarian Services Leadership recognized this gap and committed to steps to reinstate the program.

A skilled and experienced Sanitarian is created through education, mentoring and experience. We have been able to employ in- training sanitarians with the appropriate educational background, but have been lacking in providing adequate training and mentoring. While education is important, there is nothing that can compare with good training and mentoring of a new employee. This provides the employee with the skills and confidence to perform their duties in a purposeful and effective manner. Our mission is to protect public health; the better trained our inspectors are, the better they are able to accomplish our mission. In addition, these training experiences can potentially reveal gaps in our policies or areas where additional guidance or clarification is needed from Executive management.

C. Who benefits and how?

All of the 24 million citizens and visitors to our State benefit from a well-trained, competent and confident inspector. The inspectors themselves benefit by becoming a competent, confident and successful employee. Business owners are able to conduct their business in a manner that endorses public health, without delay or cost associated with poor service from OPH Sanitarian Services.

D. How was the accomplishment achieved?
Sanitarian Services Leadership worked as a team to bring all the Field Operations Programs together to develop a current training program that would include several different learning models, including but not limited to: classroom, field exercises, expert presentations, testing, and other interactive activities to promote not only the academic learning but the practical application of skills and knowledge. This year 208 hours were spent to train all 158 Field Operation Sanitarians in Food, Sewage and Institutional work responsibilities. We also developed a week long training for all new hire sanitarians to cover specific areas of food safety, sewage systems, administrative functions and LDH information and policies. This training is now part of the onboarding process for new sanitarians.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?
Yes. Our mission is to protect public health and by providing training, education, and mentoring. We are poised, more now than ever, to perform efficient and effective inspections that serve to accomplish that mission. This accomplishment contributed to the success of the following specific strategic plan goals:

Health Information, Technology, Infrastructure, Integration, and Utilization Priority

Goal 1: Adopt and maintain a modern IT infrastructure to ensure a well-equipped workforce that has the tools to meet or exceed performance standards and funding requirements.

Goal 2: Leverage health information technology to maximize use and integration of data to drive decision making.

Improved Workforce Development Priority

Goal 1: OPH attracts and retains a competent and diverse staff throughout our workforce to maximize productivity, deliver high quality service, and improve outcomes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. A well balanced and robust training program is always a Best Management Practice.

Accomplishment #7: Grant Management

A. What was achieved?

Public Health Emergency Preparedness Cooperative Agreement and Ebola Grant (PHEP) Compliance (Bureau of Community Preparedness)

The Bureau was successful in the overall management of the Public Health Emergency Preparedness Grant ($8,899,256) and the Ebola Grant ($2,008,700) by maintaining compliance with federal mandates. The federal funding is used to support the state's overall public health preparedness efforts that include the Strategic National Stockpile Program, Health Alert Network, Workforce Development, Volunteer Management, Emergency Inventory Management, Emergency Operations, Community Preparedness and Recovery, Training and Exercise Program, and efforts to decrease the likelihood of a LA citizen contracting Ebola through education and proper maintenance and use of Personal Protective Equipment (PPE).

B. Why is this success significant?

Success in this area is significant because it serves a federal benchmark of the state's overall readiness for public health emergencies. Louisiana's efforts in emergency preparedness are trend setting and is seen once again by the Advanced level achieved in the ORR process. Louisiana ranks 3rd in the nation in Emergency Preparedness and has had special visits from high ranking officials from the CDC to brief them on our best practices.

C. Who benefits and how?

The successful compliance of the deliverables of these grants will be felt by the agency, program, stakeholders, and the general public.

D. How was the accomplishment achieved?

Both grant compliances were achieved through staff who have aggressively sought to review, understand and prepare grants for the state for the purposes of community preparedness during times of a CBRNE event.

E. Does this accomplishment contribute to the success of your strategic plan/business plan?

Yes. Community Preparedness (Capability #1 of the PHEP grant) is one of the federal government's "Big Bets" in Emergency Preparedness.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. This effort took coordination and cooperation between local, regional, and state entities as well as the private sector to accomplish. This accomplishment contributed to the success of the following specific strategic plan goals:

Improved Financial Stability priority

Goal 1: Increase financial stability by more efficient utilization of resources and increased revenue.

Accomplishment #8: Project Public Health Ready

Bureau of Community Preparedness

A. What was achieved?

Facilitated the Project Public Health Ready (PPHR) Application and Recognition process for the New Orleans Health Department (Bureau of Community Preparedness)

The Bureau of Community Preparedness diligently worked with the New Orleans Department of Health and subject matter experts throughout LDH to develop, complete and submit strong applications for the National Association of County and City Health Officials (NACCHO) PPHR. New Orleans Health Department is now PPHR recognized. The PPHR criteria includes the most current federal preparedness initiatives which are divided into three goals: all-hazard preparedness planning, workforce capacity development, and demonstration of readiness through exercises or real world response.

B. Why is this success significant?

Success in this area is significant because it demonstrates that the health department was able to successfully meet a standard of rigorous requirements in the areas of all-hazard preparedness planning, workforce capacity development, and demonstration of readiness through exercises or real world response.

C. Who benefits and how?

The citizens of Region 1 in particular the Orleans Parish benefit as well as visitors, businesses, and community partners.

D. How was the accomplishment achieved?

The accomplishment was achieved through relationships and collaboration with agency officials, community partners and stakeholders within the Region and State. These relationships are critical to leveraging expedient preparedness resources.

E. Does this accomplishment contribute to the success of your strategic plan/business plan?

Yes. This accomplishment was a “first” in the future process of the entire state meeting the requirements to be Public Health Ready. This accomplishment contributed to the success of the following specific strategic plan goals:

Meaningful Internal and External Collaboration priority

Goal 1: Operate as a cross-functional, cohesive agency throughout all programs, services and regions, while being reliable and responsive and meeting national standards.

Goals 2: OPH is valued as a leader in public health in Louisiana and facilitates partnerships for the alignment of efforts and overall impact on health and wellness of individuals and communities.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. Public Health Ready is a benchmark that aims to protect the public's health and increase the public health infrastructure by equipping local health departments with sustainable tools to plan, train, and exercise using a continuous improvement model.

Accomplishment #9: Implementation of Electronic Vital Record Amendment Portal

A. What was achieved?

Bureau of Vital Records and Statistics, Center for OPH Operations

An online service for requesting and processing paperwork for legal record amendments was designed and implemented for public use. This allows customers to interface with Vital Records electronically when attempting to make changes to an existing vital record or when attempting to establish certain delayed registration. Customers are able to securely upload their documentation and have it pre-approved or provided with additional information regarding what will be needed via email.

B. Why is this success significant?

This allows customers to save days or even weeks throughout the record amendment process by eliminating the need for mail correspondence as they supply the documentation that is required by law to amend a birth record. The electronic format also enhances communication regarding specific document requirements. Vital Records staff are able to process more requests with increased ease of organization through the online portal system.

C. Who benefits and how?

The amendment portal benefits customers and Vital Records staff equally. Customers are able to confidently follow the process of establishing a record amendment without the need to wait for mail processing times. Vital Records staff are able to process cases much more efficiently and with the benefit of electronic organization of materials and cases.

D. How was the accomplishment achieved?

Vital Records worked with longtime third party partner VitalChek to implement a portal that would interface with the customer while seamlessly integrating into Louisiana's existing LEERS software to create cases for Vital Records staff to work.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Using existing LEERS infrastructure to find additional benefit to the public while maximizing efficient use of state resources supports the Vital Records' strategic plan of fully utilizing the benefits of an electronic records system for all business uses. This accomplishment contributed to the success of the following specific strategic plan goals:

Health Information, Technology, Infrastructure, Integration, and Utilization Priority

Goal 1: Adopt and maintain a modern IT infrastructure to ensure a well-equipped workforce that has the tools to meet or exceed performance standards and funding requirements.

Goal 2: Leverage health information technology to maximize use and integration of data to drive decision making.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. The implementation of the LEERS amendment portal represents state governmental resources leveraging appropriate opportunities in the private sector to find optimal benefit between the vendor, the customer, and the state agency to further the ultimate goal of providing quality customer service.

Accomplishment #10: Refinement of Electronic Health Records

A. What was achieved?

Refinement of Electronic Health Records (EHR) in Parish Health Units (PHU) (Bureau of Health Informatics)

Through the implementation of the EHR, Health Informatics has worked to refine the system to support the clinical needs of the patients and tailor workflows that align with the programmatic needs of the provided services. This continued refinement has allowed for oversight related to clinical delivery and billing. Health Informatics intends to leverage this system in way that improves clinic quality, alignment with clinical recommendations, and the identification of best practices.

B. Why is this success significant?

The ongoing maintenance and refinement of the system is vital in improving the efficiency and delivery of services, but it has a direct effect on clinical outcomes. This improvement in clinical outcomes is accomplished through clinical standards and ongoing improvement through data-driven decision making. In addition, improved workflows can allow for improved documentation that can have a direct impact on billing of clinical services.

C. Who benefits and how?

First, the patients served within the health units stand to benefit from improved processes and quality. The impact will not only be clinically, but also related to their experience with the clinic. It is important that the patients feel they are receive safe, efficacious care each time they visit the health units.

Second, the staff benefit from these improvements by having improved workflows that make it easier to do their jobs. In addition, they will be able to focus more attention on the patient once the tool is effectively implemented for their clinical needs.

D. How was the accomplishment achieved?

The accomplishment was achieved through the development of interdisciplinary teams and the identification of clinical champions. This allowed for users and clinical programs to determine barriers and define more standardized approaches to deliver care. This will be an ongoing process that will require continued participation from these teams.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes. This accomplishment directly contributes to the plan through the following specific strategic plan goals:

Health Information, Technology, Infrastructure, Integration, and Utilization Priority

Goal 1: Adopt and maintain a modern IT infrastructure to ensure a well-equipped

workforce that has the tools to meet or exceed performance standards and funding requirements.

Goal 2: Leverage health information technology to maximize use and integration of data to drive decision making.

In addition, this ongoing system improvement/evolution serves the patients in the Parish Health Units through the improvement of care delivery and quality. The revenue generation improvements will directly affect financial stability. Improved Financial Stability priority Goal 1: Increase financial stability by more efficient utilization of resources and increased revenue.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. This project demonstrates a wide range of collaboration between multiple Programs and Offices, bringing an improvement to all of them.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

Please provide a brief analysis of the overall status of your strategic progress. What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

BUREAU OF FAMILY HEALTH

Three main elements to the OPH-Bureau of Family Health Reproductive Health Program plan: 1) Maximize the quality, efficiency, and use of OPH clinical reproductive health services; 2) Lead a fruitful Reproductive Health Quality Collaborative to increase the capacity of community primary care settings (e.g. Federally Qualified Health Centers (FQHCs) to implement quality reproductive health services; 3) Maximize enrollment in the state's coverage options for family planning services.

IMMUNIZATION

Yes, the LOPH Immunization Program is on target to achieve program goals and objectives. Strategies include vaccine provision, assessment of both vaccination rates and practices, quality assurance, and technology to ensure providers and parents can participate in the "on time" vaccination of children. We expect by investing in these strategies, we will see an overall increase in our vaccination rates within 3-5 years.

VITAL RECORDS AND STATISTICS

Vital Records achievements during the previous fiscal year align with the goal to improve customer service timeliness and experience through the online vital records

amendment portal. In addition, the portal represents a step toward the goal of greater efficiency and reduced manual processes for vital record processing.

INFECTIOUS DISEASE EPIDEMIOLOGY
The overall timeliness and progress toward accomplishment of results targeted in IDEpi's goals and objectives meet the goals. The IT strategy used has been very effective and sustainable. All progress has been achieved with the existing staff of the section.

CENTER FOR COMMUNITY PREPAREDNESS
Louisiana's emergency preparedness efforts contribute to the overall success of the agency's core function of emergency preparedness. Louisiana's efforts in emergency preparedness are considered best practices and have been spotlighted in CDC's *Public Health Preparedness: Strengthening the Nation's Emergency Response State by State and Trust for America's: Ready or Not? Protecting the Public from Diseases, Disasters and Bioterrorism Report.* The department's all-hazards preparedness approach to disasters has been tested through many exercises and real-world events.

Once tested, the agency reviews, reevaluates and updates plans according to those lessons learned and national standards. This process has proven effective in moving the state towards being a leader in emergency preparedness planning and response.

It should be noted that the American College of Emergency Physicians report released in January 2014 ranked Louisiana 3rd in Disaster Preparedness. Louisiana was seen as having strong plans and protocols to serve medical fragile patients as well as above average rates of nurses who received emergency training. Further, in the Preparedness Report Released in January 2015 Louisiana met all indicators in the following:

- Laboratories: Biological and Chemical
- Response Readiness: Emergency Operations Coordination
- Administrative Preparedness

BUREAU OF PRIMARY CARE AND RURAL HEALTH, Community and Rural Health Clinic Development
The BPCRH provides a large amount of hands-on technical assistance from the beginning thoughts of practice development in rural areas to sustainability support for RHCs after they are developed. Typically RHC development takes one to one and a half years to develop in Louisiana. The BPCRH provides regulatory knowledge, connections to needed programs, and other services required during RHC development. Timeliness of these services depends on many factors including health standards staffing, CMS regulations, and follow through of providers.

Where are you making significant progress?

Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

LABORATORY
Replacement of staff lost due to laboratory relocation and consolidation is occurring

at an accelerated rate due to LSS Program and engagement of all parties in the process.

INFECTIOUS DISEASE EPIDEMIOLOGY
Very significant progress has been made due to utilizing simple information technology to simplify the process of acquiring, evaluating and sharing data. Progress is expected to continue by continuously monitoring the process.

IMMUNIZATION
Using technology and community partnerships, the Louisiana OPH Immunization Program has increased reminder recall efforts from once or twice a year to monthly. This is a partnership between the State, the Immunization Registry, and community advocates who all bring resources to the table to make our Reminder Recall effort successful.

This is not a one-time gain. Monthly Reminder Recall will continue to improve Louisiana vaccination rates in the future. The OPH Immunization Program also plans to expand the program to other age groups to achieve overall high vaccination rates.

BUREAU OF FAMILY HEALTH (BFH)
The Bureau of Family Health, Reproductive Health Program (RHP) is making significant progress in setting standards for quality clinical care. Updating clinical protocols according to national guidelines for evidence-based care has modernized the array of services available through Parish Health Units (PHUs). BFH RHP has tapped into a variety of national expertise and brought technical assistance and training opportunities to Louisiana, including technical assistance from the University of California – San Francisco (UCSF) to provide Long-Acting Reversible Contraceptive (LARC) Trainings with PHUs in September 2015, a cost analysis project with National Family Planning and Reproductive Health Association (NFPRHA), and an outreach and marketing project with the Family Planning National Training Centers (FPNTC). BFH RHP has also participated in a variety of learning collaboratives and communities, such as the Centers for Disease Control (CDC) 6|18 Initiative, ASTHO LARC Learning Community, and Office of Population Affairs (OPA) Performance Measurement Learning Collaborative, as well as Zika response meetings hosted by OPA and CDC. By proactively seeking out training and technical assistance opportunities the BFH RHP has been able to make significant progress not only in improving PHU services, but also in developing new approaches to improving access and quality of reproductive health outside of the Title X network through provider outreach and training, policy interventions, quality improvement work, and more. The Bureau of Family Health RHP has made significant progress in addressing payment barriers to the provision of contraceptive services in Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) settings by working closely with LDH Medicaid to complete a fiscal analysis for a rule change allowing for long-acting reversible contraceptive devices and procedures to be carved out from the prospective payment system (PPS) encounter rate. This rule change has not been made yet, but will be a key step in increasing access to contraception.

OPH-BFH has allocated resources to hire and develop a lean strategic team who

have travelled extensively to work directly with the experts in the field (clinic staff) and get their assistance to refine, improve, and implement the work plan.

HIV/STD
The STD/HIV Program is making substantial progress toward goals related to HIV and syphilis testing, linkage to HIV medical care and timely syphilis treatment, and viral suppression among persons living with HIV. The success of linkage-to-care efforts has been a result of successful competition for federal grant funds, the strong data collection and management practices regarding surveillance data, and careful, compassionate engagement of persons with HIV and syphilis.

Where are you experiencing a significant lack of progress? If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

- Is the lack of progress due to budget or other constraint?
- Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.

2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

BUREAU OF FAMILY HEALTH

- Progress towards realizing productivity and efficiency goals has been slower than anticipated.
- Expertise related to practice management is not fully and cohesively integrated into the OPH organizational structure
- Efforts to improve quality and productivity related to OPH clinical services is not operating from a common plan.
- Limited investment in staff to manage clinical revenue processes. Although the new department established in OPH, as well as having an EHR, have increased capacity in this area, the full possibility of revenue generation and increased sustainability has not been realized.
- The current PHU staffing mix (type, number, and location) and skills requires change in order to achieve desired quality and efficiency of the OPH clinical care system.
- Other public health priorities, such as emergency response, may be a competing priority with clinical services or clinical quality improvement activities
- With regard to increasing access to reproductive health services in other settings (FQHCs and RHCs), barriers inherent in existing payment models and financing mechanisms have proved challenging and complicated to work through.

Has your department revised its strategic plan to build on your successes and address shortfalls?

☒ No. If not, why not?

OPH did not revise its strategic plan in FY 2015, but is laying the groundwork for the development of the new five-year strategic plan that is due on June 30, 2016.

How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation? Use as much space as needed to explain fully.

On a Department-wide level, Performance Based Budgeting activities (including, but not limited to, strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. Recommendations are made directly to the Assistant Secretaries or the Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

The formulation of the OPH strategic plan adheres to management strategies implemented by the Executive Management Team. These strategies, at a minimum, include:

- **Training:** Ongoing training is provided to ensure staff develops the necessary skills to understand and apply the concepts of the OPH strategic plan.
- **Input:** Gathering input from all levels of the agency's functional areas. Discussions are conducted with Team Leaders and participants representing functional areas essential to support agency priorities.
- **Communication:** Receiving and sending information at the central office.
- **Performance measurement:** Formulation of objectives that are specific, measurable, attainable, results oriented and time-bound. Performance indicators are formulated to ensure monitoring of progress in goal/objective attainment.
- **Evaluation:** The Strategic Plan will be revised, as warranted, to reflect fiscal, managerial and programmatic changes. These revisions will be conducted using the same strategies as the original plan, as warranted. Plan revisions will utilize strategies that are pertinent to the task at hand.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

None.

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   5. How long has the problem or issue existed?
   6. What are the causes of the problem or issue? How do you know?
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☐ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   4. Are corrective actions underway?
      a. If so:
         - What is the expected time frame for corrective actions to be implemented and improvements to occur?
         - How much progress has been made and how much additional progress is needed?

b. If not:
   - Why has no action been taken regarding this recommendation?
   - What are the obstacles preventing or delaying corrective actions?
   - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of financing for any additional funds.
      - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal Audit**
The Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste & abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

Internal Audit also provides management with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

Within OPH, the internal audit process is a systematic, objective appraisal of the operations and controls within OPH to ensure the reliability and integrity of information and data; Compliance with office policies and procedures; safeguarding of our assets; economical and efficient use of resources; and the accomplishment of established objectives and goals for operations and programs.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**

The Louisiana Department of Health (LDH) has a designated Audit Coordinator for financial audits. The LDH Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

☒ **Policy, research, planning, and/or quality assurance functions in-house**
Through the policy review functions and in-house quality improvement projects have all been used to evaluate program efficiency and effectiveness. Ex: OPH has completed an agency wide policy review. The review process revolved around a needs assessment that ultimately sought to determine whether a given policy should be rescinded, retained, retained but revised, or consolidated with another policy and/or recast as an alternative type of guidance.

☒ **Policy, research, planning, and/or quality assurance functions by contract**
Through external contracts, the Lean and Six Sigma methodologies have been employed to evaluate program efficiency and effectiveness. The Lean methodology relies on a collaborative team effort to improve performance by systematically removing waste. Six Sigma is a disciplined, data-driven approach and methodology for eliminating defects (driving toward six standard deviations between the mean and the nearest specification limit) in any process.

☒ **Program evaluation by in-house staff**
OPH programs internal staff uses innovation and sound program design and the use of performance and evaluation data for continuous improvement. OPH program managers assess the value and impact of their work by asking questions, consultation with partners and stakeholders, and obtain feedback. They then use the information collected to improve the program.

Ex: HIV/STD Targeted Evaluation Plan and methodology.

☒ **Program evaluation by contract**
OPH programs utilize external bodies to evaluate program implementation, effectiveness, accountability, and outcomes. Ex. Lean Six Sigma

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory Notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

☒ **In-house performance accountability system or process**
The OPH internal performance management system ensures that progress is being made toward agency goals by systematically collecting and analyzing data to track results and to identify opportunities and targets for improvement. Agency leadership is engaged in setting standards, goals, targets, and communication of expectation. Ex. OPH dashboard

☒ **Benchmarking for Best Management Practices**
OPH is serious about improving performance, financial and otherwise, and continually search for better practices by maintaining relationships with national, state, and local partners/stakeholders; involvement in national, state, and local organizations.

☒ **Performance-based contracting (including contract monitoring)**
All OPH contracts contain requirements of performance based monitoring. The performance based contracting is results-oriented contracting that focuses on the outputs, quality, or outcomes that may tie at least a portion of the contractor's payment, contract extensions, or contract renewals to the achievement of specific, measurable performance standards and requirements. These contracts may include both monetary and non-monetary incentives and disincentives.

☒ **Peer review**
OPH engages in the quality control process of peer review whereby work is evaluated by staff members who are recognized experts in an appropriate field.

☒ **Accreditation review**
OPH engages in the quality control process of peer review whereby work is evaluated by staff members who are recognized experts in an appropriate field.

☒ **Customer/stakeholder feedback**

Customer/stakeholder feedback informs and guides our agency/program decision making by way of needs assessments, focus groups, satisfaction surveys, Voice of the customer processes.

☐ **Other (please specify):**

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☒ Yes. Proceed to Section C
☐ below. No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

BUREAU OF FAMILY HEALTH

Targeted Chart Review

1. Quarterly audits with central office review
2. Chart reviews are a standard quality assurance practice in direct service
3. Review tool designed by program which is commensurate with industry standards and reflects Quality Family Planning (QFP) Guidelines
4. Staff costs – Nurse Consultant time and field staff time. No cost for the report itself
5. Top Opportunities for Improvement Noted:
    1. All documents which required signature and dates completed
    2. Visit Type documented
    3. Any required referral & follow-up documented
    4. Most current forms used
    5. Medicaid eligibility verification document available from date of visit (if appropriate)

6. Major Recommendations - All areas have implemented corrective actions to correct and monitor these activities. All indicators have demonstrated steady improvement each quarter.
7. Action taken in response to the report or evaluation - Nurse Consultant provided regional technical assistance to all regions regarding results and corrective action plan.
8. Availability – electronic version
9. Contact person for more information, including
   Name: Gail Gibson
   Title: OPH BFH Nurse Consultant
   Agency & Program: OPH
   Telephone: 504-568-3504
   E-mail: gail.gibson@la.gov

Clinic Flow Analysis

1. Automated quarterly reports provided to field staff by BFH RHP
2. Clinic flow analyses are a standard quality improvement practice in direct service and are a cornerstone of the program's goal to improve productivity and patient experience
3. Review tool designed by program which is commensurate with industry standards
4. Staff costs – Nurse Consultant time, CQI Coordinator time, and field staff time. No cost for the report itself
5. Top Opportunities for Improvement Noted: The data collected in these analyses show a need to continue monitoring and improving clinic flow in order to increase productivity and patient experience.
6. Major Recommendations - The bottlenecks and opportunities for improvement included:
   1. Staff utilization (esp. RN & support staff)
   2. Space utilization (includes both use and availability of space for clinic)
   3. Scheduling
   4. Registration process
7. Action taken in response to the report or evaluation - Nurse Consultant provided regional technical assistance to all regions regarding results and corrective action plan.
8. Availability –electronic version
9. Contact person for more information, including
   Name: Gail Gibson
   Title: BFH Nurse Consultant
   Agency & Program: OPH
   Telephone: 504-568-3504
   E-mail: gail.gibson@la.gov

In addition to the reports above, an annual comprehensive site assessment is completed in the fall according to the federal Title X quality assurance tool.

HIV/STD

1. Title of Report or Program Evaluation: 2016 Targeted Evaluation Plan (TEP)
2. Date completed: January - December 2016 (in progress)
3. Subject or purpose and reason for initiation of the analysis or evaluation: The purpose of the 2016 STD/HIV Program (SHP) TEP was to evaluate the effectiveness of the program's implementation of nucleic acid amplification tests (NAATs) for the detection of rectal and pharyngeal gonorrhea and chlamydia (GC/CT) in the sixty-three (63) parish health units (PHUs) providing STD services throughout the state.
4. Methodology used for analysis or evaluation:
   Four (4) PHUs were selected as pilot sites to implement rectal and pharyngeal testing. Staff were trained and the Louisiana state lab completed validation activities to process rectal and pharyngeal NAAT specimens. Rectal and pharyngeal testing began at these pilot sites in February, 2016, with anticipation to expand to all PHUs by December 31, 2016. This project was evaluated based on the following: 1) the number of pilot and non-pilot PHU clinical staff trained, 2) the number of pilot and non-pilot PHUs successfully implementing rectal and pharyngeal GC/CT testing, 3) the number of rectal and pharyngeal GC/CT samples collected, 4) the number of positive rectal and pharyngeal tests detected, and 5) the number of individuals with positive rectal and pharyngeal GC/CT tests that had negative urine, urethral, or cervical GC/CT at the same visit.
5. Cost (allocation of in-house resources or purchase price): As of August 11, 2016, approximately $15,756 (testing/lab processing costs)
6. Major Findings and Conclusions:
   As of August 11, 2016, 1,313 rectal and pharyngeal tests had been successfully collected and tested at the pilot sites. There were 78 positive GC detected and 42 positive CT detected using this method of testing. Of the individuals testing positive with rectal and pharyngeal GC/CT testing, 42 cases of GC and 23 cases of CT would have been missed if rectal and/or pharyngeal testing had not been done. Among these individuals testing positive, a higher positivity rate was noted in rectal vs. pharyngeal testing and there was more positivity in males compared to females tested.
7. Major Recommendations: Based on the results of this TEP, it is recommended that rectal and pharyngeal testing be offered at PHUs to clients reporting sexual exposure at these sites. There is conclusive evidence of GC and CT infections that may be undetected, undiagnosed, and left untreated without this method of testing available.
8. Action taken in response to the report or evaluation: Based on the successful implementation and significant findings of this TEP, SHP has requested additional state general funding to expand the availability of rectal and pharyngeal testing at all PHUs providing STD services in the state. SHP is also working with the Medicaid program to explore the feasibility of reimbursement for this type of additional testing across the state.
9. Availability (hard copy, electronic file, website): hard copy or electronic file
10. Contact person for more information:
    Name: DeAnn Gruber
    Title: Director, Bureau of Infectious Diseases

Agency & Program: Louisiana Department of Health - Office of Public Health, STD/HIV Program
Telephone: (504) 568-7474
E-mail: deann.gruber@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
330 Office of Behavioral Health

Department Head: **Rebekah E. Gee MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Assistant Secretary: **James Hussey, MD**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

The Office of Behavioral Health (OBH) achieved six major accomplishments during the fiscal year under review: (1) integration of specialized behavioral health services into Healthy Louisiana; (2) implementation of the Louisiana Care Authorization Management System (LaCAMS) for the uninsured; (3) general accomplishments related to the Coordinated System of Care (CSoC); (4) OBH systems development and expansion of data collection and archiving capabilities; (5) expanding the use of evidence-based programs in the treatment of individuals with early serious mental illness and a first episode psychosis; and (6) advancements in the area of the prevention and treatment related to opioid use.

Accomplishment #1: Integration of Specialized Behavioral Health Services into Medicaid's Managed Care System, Healthy Louisiana

A. What was achieved?

In November 2014, LDH announced its plan to change the way Medicaid members get behavioral health services (mental health and substance use treatment). Beginning Dec. 1, 2015, LDH integrated behavioral health care into the existing physical health managed care network, then called Bayou Health, now known as Healthy Louisiana. All Louisiana Medicaid members now receive their behavioral health services through integrated managed care in one of the five Healthy Louisiana Plans.

B. Why is this success significant?

Integrating management and services of physical health and behavioral health is an extremely important concept and a national trend. People with serious mental illness (SMI) have disproportionately high rates of mortality from the preventable conditions that are among the leading causes of death in the general population, including cardiovascular and pulmonary disease. People with SMI also have higher rates of modifiable risk factors for these conditions, such as smoking and obesity. They experience higher rates of homelessness, poverty and other causes of vulnerability. They also face symptoms associated with SMI that impair compliance and self-care, such as disorganized thought and decreased motivation. According to the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project report, "Three of the top 10 diagnoses for hospital stays for Medicaid super-utilizers were mental and behavioral health conditions. Mood disorders, schizophrenia and other psychotic disorders, and alcohol-related disorders were the first, second, and sixth most common reasons for hospitalization, respectively, for Medicaid super utilizers. These data indicate how vital it is that Louisiana move toward integrated care in order to prevent unnecessary, high-cost hospitalization through the coordination of care. Despite the high rate of substance use comorbidities that are also prevalent among people with SMI, the mental health and substance use systems are often entirely separate, and both are segregated from the physical health system. To improve outcomes, Louisiana joined many other states and providers in moving toward the integration of behavioral and medical health care. Integration can lead to fewer readmissions and lower costs, as well as improved health outcomes for members.

C. Who benefits and how?

Enrolled members of the Louisiana Medicaid program suffering (or with the potential to suffer) from behavioral health challenges will benefit. The best possible outcomes are achieved when the care of the whole patient is effectively managed. By coordinating primary care and behavioral healthcare, providers will be able to look at the whole person, identifying behavioral health issues that need treatment and helping to prevent problems before they occur. Behavioral health services include treatment and prevention for both mental health and substance use disorders.

D. How was accomplishment achieved?

LDH took a thoughtful and diverse approach to integrating services. A combination of thorough member and provider outreach was conducted and described below.

LDH created an Integration Advisory Group by gathering a group of key stakeholders from various provider types, advocates, and consumers of services to contribute toward the planning for integration of behavioral health services into Healthy Louisiana. The Integration Advisory Group met on January 30th, February 20th, and March 20th of 2015 to respond to and make recommendations relative to a set of specific questions posed by LDH in preparation for drafting the integration contract amendments for the existing physical health plans.

LDH provided training resources to assist providers with the process of transitioning from one managed care organized solely delivering behavioral health services to five managed care organizations. Three times a week noon provider calls were established for LDH staff to directly answer provider's questions, concerns and complaints.

LDH commissioned a third party vendor to conduct Focus Groups and Surveys for both Recipients and Providers. Seven focus groups were conducted around the state consisting of Louisiana Medicaid enrollees receiving services (or their children who are receiving services) to inform what concerns exist about transition, areas of interest and members understanding of the transition.

LDH published informational bulletins and health plan advisories as guiding documents and further clarifications for providers and health plans on the transitions and specifics of the services.

LDH held 10 in person informational sessions around the state for advocates, members and providers. Several facilitated integration summits were hosted at LDH on feelings around integration, including a separate round table discussion member focus group with only members, or family members of people receiving services and advocates.

FAQ were published on the LDH website. These questions were from the perspectives of both providers and members. A special email address was established on the LDH website for provider or member complaints and questions.

E. Does this accomplishment contribute to the success of your strategic plan?

Yes, the integration initiative has been a running theme throughout OBH and LDH's guiding documents. Several objectives in the strategic plan are based on completion of the integrated management model. Goal I in the strategic plan focuses on serving children and adults with extensive behavioral health needs by leading the transition to managed care (formerly known as the Louisiana Behavioral Health Partnership) and ensuring full compliance and quality/outcomes of services provided for the duration of its

contract with the statewide managed care vendor. While integrated care was not anticipated at the time of drafting of the past strategic plan, there was a focus on implementing managed care in general. Integration of services takes managed care to the next level of achievement.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. LDH's well-rounded approach to educating providers and members through multiple avenues and mediums on the transition may be a best practice.

Accomplishment #2: Implementation of the Louisiana Care Authorization Management System (LaCAMS) for the Uninsured

A. What was achieved?

The development of a system to provide medical and clinical necessity determinations for mental health and substance use disorder clients was achieved.

A Request for Proposals (RFP) was advertised to solicit vendors interested in serving as an administrative services organization (ASO) for the uninsured population. There were no vendors who submitted a proposal to perform this service. Therefore, the decision was made to develop a mechanism to address this issue within OBH. Identified as the Louisiana Care Authorization Management System (LaCAMS), OBH staff has successfully managed the program since February 2016.

B. Why is this success significant?

OBH accepted the responsibility of this task due to the urgent need for un-insured residents of Louisiana to receive the same service provided to eligible Medicaid recipients through the Healthy Louisiana plans. The OBH staff that assisted with the creation of LaCAMS, including Executive Management, provided weekly calls with the providers and the Local Governing Entities (LGE) staff. These calls addressed any issues with authorization dates, criteria for approvals and overall process questions. These calls took place for several months and were discontinued when the process was stable. The feedback given by the providers and LGEs helped make the approval process a smooth transition from Magellan, the previous contractor, contributing to the overall success of the process. Throughout the transition, the clients received services without interruptions or breaks in coverage.

C. Who benefits and how?

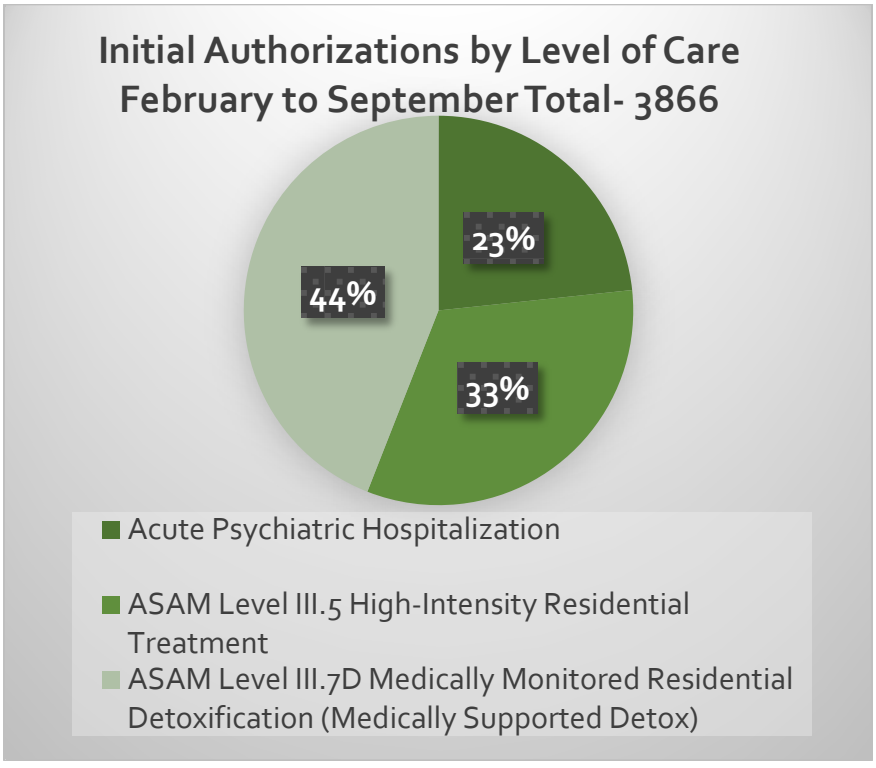
Any interruption could potentially have had a negative impact on the indigent population who are depending on the authorized services. As well, the LGEs who were the service providers, were recipient of clinical services to help them expedite service delivery for

clients who could not afford to pay.

The LGEs benefit from this service, through the clinical consultation that the LaCAMS staff is able to provide and the efficient handling of the service calls to assist with immediate placement of clients for their care. Additionally, there were no funds available for the LGEs to create new positions to handle these calls. With the authorizations being handled in-house, this was a big cost savings to OBH Headquarters. Additionally, the authorization process has assisted OBH to further develop the working relationships with community providers who make LaCAMS referrals.

D. How was the accomplishment achieved?

The system that was put into place allowed the state to prevent the disruption of services for clients who were in need of initial authorizations for specific levels of care. The program has staff who manage the in-coming calls on a real-time basis during the week and refers to on-site care managers who work closely with the providers. Since the inception of the process for LaCAMS (February, 2016) a total of 3866 authorizations have been completed. Medically Monitored Residential Detoxification services represents the highest number of authorizations to date. Without these services being available and closely monitored, clients would have very limited options for receiving this type of care.



E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes. The uninsured population receives the same consideration for services as the Medicaid population. Providing authorizations through the LaCAMS program serves the goal of ensuring behavioral health services for the indigent population, while using medical necessity as a guideline for authorizations.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

No. The best practice being used by LaCAMS is a practice that local providers and managed care companies use to determine medical and clinical necessity for placement into treatment. The accomplishment is that the service is provided by a state agency.

Accomplishment #3: Continued statewide implementation and refinement of the Coordinated System of Care (CSoC) for children and youth

A. What was achieved?

FY 2016, was the first full year of statewide implementation of CSoC which began in 2012 as the result of a Centers for Medicare and Medicaid Services (CMS) waiver. Throughout the course of the fiscal year, enrollment numbers continued to increase. At the close of FY 2015, the enrollment in CSoC stood at 1,641 children and youth. As of June 30, 2016, 2,217 children and youth were enrolled in CSoC, with a maximum enrollment of 2,400 children and youth at any given time. 7,675 children, youth and their families have been served in CSoC from implementation in March of 2012 to the end of FY 2016.

B. Why is this success significant?

The CSoC implementation results from a multi-year collaborative planning effort between LDH, the Department of Children and Family Services (DCFS), the Office of Juvenile Justice (OJJ) and the Department of Education (DOE). CSoC uses an evidence-informed approach to support young people with significant behavioral health challenges who are in or at risk of out-of-home placement to remain with their families, in the community, which research demonstrates results in more positive outcomes over time. It also makes better use of state resources, by leveraging additional Medicaid funding, to enhance available services for high-risk children and youth within the State of Louisiana. The successful implementation of CSoC is particularly significant because it represents true partnership across the child-serving state agencies to ensure that youth who are at highest risk and in greatest need, and their families, receive timely access to appropriate services and supports.

C. Who benefits and how?

CSoC serves children and youth aged 0 through 21 with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out-of-home placement. Children and youth with complex behavioral health challenges and their families benefit from a coordinated approach to care. New behavioral health services that were previously not part of the service array in Louisiana are now available as part of the Medicaid State Plan Amendments and Waivers that support CSoC. These new services include an organized planning process for young people with significant emotional and behavioral challenges, called Wraparound, which helps to ensure that individual and family needs are identified and addressed with an array of specialized services and natural supports. These efforts are proven to result in a reduced need for costlier out-of-home placement options. Families and young people also benefit from other specialized services which include: Parent Support and Training, Youth Support and Training, Crisis Stabilization, Independent Living/Skills Building and Short-term Respite.

D. How was the accomplishment achieved?

During 2009, LDH, DCFS, OJJ and DOE began collaboration on a multi-year planning process to develop a common vision and goals to improve behavioral health outcomes and reduce out-of-home placements among children and youth with significant mental health and/or substance use disorders. During the planning phase, eighteen (18) stakeholder workgroups participated in designing the initial CSoC. Subsequently, Governor Bobby Jindal issued Executive Order BJ-2001-5 on March 3, 2011, to formally establish a policy-level Governance Board with members including leadership of LDH, DCFS, OJJ and DOE, a representative of the Governor's office, two family representatives, an advocate representative, and a youth representative. This board is charged with providing oversight to the development and implementation of CSoC. Each of the four collaborating agencies (LDH, DCFS, OJJ and DOE) also assigned staff to form a unified CSoC team, housed at OBH headquarters, to participate in development of the Medicaid State Plan Amendments and Waivers necessary to support service development, enhancement, and support and guidance for CSoC implementation. OBH used a community driven process to select initial regions for statewide implementation.

To support the availability of CSoC in each region, a community process selected a Wraparound Agency (WAA) that would serve as the locus for treatment and care coordination for every enrolled youth.

During FY2016:

- As of June 30, 2016 CSoC has served 7,675 youth and children, with the fiscal year end enrollment of 2,217 children/youth. Fiscal year end enrollment ranges from 123 to 411 per region as follows: Greater New Orleans (411), Baton Rouge (322) Covington (271), Thibodaux (250), Lafayette (123), Lake Charles (141), Alexandria (179), Shreveport (219), and Monroe (301).
- The CSoC team composed of a CSoC Director with over twelve years of experience

leading system of care efforts, a Family Lead and two additional team members provided guidance and technical assistance to the WAAs and Family Support Organization (FSO) in each region in order to ensure that the appropriate certification and training requirements were completed.

- The CSoC team was also responsible for the oversight and monitoring of quality measures and waiver performance measures.
- Quarterly meetings of the CSoC Governance Board were held to review progress, provide guidance, and establish policy as needed. Governor John Bel Edwards continued the CSoC Governance Board with signing of a new Executive Order JBE 16-31 on June 28, 2016.
- The Statewide Coordinating Council (SCC) provided community level input to the CSoC Governance Board.
- WAAs in each region ensured that youth with complex needs benefited from a coordinated care planning process that produced a single plan of care that was created with the youth, their family, natural supports and all agencies and providers involved with the youth and family.
- OBH collaborated with the WAAs and the FSO to ensure in state sustainability of training for staff. These agencies have taken responsibility for in-house staff training. In previous fiscal years, OBH contacted with an external consultant for training.
- During FY16, the CSoC Team contracted with two national wraparound coaching trainers to support the on-going skill development of the WAA supervisor/coaches. The goal of this training is to assure these supervisors /coaches have the knowledge, skills and experience needed to coach their wraparound facilitators to provide high fidelity wraparound.
- Outcomes data reflects positive trends for the children, youth and families enrolled in CSoC.
  - An analysis of the global Child and Adolescent Needs and Strengths (CANS) Assessment scores beginning at initial intake and then at discharge for 230 children/youth discharged in the last quarter of FY16 revealed that 74.78% of children and youth demonstrated improved functioning in their homes and communities. Although this sample size is small, the results are promising and during FY16, a requirement for tracking this data for all children/youth was implemented.
  - The CANS school module which evaluates school functioning showed the following results:
    - 73.24% showed improved school function
    - 26.29% showed improved school attendance
    - 65.26% showed improved school behavior
  - The use of Home and Community Based Services, one of the factors that contributes to children and youth being able to stay successfully in their homes and communities, has shown a steady increase since implementation of CSoC.
  - In addition, the number of children, youth and families connecting to natural supports evidenced by their participation on child and family (CFT) teams continues to grow. In the last quarter of FY 16, the WAAs report that 84.9% of their Child and Family Teams had a natural and/or informal member (this number excludes family members living with the child).

- One of the primary goals of CSoC is to maintain children and youth safely in their homes and communities. In the last quarter of FY 16, the living situation at discharge from CSoC for 89.7 % of children and youth was to a home and community based setting.
- Another goal of CSoC is to decrease the use of inpatient psychiatric hospitalization. Data from Medicaid claims during the period of January 1, 2016 – March 31, 2016 revealed a decrease in utilization of inpatient psychiatric hospitalization for CSoC youth who were enrolled in CSoC for more than 90 days. Review included use of inpatient psychiatric hospitalization 90 days **before enrollment i**n CSoC and 90 days' **post discharge** from CSoC. The data reveals a 59.5% decrease in the use of inpatient psychiatric hospitalization in the 90 days post discharge from CSoC.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes. The CSoC initiative was included in the OBH business and strategic plans as a top priority.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes. There are several aspects of the CSoC initiative that represent best practices from a national perspective:

The formation of the Governance Board through Executive Order No. BJ 2011-5 and continuance through JBE 16-31 represents a significant accomplishment. Across the country, there are very few states that have a Governor endorsed and supported CSoC initiative and policy-making Board. This collaboration and breaking down of historic silos between agencies has resulted in improved services for children and families and for enhanced collaboration across multiple efforts and initiatives.

The CSoC Governance Board consists of leadership from all four child and family serving agencies: LDH, OJJ, DCFS and DOE. This collaboration increases understanding and familiarity of the mandates and requirements of each state agency and helps all members develop a deeper understanding and appreciation for each child-serving agency. In addition, the Board has two family members of children with emotional and/or behavioral challenges, as well as a mental health advocate, ensuring that CSoC at all levels is promoting family voice, choice and access.

Developing Medicaid state plan amendments and waivers and leveraging braided funding across child-serving state agencies to support service development and expansion is an example of best practices in the system of care field. This also represents a higher level of coordination across agencies which results in less fragmentation, duplication and redundancy.

Accomplishment #4: OBH Systems Development, Data Collection and Archiving

A. What was achieved?

Integration of physical and behavioral health and the change from a single statewide health plan for behavioral health services through Magellan to five Healthy Louisiana plans for Medicaid members brought several system changes. These changes included the decommissioning of Magellan's statewide electronic health record (EHR), Clinical Advisor, on March 1, 2016. During this project, the OBH worked to maintain the continuity of data flow used for state and federal block grant reporting. Previously, most LGEs and OBH relied on Clinical Advisor to collect and transfer client-level data to the OBH data warehouse. This data is used for reporting which is mandated for the sustainment of block grant funds. Most LGEs did not have their own individually purchased electronic health record and thus began the process of contracting with an EHR vendor of their choice. To ensure minimal data disruption, OBH began working on standardized methodology for LGEs to send data directly to the OBH data warehouse. This methodology includes a data validation process by which certain data elements must be present for data to enter into the warehouse.

In addition, OBH worked with an archiving vendor and the LGE stakeholder team to archive data from Clinical Advisor. This data is currently available for LGEs to use for historic records requests.

Post integration, OBH also began completing authorizations for services to the uninsured population served under the LGEs. OBH designed the data capture and authorization system in-house. The system collects data necessary for a care manager to make an authorization of services and supports communication with the provider regarding their authorizations.

B. Why is this success significant?

This success represents data loss prevention and bringing data sources together to maintain complete and accurate state and federal reporting. In addition, the authorization system development and the new methodology for bringing data into the OBH data warehouse illustrates OBH's responsiveness to the changing environment for operational continuity.

C. Who benefits and how?

OBH, LGEs and providers subcontracted with the LGE benefit, in that OBH is able to complete reporting required by the Substance Use Prevention and Treatment Block Grant (SAPT) and Mental Health Block Grant (CMHS) as we begin to get more data from the LGEs. In addition, LGEs are able to provide court-ordered documents in an acceptable format upon request using the data archival system, and OBH is able to complete in-house authorization tracking. All systems and data activities benefit providers and clients who utilize block grant funds.

D. How was the accomplishment achieved?

Prior to Clinical Advisor decommissioning, the OBH team met with each LGE to survey their needs and plans for moving to their own electronic medical record solution. During these conversations, OBH offered varying levels of technical assistance. OBH hosted an EHR vendor fair which allowed providers to connect with various types of EHR technology. In addition, OBH redeveloped a manual for distribution to LGEs which named require data sets for consistency across all regions and reflected the new strategy of extracting data from several EHR vendors rather than a statewide EHR.

As part of the process for sending data to OBH, LGEs completed crosswalks of data which illustrated how they would transform information from their customized EHR into the format needed for the OBH data warehouse. As crosswalks are approved, OBH is working with LGEs to put data quality improvement activities into action. As the LGEs begin sending data, test files are run through validations to ensure correct formatting and the presence of all required data. Once the LGE successfully tests, they send semi-monthly data to the OBH data warehouse.

Parallel to these activities, OBH worked with a vendor that specialized in data archiving to extract data from the Clinical Advisor database. These steps included project planning, gathering business requirements, configuring the application, testing, and deploying with a group of LGE stakeholders that served as subject matter experts on their data. Upon system implementation, OBH retains a management role over the system.

Finally, in implementing the authorization management system, OBH utilized a current platform to build a new system at no cost to the agency. Technical staff worked with programmatic staff to ensure workflows were in place that captured the authorization information necessary for a care manager to make an informed decision. In turn, these workflows were programmed into the system. OBH maintains the system in house.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes, per the Program A mission, these activities uphold and improve the “supportive functions necessary to adhere to state and federal funding requirements…and support the provision of services not in the scope of the Statewide Management Organization (SMO).” This includes successfully archiving data from Clinical Advisor to prevent data loss, successfully supporting the continuity of data collection through the development of transfer methodology for data from EHR vendors to the OBH data warehouse (state and federal reporting), and successfully implementing an authorization system that supports the provision of services not under the scope of the SMO.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes, from a team and resource perspective, the success of this project represents best management practices in utilizing available resources. OBH used a current system to

build a new authorization system. OBH also utilized the talent of its current analyst team and its current OBH data warehouse contractor to begin capture of data from several sources and ensure minimum disruption to data flow. In addition, the successful implementation of the archival solution for Clinical Advisor data represents the important best management practice of managing an application implementation while maintaining open communication and channels for stakeholders to give feedback into the project without extending past the scope of work for the project.

Accomplishment #5: Expanding the Use of Evidence-Based Programs in the treatment of Individuals with Early Serious Mental Illness and a First Episode Psychosis

A. What was achieved?

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress through its FFY 2016 Omnibus bill, Public Law 114-113, to set aside 10 percent of the CMHS allocation for each state to support evidence-based programs that provide treatment for those with early serious mental illness (SMI) and a first episode psychosis (FEP) – an increase from the previous 5% set aside that was mandated in FFY 2014. To address this need, Louisiana built upon the activities achieved in prior fiscal years which included the completion of a needs assessment, funding for Peer Support Specialists (PSS) within each of the 10 LGEs and the completion of broad-based training throughout the state on the tenants of service provision to individuals experiencing early SMI including psychosis. Through these activities, Louisiana was able to improve service provision to individuals with new psychosis while identifying and training those areas of the state with the interest and capacity to implement a full-fidelity FEP program. Three LGEs, Jefferson Parish Human Services Authority (JPHSA), Capital Area Human Services District (CAHSD), and Florida Parishes Human Services Authority (FPHSA) made the commitment to implement FEP programs utilizing the NAVIGATE model (formerly RAISE). Staff within these LGEs have participated in the NAVIGATE training and have begun the process of identifying and serving individuals through their clinics. Continued support for their efforts are provided by the NAVIGATE consultants through monthly conference calls.

Training – In previous years, a training series was developed in conjunction with consultants from Rutgers University who had conducted the Needs Assessment. A series of webinars and face to face trainings were initially provided to LGES throughout the state on topics related to FEP. While 164 individuals participated in the initial phase of training, this number rose to 468 including the second phase of implementation which included additional training by staff from Rutgers University and NAVIGATE-specific training. These trainings conducted during the second phase of implementation included the following:

- Psychiatric Rehabilitation Readiness Determination Profile (PRRDP) Training – The PRRDP is an instrument developed by Rutgers University that assists in

understanding the factors impacting the change process. Knowledge of this process enables providers to more effectively work with the individuals they serve. This day-long, face to face training was held in 3 areas of the state; 68 individuals participated in this training including PSS, LGE staff, and Assertive Community Treatment (ACT) providers.

- NAVIGATE Team Overview – This webinar provided an overview to individuals throughout the state on the NAVIGATE model of treatment for individuals experiencing FEP; 105 individuals participated in this training including PSS, LGE and hospital clinicians as well as private providers.

- FEP Prescriber Training – This face to face training provided an overview of best prescriptive practices for individuals experiencing FEP. The training was held in 5 areas of the state and attended by a total of 107 behavioral health clinicians from the LGE and hospital systems as well as various private providers.

- 2 day NAVIGATE Training – This training was targeted towards those staff members working within an LGE-sponsored NAVIGATE team. Through this process, specific sessions were provided to those individuals functioning as Team Leaders/Family Education Clinicians, Individual Resiliency Trainers, and Supported Employment and Education Specialists. LGE staff, administrators and PSS participated for a total attendance of 24 individuals.

NAVIGATE Programs – Three LGEs, (JPHSA, CAHSD, and FPHSA) have made the commitment to implement FEP programs using the NAVIGATE model of Coordinated Specialty Care (CSC), an evidence based approach to the treatment of individuals with FEP. These programs have begun the process of identifying and enrolling clients within their programs. As they are in the preliminary stages of start-up, ongoing consultative calls are occurring with the NAVIGATE trainers during which time issues related to program implementation and service provision can be discussed.

Peer Support – The LGEs have continued to dedicate funding within their CMHS allocation for FEP programming. With these funds, LGEs have been able to employ PSS to work with individuals with FEP.

B. Why is this success significant?

Through this plan, the state has been successful in providing the foundation for FEP implementation to LGEs throughout the state. Three LGEs were identified and trained in the NAVIGATE model of CSC which is an evidenced based model for serving individuals with FEP.

C. Who benefits and how?

Research on FEP programs have shown that that treating people with first episode psychosis with a team-based, coordinated specialty care approach produces better clinical

and functional outcomes than typical community care. These outcomes include higher retention in treatment and length of service, improvement in symptoms, interpersonal relationships, quality of life, and involvement in work and school. These outcomes are most effective for people who receive care soon after psychotic symptoms begin.

D. How was the accomplishment achieved?

The ongoing success and accomplishments of implementing the FEP program has been achieved through the training of staff throughout the system of care and inclusion of LGEs in the development of the program.

E. Does this accomplishment contribute to the success of your strategic plan?

Yes, the implementation of FEP programming supports the OBH Business Plan through the continued refinement and improvement of the system of care and promotion of an evidence based practice.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, this accomplishment represents a best management practice which should be shared for the purpose of further collaboration with those entities who serve the same population.

Accomplishment #6: Enactment of HCR 113 and ACT 370 of the 2016 Regular Legislative Session Relative to Addressing the Opioid Epidemic in Louisiana

A. What was achieved?

Governor Edwards enacted HCR 113 during the 2016 Regular Legislative session creating an interagency group to address the Opioid epidemic in Louisiana. The group is co-chaired by Eric Torres (State Board of Medical Examiners) and Malcolm Broussard (LA State Board of Pharmacy) who are assigned the task of reviewing relevant areas that should be addressed and assigning members to specific areas wherein change is needed to address Substance Use Disorder treatment. In addition, the goal of the Commission is to have a response to the Governor by February 2017.

Additionally, under ACT 370, a pharmacist may dispense Naloxone or another opioid antagonist utilizing a non-patient specific standing order as provided for in emergency rulemaking promulgated by the Louisiana State Board of Pharmacy. Naloxone is a medication approved by the Food and Drug Administration (FDA) to prevent overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.

B. Why is this significant?

According to the Centers for Disease Control and Prevention (CDC), there are currently 118 prescriptions per 100 people in Louisiana, and Louisiana has the 8th highest ratio of prescription painkillers per person. Accidental overdose deaths are now the leading cause of accidental death in the United States, exceeding even motor vehicle accidents among people ages 25 to 64.

C. Who benefits and how?

Persons with Substance Use Disorder and their families/person affected are anticipated to benefit from this legislation in terms of the number of lives saved.

D. How was the accomplishment achieved?

This accomplishment was achieved with the 2016 Regular Legislative Session, during which OBH worked with the Office of the Governor, the Office of the Secretary and the State Board of Pharmacy to provide subject matter expertise, research, information, and testimony to assist in coordinated efforts to address the Opioid epidemic.

E. Does this accomplishment contribute to the success of your strategic plan?

As per the strategic plan, OBH's mission is to lead the effort to build and provide a comprehensive, integrated, person-centered system of prevention and treatment services that promote recovery and resilience for all citizens of Louisiana. OBH assures public behavioral health services are accessible, have a positive impact, are culturally and clinically competent and are delivered in partnership with all stakeholders. This legislation supports OBH’s mission promoting recovery by requiring victims of overdose to be connected with treatment after administration of emergency care, and working to prevent future relapses and overdose situations.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

The agency does not have programmatic oversight of the opioid Commission; however, subject matter experts are assigned to work groups and are involved to assist with the final product.

In reference to ACT 370, there is a national trend of pharmacies offering naloxone in an outpatient setting (without bringing in a prescription from a physician), as evidenced with CVS stores - no prescription needed in Ohio, Arkansas, California, Minnesota, Mississippi, Montana, New Jersey, North Dakota, Pennsylvania, South Carolina, Tennessee, Utah, and Wisconsin; as well as Walgreens stores – slated to be available in many states without a prescription by the end of 2016.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

Yes. Significant progress has been experienced in two distinct areas: quality management of specialized behavioral health services provided through managed care; and the development of network access monitoring and compliance tools for specialized behavioral health providers.

Significant Progress #1: Development of a Comprehensive Quality Management Reporting Package, Processes and Policies for the Review, Validation and Dissemination of Reported Data Related to Contract Compliance

A. Where are you making significant progress?

OBH has made tremendous strides in the quality management of specialized behavioral health services since the implementation of managed care in 2012 through the use of clearly defined performance metrics which are tied to program goals, federal waiver requirements, and key contractual standards; development of standard operating procedures to aid in subject matter review of performance metrics; transition from single subject matter expert review of performance metrics to group review to ensure all perspectives are accounted for and to utilize the unique skills and expertise of subject matter experts; validation of reports to ensure managed care plans are adhering to the defined reporting methodology (e.g., numerator, denominator, sample size); move toward in-house data collection and reporting; and use of dashboards which are shared with leadership and subject matter experts to focus attention on key metrics and identify areas of growth.

1. To what do you attribute this success?

OBH subject matter experts (SME) were directly responsible for the revamping of the quality management and monitoring process as it relates to the provision of SBHS. The collaboration amongst the SMEs resulted in the identification of reporting needs and barriers, which were then used in the development of a comprehensive reporting package with clearly defined reporting methodology to ensure validity and reliability of data. Subject matter experts continue to collaborate through team review of reports and metrics and participation in quality committees.

Through the integration of specialized behavioral health services into Healthy Louisiana, OBH was able to adopt a number of Healthcare Effectiveness Data and Information Set (HEDIS) measures which allow for performance measurement on important dimensions of care and services, such as monitoring the percentage of individuals with schizophrenia or bipolar who are on antipsychotic medication and had a diabetes screen.

OBH consulted with Medicaid during the development of these reporting tools and policies. OBH also includes Medicaid staff in the review of applicable SBHS reports.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

   Progress is expected to continue as the quality teams develop quality improvement plans on an annual basis, establish quality improvement priorities and activities, monitor progress toward goal attainment on a routine basis, and take action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.

B. Where are you experiencing a significant lack of progress?

   At present there are no areas lacking in progress.

Significant Progress #2: Specialized Behavioral Health Services Provider Network Monitoring

A. Where are you making significant progress?

In preparation for the integration of Specialized Behavioral Health Services (SBHS) into Healthy Louisiana on December 1, 2015, and as a result of the CMS New Medicaid Managed Care Rule focus on States' monitoring of provider network access and sufficiency, LDH-OBH began developing a formal SBHS Provider Network Monitoring Plan in order to assess compliance by the Healthy Louisiana Managed Care Organizations (MCOs) and the CSoC Contractor with network related contract requirements and deliverables inclusive of meeting contractual access standards, appointment availability and network sufficiency for its members. The monitoring plan is a culmination of research performed by OBH into efforts implemented by other States relative to monitoring network access and sufficiency in managed care environments, anticipated requirements for States associated with monitoring access and sufficiency evidenced in the Medicaid Managed Care Rule, recommendations by the Department of Health and Human Services (HHS), Office of Inspector General (OIG) via their *State Standards for Access to Care in Medicaid Managed Care* study, and the unique makeup of Louisiana's specialized behavioral health workforce and services. The SBHS Provider Network Monitoring Plan was finalized in May 2016 and includes implementing administrative desk reviews, on-site visits and "secret shopper" calls at both the MCO/Contractor-level and the provider level, performed by OBH staff utilizing monitoring tools specifically designed to assess compliance in meeting LDH standards for provider networks in the delivery of SBHS.

Monitoring additionally includes review of network reports submitted by the MCOs and the CSoC Contractor. OBH developed report templates for the managed care entities to populate and submit for the purpose of analyzing, tracking and trending data. This data

will allow LDH to assess the sufficiency through reports associated with adequacy of SBHS provider types, access to levels of care, prescriber sufficiency, cultural competency, provider density, and GeoAccess mapping.

LDH-OBH has identified Access to Behavioral Health & Clinical Workforce Development as a Transformational Priority of the Office over the next five years. The SBHS Provider Network Monitoring Plan through its processes and implementation will yield data and analysis that the OBH Transformational Priority Committee on Access can use to determine SBHS gaps or shortages in the State. This information will assist the Committee in determining where to devote resources for the further development of the SBHS workforce. Preliminary strategies involve enhancing behavioral health service offerings through the use of evidenced-based practices (EBPs), assisting in the further development of integrated care, and utilization of trained, certified peer specialists in the workforce.

1. To what do you attribute this success?

   Even prior to integrating specialized behavioral health service delivery into Healthy Louisiana and the passing of the new Medicaid Managed Care Rule, OBH began researching steps other states were taking to monitor access to care for their members. This is due in part to emerging publications and studies evaluating States' effectiveness in not only monitoring access to care, but in determining appropriate access standards given the unique geography of states and other variables including rural and urban population density. Getting ahead of the game allowed OBH the time needed to develop a thoughtful plan, processes and monitoring tools before CMS required it.

   OBH spearheaded and facilitated numerous workgroup meetings this year with Medicaid and LDH Health Standards Section (HSS) for the purpose of collaborating on these efforts inclusive of gaining provider stakeholder input from a sample of high volume SBHS providers, e.g. LGEs and Mental Health Rehabilitation providers. This group additionally garnered feedback from the Department of Children and Family Services (DCFS) and the Institute for Family Development relative to providers of their Homebuilders evidenced-based practice program. The feedback gained during these workgroup sessions provided relevant information for further developing network monitoring processes and tools. In addition, these collaborative efforts have been successful in developing processes for joint review of network reports, analysis of MCO/CSoC Contractor network data, and findings of gaps in access to certain SBHS levels of care. This has allowed and will continue to allow for joint recommendation by OBH and Medicaid Behavioral Health in recommending corrective action of the managed care entities to address access and sufficiency gaps and shortages.

   OBH continued collaborations in developing its Monitoring Plan. OBH staff worked closely with Medicaid to determine appropriate behavioral health

access standards including time and distance criteria for behavioral health specialists, which was incorporated into the Healthy Louisiana RFP Contract Amendment, the CSoC Statement of Work, as well as the OBH Network Monitoring Plan. Additional collaboration has included joint meetings with the LDH HSS to learn more about regulatory processes in place for providers inclusive of promulgation of the Behavioral Health Service Provider License Rule in September 2015. This collaboration has allowed LDH Offices to develop complementary processes for monitoring SBHS providers, Healthy Louisiana MCOs and the CSoC Contractor.

At the end of FY 16, OBH initiated a process for testing the monitoring tools developed for different SBHS provider types (mental health, addiction, community-based, residential) for the purposes of assessing compliance with provider qualifications as well as meeting standards on access and appointment availability. OBH staff requested assistance from several high volume providers in volunteering their facilities for on-site visits for the purpose of testing the tools. This process will allow OBH to tweak monitoring tools to capture additional important information as well as to make the process of gathering information from providers more efficient.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

   Progress is expected to continue through full implementation of the SBHS Provider Network Monitoring Plan beginning January 2017, and throughout the Healthy Louisiana MCO and CSoC contract terms. As a result of the efforts to date, LDH, Medicaid and OBH have established effective working relationships. This continued collaboration is expected to produce efficient mechanisms for jointly monitoring SBHS network access and sufficiency as well as for recommending future development of the SBHS workforce and its offerings.

B. Where are you experiencing a significant lack of progress?

Efforts to acquire the necessary staff resources for the purposes of adequate monitoring of access to SBHS and sufficiency of the SBHS network of providers throughout the State have stalled due to budgetary concerns. Our expectation is that with the continued growing emphasis on State monitoring of access to healthcare by CMS and other national bodies, additional resources will be made available for monitoring managed care entities and providers for this purpose.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☒ Yes. If so, what adjustments have been made and how will they address the situation?

☐ No. If not, why not?

With the revision of OBH's Strategic Plan, which took place in FY16, the Office has placed a focus on a series of transformational priorities which focus on improving both the quality and availability of specialized behavioral health services for the populations we serve. OBH will continue to develop our quality management and network adequacy monitoring policies and programs to ensure we not only identify areas of need, but also have the tools necessary to exact change in those areas.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**

On a Department-wide level, Performance Based Budgeting activities (including, but not limited to, strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. Recommendations are made directly to the Assistant Secretaries or the Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

Within OBH, agency-level goals and objectives included in the strategic plan are further translated into comprehensive work plans which describe the action steps that will be taken to accomplish the objective, associated timelines, and person responsible for each action step; these work plans are reviewed and updated on a regular basis by gathering input from all levels of the agency's functional areas. Discussions are conducted with Team Leaders and participants representing functional areas essential to support agency priorities. Further, agency goals and objectives are embedded in the performance planning and evaluation process for employees.

III. What significant department management or operational problems or issues exist?

Operational Problem or Issue #1: <u>Lack of Access for Children Requiring a Residential Level of Care, yet have specialized needs</u>

A. Problem/Issue Description:

1. What is the nature of the problem or issue?

   OBH has identified problems with the ability of the provider network at the Psychiatric Residential Facility (PRTF) level of care to serve youth with particular needs. Access to PRTF services is often limited based on PRTF providers rejecting referrals for youth based on the youth's aggressive behaviors, multiple unsuccessful residential treatment episodes, or co-occurring developmental disability or borderline intellectual functioning.

2. Is the problem or issue affecting the progress of your strategic plan?

   Yes, in that this issue impacts OBH's ability to ensure a comprehensive service array for children, youth and families that appropriately addresses their behavioral health needs.

3. What organizational unit in the department is experiencing the problem or issue?

   Our Children's Services and Workforce Development units.

4. Who else is affected by the problem?

   The youth with particular presenting problems and their families, OBH's sister child-serving agencies, as well as the MCOs responsible for care management of these youth.

5. How long has the problem or issue existed?

   Access issues related to PRTF have existed to some degree since these facilities first began to operate in Louisiana in 2012. Contributing to this issue, has been the reduction of other sources of appropriate residential and inpatient settings for youth, which formally accommodated children with co-occurring disorders. A reduction in the utilization of private contractors by sister agencies, has also contributed to an increase in the prevalence of these access issues.

6. What are the causes of the problem or issue?

   Current PRTF providers may reject these referrals based on:
   - Provider concern that their clinical programming is not currently suited to serve youth with cognitive impairments, or is not adapted to serve youth with autism spectrum needs, or
   - Provider concern that the provider cannot adequately serve/protect currently-served youth if they accept the referral for a youth presenting

with aggressive behaviors, or
- Provider concern that based on previous unsuccessful episodes in residential care, the youth cannot be expected to benefit from additional PRTF treatment.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

   These identified problems in accessing PRTF services for youth with particular presenting problems can result in serious difficulties for our sister child-serving agencies, as these youths often touch the Department of Children and Family Services (DCFS), Office of Juvenile Justice (OJJ), and/or the Office for Citizens with Developmental Disabilities (OCDD) systems. Additionally, this lack of local access may also result in the need to seek out-of-state residential treatment for youth, which is not ideal given that this reduces the ability to maintain and strengthen family connections during the youth's time in residential treatment. Finally, lack of access to this level of care also results in concerns expressed by juvenile judges, who have sometimes court-ordered treatment and/or placed youth in OBH custody in an attempt to assure access to medically necessary services

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

   ☐ No. If not, skip questions 2-5 below.
   ☒ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   OBH seeks to address this access issue while aligning with best practices that correlate with long-term, sustainable outcomes for youth and families. This means that OBH concurrently seeks to:
   - Increase appropriate access **without** driving a significant net increase in the use of (or beds for) residential treatment for youth. Behavioral health residential treatment for children is the most expensive and most restrictive intervention for youth, and we continue to focus our efforts on reducing its necessity by increasing access to and the effectiveness of home- and community-based services for youth.
   - Increase the use of best practices that correlate with long-term, sustainable outcomes for youth and families. These include shifting from coercive to collaborative approaches (resulting in a reduction in restraints and seclusions), family-driven and youth-guided care, making the family and the post-

discharge placement the center of treatment from day one, and strong connections with family and community both during and after the residential treatment episode.

- Increase the measurement of outcomes and movement towards value-based behavioral healthcare, such that we can monitor and incentivize the value being produced by behavioral health residential treatment for youth in terms of its ability to produce long-term, sustainable outcomes for youth and families.
- OBH, in collaboration with the Office for Citizens with Developmental Disabilities (OCDD), have agreed to offer clinical program assessment and consultation to PRTFs, so as to increase PRTF capacity to serve both aggressive and intellectually disabled youth, who are currently having problems accessing this level of care.

3. Has this recommendation been made in previous management and program analysis reports?

   This specific issue has not been identified in previous AMPAR submissions.

4. Are corrective actions underway?

   Yes. OBH, through our Strategic Plan, has identified objectives including engaging residential facilities in initial and ongoing training and technical assistance opportunities, in conjunction with the MCOs, Medicaid and child serving agencies such as DCFS and OJJ. In addition, we are currently reviewing current contract standards in order to identify areas that would benefit from the implementation of more stringent and specific requirements as to the necessity of contracting with in state residential facilities that can accommodate children with an identified need that currently impacts their placement.

   As we progress with our plans for reform, OBH also intends to lead the implementation of a workgroup to review the policies applicable to residential treatment facilities in order to identify areas where improvements can be made that support value based healthcare that aligns with best practices.

5. Do corrective actions carry a cost?

   ☒ No. If not, please explain.
   ☐ Yes. If so, what investment is required to resolve the problem or issue?

   While resources will obviously be required in order to ensure appropriate local access for children in need of residential treatment, OBH's intention is to attempt to address the needs with available resources within the Department and amongst stakeholders.

Operational Problem or Issue #2: Maximizing Current Resources for Hospital Based Treatment Program

A. Problem/Issue Description:

1. What is the nature of the problem or issue?

   Eastern Louisiana Mental Health System (ELMHS) is the only one of the state's freestanding psychiatric facilities that includes a division solely designated for the provision of inpatient psychiatric treatment to forensic clients who are deemed Not Guilty By Reason of Insanity (NGBRI) or who are ordered to receive hospital-based competency restoration services, and includes the Forensic, Acute/Civil Intermediate, and Hospital-Affiliated Community Services divisions. ELMHS must have the ability to provide placement for those individuals who are NGBRI, Incompetent to Proceed to Trial (IPT), Judicial Civil (JC), and Unable to be Restored to Competence (648B), or who are court-ordered to receive competency restoration services. The intent being to provide placement of all clients in the most cost-effective and compliant manner and allowing clients to flow throughout the system as they move toward recovery. Without increased capacity, LDH, along with the State of Louisiana as a whole, will more than likely b under constant threat of civil rights litigation.

2. Is the problem or issue affecting the progress of your strategic plan?

   Yes, compliance with forensic consent decree factors is included in the current OBH Strategic Plan.

3. What organizational unit in the department is experiencing the problem or issue?

   ELMHS and those fiscal and forensic staff located within OBH Headquarters.

4. Who else is affected by the problem?

   The clients, their families, the community, the Department of Corrections, as well as the State as a whole, are impacted by this issue.

5. How long has the problem or issue existed?

   Overall forensic admissions have increased by 30% from FY 2012 to FY 2015, competency restoration admissions have increased by 41%, and all others have increased by 8%. In FY 2015, forensic admissions made up 30% of the total; this trend is expected to continue. The number of admissions for hospital-based competency restoration services has increased by 54.02% from prior to the onset of the federal consent decree of 2010 regarding the

responsibility of LDH for the timely admission of those clients that into effect on July 1, 2011; As of June 23, 2016, there was a waiting list of 10 NGBRI and seven ITP clients for admission to ELMHS. The demand for beds to accommodate judicial admissions is projected to increase by 3-4% each year, from 289 clients in 2016 to 398 clients in 2025. Over the past three years, an average of 24 clients was admitted per month, which exceeded the initial projected demand of 14 clients per month.

6. What are the causes of the problem or issue?

   ELMHS' current resources may not be sufficient to timely admit the client types mentioned above in order to comply with federal law. There are several factors that have impeded the program's ability to effectively move clients throughout the system: the increasing demand for bed placement to accommodate judicial admissions; the majority of civil clients admitted for inpatient psychiatric treatment at ELMHS are indigent, which has resulted in a decrease in Federal Funds and Self-generated Revenues; higher acuity levels of clients who require specialized medical care; and the lack of resources to properly manage and coordinate statewide referrals for intermediate bed placement.

   Beginning in 2015, lawsuits (Cooper and Jackson) were filed by plaintiffs who have either been adjudicated NGBRI or are IPT detainees who have been determined mentally incapable to stand trial. The plaintiffs argued that the state is violating their due process rights, the Americans with Disabilities Act (ADA) and the Rehab Act by not transferring them from jail to ELMHS timely. The lawsuits received a provisional 60-day dismissal by the judge because both LDH and the advocates reached a conceptual agreement to increase the number of available beds for these client types. However, there are several factors that have impeded the program's ability to effectively move clients throughout the system: the increasing demand for bed placement to accommodate judicial admissions; the majority of civil clients admitted for inpatient psychiatric treatment at ELMHS are indigent, which has resulted in a decrease in Federal Funds and Self-generated Revenues; higher acuity levels of clients who require specialized medical care; and the lack of resources to properly manage and coordinate statewide referrals for intermediate bed placement.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

   ELMHS needs additional resources to keep up with the demand for admissions of all legal status types, in order to remain in compliance with the PT Consent Decree requirements, as well as the requirements of the Cooper/Jackson Case.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

☐ No. If not, skip questions 2-5 below.
☒ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

OBH analyzed the current bed and funding structure of the ELMHS system in order to determine the most efficient and cost-effective way to meet the mandates of the agreement with the advocates, and to help insulate LDH and the State from future litigation. The result was a redesign of the system that allowed the agency to maximize all available funding to increase the number of beds at the least cost to the state. The proposed plan consists of two phases: Phase I will result in a net bed increase of 86, which includes expanding civil bed capacity by 40 on the ELMHS Jackson campus that will allow 648B clients who currently reside in forensic beds to be transferred to civil beds, thereby allowing forensic clients that are on the waiting list to be admitted to the hospital. The plan also increases Forensic Supervised Transitional Residential Aftercare (FSTRA) program beds - 26 first-level step-down beds on the ELMHS campus, and 20 second-level beds in the community setting – that will allow forensic clients to transition out of the hospital to make room for those who are on the waiting list. In Phase II, ELMHS projects the need for an additional 60 civil beds and 20 community beds once Phase I is complete.

3. Has this recommendation been made in previous management and program analysis reports?

Yes, this issue was also presented in the FY15 AMPAR submission by OBH.

4. Are corrective actions underway?

Yes. In August 2016 the Joint Legislative Committee on the Budget (JLCB) approved Phase I of the system redesign and expansion to increase beds by 86 and add 76 positions. The hiring process and physical plant modifications started immediately thereafter in order to begin phase-in of the beds. Phase II will be proposed for FY 2019, which will allow OBH time to fully implement Phase I and to collect the necessary data to support Phase II.

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☒ Yes. If so, what investment is required to resolve the problem or issue?

OBH is maximizing all available funding for the purposes of meeting the mandates of the recent settlement to increase the number of available beds for individuals currently in the correction system, and to place them in a timely manner. The total cost for Phase I is $10,553,564, of which, $3,980,804 is SGF and $6,572,760 is federal (UCC/DSH). OBH will maximize DSH/UCC funding on the 40 new civilly-licensed beds as well as on 50 of the current civilly-licensed beds. In addition, ELMHS will utilize 100% SGF to operate the 26 new on-campus FSTRA beds and 20 new FSTRA beds in the community. The SGF match required to draw down the additional federal dollars are included within OBH's existing FY 2017 budget. For Phase II, approximately $6M will be requested in IAT/UCC budget authority for the UCC federal portion. ELMHS does not anticipate that additional SGF will be requested for Phase II due to the change in funding source for 648B beds that will now draw UCC/DSH.

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
The Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste & abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

Internal Audit also provides management with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The Louisiana Department of Health (LDH) has a designated Audit Coordinator for financial audits. The LDH Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

☒ Policy, research, planning, and/or quality assurance functions in-house
☒ Policy, research, planning, and/or quality assurance functions by contract
☒ Program evaluation by in-house staff
☒ Program evaluation by contract

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory Notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

☒ In-house performance accountability system or process
☒ Benchmarking for Best Management Practices
☒ Performance-based contracting (including contract monitoring)
☐ Peer review
☒ Accreditation review
☒ Customer/stakeholder feedback
☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☒ Yes. Proceed to Section C below.
☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Prevention Management Information System Reporting on Prevention Services (Quarterly and Annual)

a. *Date completed:* July 1, 2015 – June 30, 2016

b. *Subject / purpose and reason for initiation of the analysis or evaluation:*

OBH is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and

transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the SAPT is the primary funding source for prevention services. It requires 20% of the grant be set aside for primary prevention services. An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report is a continuing process to measure the number of services we provide and the populations that are served.

c. *Methodology used for analysis or evaluation:*

The data in this report is from the Prevention Management Information System (PMIS), the primary reporting system for the SAPT for prevention services.

d. *Cost (allocation of in-house resources or purchase price):*

There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from PMIS to generate this document. Data is entered into PMIS by the LGE prevention staff, their contract providers statewide and OBH staff.

e. *Major Findings and Conclusions:*

During FY 2016, Prevention Services provided evidence-based services to 83,476 enrollees.

FY 2015 block grant funded one-time services provided to the general population reached 3,596,814 participants. This number reflects the number of individuals that are impacted by PSAs, billboards, and other media campaigns. This number included the combined services provided by Prevention Staff and Prevention Contract Providers.

f. *Major Recommendations:*

The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.

g. *Action taken in response to the report or evaluation:*

No actions other than the recommended (above) were pertinent.

h. *Availability (hard copy, electronic file, website):*

The report is distributed via e-mail and is available by hard copy upon request.

i. *Contact Person:*

Dr. Leslie Brougham Freeman
Director of Prevention Services
LA Department of Health
Office of Behavioral Health
Leslie.BroughamFreeman@la.gov
225.342.5705

2. Synar Report: Youth Access to Tobacco in Louisiana

a. *Date completed:* December 31, 2015

b. *Subject / purpose and reason for initiation of the analysis or evaluation:*

OBH conducts this annual Synar Report to examine the current level of accessibility of tobacco products to minors as pursuant to Federal Government guidelines. SAMHSA is the enforcing agency. An amended Synar Regulation, issued by SAMHSA in January 1996, requires each state receiving federal grant funding to conduct annual random, unannounced inspections of retail outlets to assess the extent of tobacco sales to minors.

c. *Methodology used for analysis or evaluation:*

The study design is a cross-sectional survey of compliance, with compliance defined as the refusal to sell tobacco to minors and the prevention of entry of a minor to outlets restricted to youth. A stratified random sample of outlets are identified and surveyed by a team of one youth operative and two adult agents Office of Alcohol and Tobacco Control (OATC). The youth operative attempts to purchase tobacco from unrestricted outlets and tests the access of restricted outlets. The adult agents record characteristics of outlets, inspection events, and outcomes, and cite non-compliant outlets and clerks. Information about outlets, inspectors, and the inspection event are entered into an electronic data system via laptop at the time of inspection.

d. *Cost (allocation of in-house resources or purchase price):*

OBH contracted with OATC to conduct the random, unannounced inspections of tobacco outlets identified by the random sample at a cost of $71,695.00 ($65.00 per compliance check x 1103 checks). The total cost to prepare and complete the Annual Synar Report was $70,000.00.

e. *Major Findings and Conclusions:*

The objective of this study was to estimate the non-compliance rate for

tobacco sales in Louisiana among youth under age 18. Annual targets were established to decrease the state's non-compliance rate to 20% by FY 2002. However, Louisiana achieved 20.3% non-compliance in FY 1999, only two years after the start of the Louisiana Synar Initiative, and three years ahead of the scheduled target date. The current rate of tobacco sales to minors in FY 2016 is 17.6%.

f. *Major Recommendations:*

OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2016 report and will adhere to any future recommendations, as warranted.

g. *Actions taken in response to the report or evaluation:*

An annual report is generated by SAMHSA including a Table listing the Synar Retailer Violations (RVRs). Louisiana was ranked among the top states in compliance, in the FY 2013 report (most recent on file). The SAMHSA report can be viewed at http://beta.samhsa.gov/sites/default/files/synar-annual-report-2013.pdf. Our goal is to continue implementing current strategies since they've proven to be successful.

h. *Availability (hard copy, electronic file, website):*

The FY 2016 Annual Synar Report is available by hardcopy, and may be accessed online at http://new.LDH.louisiana.gov/index.cfm/newsroom/detail/1390.

i. *Contact Person:*

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Director of Prevention Services
LA Department of Health
Office of Behavioral Health
Leslie.BroughamFreeman@la.gov
225.342.5705

3. Louisiana Behavioral Health Partnership (LBHP) Transparency Report (Act 158)

a. *Date completed:*

June 1, 2016

b. Subject or purpose and reason for initiation of the analysis or evaluation:

Act 158 of the 2015 Regular Legislative Session requires LDH to provide transparency relative to Medicaid managed care programs on an annual basis. For FY 2015, this involved the OBH managed contract with Magellan over the LBHP, including the contract close out period of July through November of 2015. The report outlined responses to the requests made by the legislature in Act 158 relative to Magellan's management of care within the LBHP, inclusive of the CSoC.

c. Methodology used for analysis or evaluation:

Act 158 details the types of information and data elements that are to be included in the report. Data was collected using Magellan's electronic health records and claims systems and compiled and checked by OBH for the report. The Department's contractor for encounter validation, Myers and Stauffer, independently reviewed the data submitted by Magellan as a means of third party validation

d. Cost (allocation of in-house resources or purchase price):

In-house Business Intelligence staff were tasked with validation and data mining relative to the production of the report. The SMO also contributed to data reporting as per the requirements and funding allocated through the SMO contract.

e. Major Findings and Conclusions:

The measures included in the report were used to demonstrate that the following outcomes expressed in the legislation were achieved:
1) Continued implementation of CSoC;
2) Improved access, quality and efficiency of behavioral health services;
3) Successful transition to a model of behavioral health in which human service districts or local governing entities (LGEs) deliver care locally;
4) Seamless coordination of behavioral health services with the comprehensive healthcare system without losing attention to the special skills of behavioral health professionals;
5) Advancement of resiliency, recovery and a consumer-focused system of person-centered care; and
6) Implementation of best practices and evidence-based practices that are effective and supported by data collected from measuring outcomes, quality and accountability.

f. Major Recommendations:

Not applicable.

g. Action taken in response to the report or evaluation:

Report distributed to the Senate and House Committees on Health and Welfare and posted to the LDH OBH website.

h. Availability (hard copy, electronic file, website):

Available by electronic file and on the LDH OBH website
http://LDH.louisiana.gov/assets/docs/BehavioralHealth/TransparencyReport2015/LBHPTransparencyReportFY15Closeout.pdf

i. Contact Person:

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225.342.1868

4. SAMHSA Block Grant Annual Reporting (SAPT and CMHS)

a. Date completed:

Louisiana's CMHS and SAPT Behavioral Health reports must be submitted to SAMHSA no later than December 1st of each year. Some components of reporting are completed quarterly with an annual review prior December 1. If OBH misses the statutory date for submitting the reports, it will not receive any federal Block Grant funds for that federal fiscal year.

b. Subject/purpose and reason for initiation of the analysis or evaluation:

Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. 300x-52(a)) requires SAMHSA to determine the extent to which States and Jurisdictions have implemented the State plan for the preceding fiscal year. States and Jurisdictions are required to prepare annual reporting for submission that consists of multiple components which include data submissions, performance indicators and fiscal tables. The annual reporting needs to include the purposes for which the CMHS and SAPT funds were expended, recipients of grant funds, authorized activities funded, and services purchased with such funds. CMHS and SAPT reports are not combined.

c. Methodology used for analysis or evaluation:

OBH Quality staff work in collaboration with OBH analytics, program and

fiscal staff and LGEs in the development of the annual reports. Some data is submitted quarterly. Annual reporting submissions require several months of preparation and typically begins in August of each year.

OBH Analytics staff problem solve, plan, and develop methodologies for data report analysis. OBH Analytics staff analyze performance/outcome data and prepare and disseminate monitoring and performance reports/dashboards. Additionally, they produce standard URS (Uniform Reporting System; Client Level Data Uploads) tables, performance indicators, and reporting tables. In order to complete data based reports, OBH Analytics staff maintain the operation of the OBH Data Warehouse, maintain the OBH Client Level Data Manual, and oversee LGEs' electronic health record data submissions. LGE data submissions are continuous, and are sent to the OBH Data Warehouse on a semi-monthly basis.

Most components of the December 1 reporting are submitted via SAMHSA's online portal, Web Block Grant Application System (WebBGAS). Other submissions are completed through their respective SAMHSA sponsored online portals.

d. Cost (allocation of in-house resources or purchase price):

There is no cost associated with these reports. These reports are generated in-house.

OBH program staff use data from the OBH Data Warehouse to generate client level data based reports.

e. Major Findings and Conclusions:

The primary purpose of the reports are to track and monitor fiscal, program, service and client variables/indicators across time. No major findings/conclusions.

f. Major Recommendations:

No major recommendations.

g. Action taken in response to the report or evaluation:

Data-based decision making relative to programs and services.

h. Availability (hard copy, electronic file, website):

The data is submitted directly into SAMHSA portals. SAMHSA makes the client level data reporting available to the public in PDF format. The Annual

Report from SAMHSA's WebBGAS system is distributed via email to the Louisiana Behavioral Health Advisory Council and upon request.

i. Contact Person:

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5. External Quality Review Technical Report

a. Date completed:

The final report was issued March 2016.

b. Subject or purpose and reason for initiation of the analysis or evaluation:

In order to meet federal requirements, per 42 Code of Federal Regulations (CFR) 438.310-438.364, the Department contracted with Island Peer Review Organization (IPRO) to validate select performance measures, validate performance improvement projects, and conduct a compliance review of the managed care plan's operations in terms of accessibility, timeliness, and quality of services.

c. Methodology used for analysis or evaluation:

Off-site review of member charts, claims data, audit tools, reports, training documentation, policies and procedures.

d. *Cost (allocation of in-house resources or purchase price):*

The compliance review and reporting were completed by IPRO at a cost of $63,907, funded through Medicaid.

e. Major Findings and Conclusions:

The managed care plan's overall compliance rate was 96% considering full and substantial review elements

f. Major Recommendations:

Improve care coordination and access to specialty services, such as psychiatrist and crisis stabilization services.

g. Action taken in response to the report or evaluation:
OBH required the managed care plan to submit a plan for addressing the identified opportunities for improvement as it related to the population and services that would be managed under the new contract. OBH monitors the managed care plan on a routine, ongoing basis to drive performance improvement.

h. Availability (hard copy, electronic file, website):

Hard copy and electronic

i. Contact Person:

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Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
340 Office for Citizens with Developmental Disabilities

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Assistant Secretary: **Mark A. Thomas**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Request for Services Registry - Research/Planning for Prioritization of Waiting List

A. **What was achieved?** Carried over from the prior fiscal year activities, in FY 2015-2016 the Office for Citizens with Developmental Disabilities (OCDD) continued research, design, and implementation activities related to System Transformation in the areas of prioritization of the waiting list and development of a consolidated tiered waiver system.
The current OCDD Request for Services Registry (RFSR) includes individuals who have requested and are waiting for the New Opportunities Waiver (NOW). The RFSR has

remained lengthy despite efforts to periodically fund additional NOW offers since its inception. Stakeholder input requesting that the Office address the lengthy RFSR and legislative requests to address the fiscal sustainability of developmental disability Home and Community-Based Services (HCBS) led to an internal analysis of the OCDD RFSR as part of the OCDD System Transformation Initiative which began in late 2012. Currently, over 14,000 people are on the NOW RFSR. (See Section III: *Unmanageable Number of People on the Request for Services Registry*.) Through this effort, the Office discovered that a third of individuals on the RFSR were already receiving other Medicaid long-term supports/services or other comparable alternatives [e.g., other developmental disability waiver services, Office of Aging and Adult Services (OAAS) waiver services, OCDD State-Funded services, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) personal care services, and/or Long-Term Personal Care Services]. Additionally, over 80% of the individuals were Medicaid eligible and could qualify for in-home supports via the Medicaid State Plan and yet were not accessing them. A survey of a sample of individuals on the RFSR revealed that even though over 95% of the current NOW expenditures are on in-home staff supports, this was not the support most requested or identified as needed.

Based upon results of the RFSR analysis and survey, the OCDD System Transformation Core Stakeholder Group continued to advise the Office and the Louisiana Department of Health (LDH) regarding proposed efforts to address the Request for Services Registry (RFSR). The Core Stakeholder group reviewed the current OCDD process as well as processes in other states. With input from the Core Stakeholder group, OCDD developed the Screening of Urgency of Need (SUN) tool. The SUN tool identifies the supports an individual is currently using and identifies if there are any supports a person needs but is not receiving (unmet needs) at the time. If unmet needs are identified, these needs are categorized in one of the following categories: *emergent* (immediate), *urgent* (clear need within next 90 days to a year), *critical* (anticipated need due to upcoming life changes within next year to two years), or *planning* (anticipated need due to upcoming life changes within the next 2-5 years) needs. This screening tool and process were initiated for individuals who currently receive Supports Waiver and are on the NOW RFSR. Support Coordinators began completing the tool as part of each person's annual planning process, and expected completion for all individuals meeting these criteria is November 2016. Initial data results from this pilot indicate that 77% of individuals screened have no unmet needs identified and 17% of individuals screened have no unmet needs but anticipate needing supports within the next 1 to 5 years.

B. **Why is this success significant?** The new RFSR process will offer a method for a more transparent and streamlined approach to both identify the needs of people who are waiting for services and to help individuals to access supports in the most timely and efficient manner. This will allow for a more responsive system that will be able to provide supports closer to time of need.

C. **Who benefits and how?** Individuals and families will benefit from modifications to the RFSR. Having information about the needs of people who are waiting will allow the Department to make more informed budget requests related to Home and Community-Based Waiver options and will allow for system changes that are both fiscally and

programmatically responsible. The overall system will benefit by aligning needs with availability of supports and by having a consistent waiver process.

D. **How was the accomplishment achieved?** The accomplishment occurred through use of a Core Stakeholder group, analysis of available data for individuals currently on the RFSR, and research into best practices in other states. The pilot screening process for individuals receiving the Supports Waiver and on the NOW RFSR was completed utilizing currently available resources during the annual support planning process.

E. **Does this accomplishment contribute to the success of your strategic plan?** Yes**.** Components are aligned with all six goals of OCDD's strategic plan.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes. The approaches OCDD continues to utilize in tying a comprehensive system analysis to a multi-phase strategic action plan and involving stakeholders and incorporating national best-practice recommendations are consistent with nationally recognized strategies for success in large-scale system transformation.

Accomplishment #2: Resource Center Consolidation

A. **What was achieved?** The OCDD Resource Centers (RCs) were established in 2002 to address insufficient resources and expertise available to families and providers to support people with developmental disabilities. The primary focus of Resource Center activities has been to work with the community service systems to increase capacity in the provision of more evidence-based, effective, person-centered services for people with developmental disabilities in the clinical areas of Behavioral Health Services, Medical Services, Allied Health Services, Dental and Transitional Supports. The OCDD Resource Center serves as a source of training, consultation, and technical assistance to people with developmental disabilities, families, providers, and healthcare providers and provides targeted, time-limited primary services for persons with multi-complex needs, life-threatening conditions, or who pose greater risk to public safety.
OCDD successfully consolidated from four distinct locations within the state by shifting to telework operations with office and fiscal support through local hub locations. This consolidation allowed for **decreased expenditures** previously spent on lease space for the separate Resource Centers, while clinical service efficiency and effectiveness were maintained.

B. **Why is this success significant?** This initiative resulted in a reduction of $1,322,262 ($799,790 SGF-Salaries; $522,472 IAT-Operating Services) in FY 2015-2016 through the consolidation of physical locations, the implementation of telework, and the restructuring of the service delivery model and will keep non-direct service expenses down each year. In the challenging fiscal times Louisiana is experiencing, this consolidation contributed significantly to cost reductions and future cost avoidance while maintaining an important clinical and capacity-building support for individuals with developmental disabilities, their

families, and providers. The physical footprint of the Resource Centers is decreased along with lessened administrative costs.

C. **Who benefits and how?** People with developmental disabilities, their families, and providers benefit from these efforts with the ability to access needed technical assistance, consultation and direct supports without institutionalization. The state benefits via enhanced fiscal efficiencies and maximization of positive outcomes which continue to avoid use of more costly services.

D. **How was the accomplishment achieved?** OCDD moved staff to telework operations and set up hub locations at two Cooperative Endeavor Agreement (CEA) facilities (Evergreen on the former Northlake Supports & Services Center campus and Northwest). Pop-in office locations are provided in the Local Governing Entities (i.e., Human Services Districts/Authorities) offices within the Houma/Thibodeaux, Baton Rouge, and Shreveport areas, as well as a location in Belle Chase on state-owned property.

E. **Does this accomplishment contribute to the success of your strategic plan?** Yes. OCDD has a specific goal in the Strategic Plan relative to supporting people with developmental disabilities to achieve improved outcomes, quality of life, and attain personal goals through the development and provision of capacity-building activities, partnerships, and collaborative relationships. Additionally, OCDD has specific goals and activities within its Strategic Plan that emphasize fiscal efficiencies and accountability.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes, implementation of technology solutions to enhance access and minimize costs in the healthcare arena is a national best practice.

Accomplishment #3: Enhanced Support for Individuals with High-Risk Needs

A. **What was achieved?** OCDD continued implementation of several processes for supporting individuals with high-risk needs including: 1) crisis referral and diversion process; 2) court liaison and evaluation; and 3) local oversight teams.
   1. OCDD continued local partnerships between the OCDD Resource Center and Local Governing Entities (LGEs) for crisis diversion such that fewer crisis referrals are occurring (only 48 referrals in first six months of 2016 compared to 171 in calendar year 2015). Challenges remain with more referrals (63%) from other acute/temporary institutional settings (i.e., psychiatric hospitals, jail, etc.), and increased complexity of needs and supports for participants referred in crisis (i.e., Combination of behavioral and legal needs are the most common referral profile.). The modified process and earlier/more consistent involvement of the Resource Center not only reduced the number of referrals but continue to support a diversion rate around 60%. Diversion activities not only result in avoidance of institutionalization, but also in the ability to receive enhanced

supports needed to remain in the current community living situation for many individuals.

2. With increased referrals involving legal concerns and jail as the noted location at time of referral (i.e., 14-20% of referrals occurred from jails between 2012 and 2014) along with increased requests for Louisiana Department of Health (LDH) to assume custody, OCDD focused Resource Center efforts at partnering with LGEs for court liaison and evaluation. The OCDD Resource Center clinicians now complete all court requested custody evaluations and complete consultations for individuals referred from jails as well as work to develop relationships with court/judicial counterparts. Involvement in these activities continued at the higher rate when comparing 2015 to the preceding two years. Although court involvement and related activities continue to grow in general, results of these efforts have included avoidance of LDH custody for some individuals and avoidance of unnecessary institutionalization for some individuals.
3. Efforts toward assuring that persons with a history of and/or current challenges related to non-consensual sexual behavior (NSB) have access to needed supports were formalized statewide, and Local Oversight Teams were created with membership from the OCDD Resource Centers, LGEs, providers and support coordination. Local Oversight Teams meet routinely and review each identified individual's support plan providing recommendations for any additional actions needed. The following is a summary of outcome data related to this initiative:

    - Local Oversight Teams are currently following 206 individuals statewide with high-risk nonconsensual sexual behavior.
    - Positive outcomes and improved supports occurred for those identified with NSB and ongoing risk needs. Since the initiation of the NSB process, only 23 persons have had a subsequent incident of NSB, and all but three persons had waiver supports at the time of the incident. (The other individual was residing in a community home.) For these persons, not all incidents involved direct contact. Four of the 23 incidents occurred during the most recent quarter (3/18/16-6/16/16). The majority of individuals are able to maintain their community living situation. It should be noted that on average, between 5% and 20% of known adult sex offenders will be re-arrested for a new sex crime within three to six years of follow up [Association for the Treatment of Sexual Abusers (ATSA), 2010].
    - Involvement of the Local Oversight Teams has allowed for enhanced responsiveness in several situations as the individual's NSB-related support needs increased.

B. **Why is this success significant?** These targeted partnerships with the OCDD Resource Center and LGEs continue to result in positive outcomes for individuals supported in one of the above initiatives with fewer individuals necessitating institutional services and an enhancement in supports available to individuals in their current living arrangement. Additionally, avoidance of institutionalization has positive fiscal impacts for the entire system.

C. **Who benefits and how?** People with developmental disabilities, their families, and providers benefit from these efforts with the ability to receive supports without

institutionalization as well as minimization of rights restrictions. The Local Oversight Teams result in enhanced supports for persons with multi-complex needs, or who pose a greater risk to public safety. The activities also further strengthen collaboration between the LGE and OCDD Resource Center local staff to enhance accessibility and maximize coordination of services.

D. **How was the accomplishment achieved?** The OCDD built upon the efforts achieved by the OCDD Resource Center transformation in the last two fiscal years. Resource Center specific points of contact remain in place with the LGEs for specific activities, and direct partner efforts occur now at the local level. OCDD Resource Center staff work in conjunction with the OCDD Central Office Clinical Staff to further inform continued statewide efforts and needs.

E. **Does this accomplishment contribute to the success of your strategic plan?** Yes. OCDD has a specific goal in the Strategic Plan relative to supporting people with developmental disabilities to achieve improved outcomes, quality of life, and attain personal goals through the development and provision of capacity-building activities, partnerships, and collaborative relationships.

F. **Does this accomplishment or its methodology represent a best management practice that should be shared with other executive branch departments or agencies?** Yes. This initiative continues to use existing data to identify gaps within the current developmental disabilities services delivery system in conjunction with a review of national trends and best practices, along with input from internal and external stakeholders, to identify need for system changes.

Accomplishment #4: EarlySteps Expenditure Reduction and Improved System Performance

A. **What was achieved?**
   1. Maintained performance in one of the primary program areas in that 45% of the children exiting EarlySteps improved in their development such that they were functioning at the level of their typical peers at exit of the program.
   2. Continued successful implementation of family cost participation in EarlySteps services. (Families with income above 300% of the Federal Poverty Level contribute to a portion of the cost for some services received and exceeded estimated revenue projected for FY 2015-16 by 27%.)

B. **Why is this success significant?**

   1. One of the stated purposes of the early intervention program is to minimize the potential for developmental delay in young children. This result indicates the benefit of early intervention through its positive impact on a child's development such that children entered early intervention below the level of their same-age peers, but improved their performance to a level at or above their same-age peers.

2. Implementation of cost participation was designed to support the sustainability of the program. In FY 2015-2016, an increased number of children were referred and found eligible for the program. Additional revenue received from family cost participation reduced the additional per child cost to the state by 1.6%

C. **Who benefits and how?**

1. Families and children benefit through the successful development of their children. In addition, another stated purpose of early intervention is to minimize the need for future special education services for children. By attaining developmental milestones, this risk is minimized for a child.

2. Effective service utilization benefits all children in the system by efficiently and effectively designing services, making services more available to everyone who is eligible, and eliminating delivery of unnecessary services. The early intervention system benefits overall in that stable revenue can continue to support the program without further cost containment measures.

D. **How was the accomplishment achieved?**

1. Beginning in 2012-13, EarlySteps developed a system improvement plan to improve child outcomes through team-based supports that are focused on family priorities. Service delivery, focused on these specifically identified family needs to assist both providers and families in targeting support to their children. This focus assists teams in selecting appropriate services and avoiding duplication and over utilization. These activities are continuing and contribute to the ongoing successful implementation.

2. EarlySteps staff utilized the resources of its Central Finance Office (CFO) contractor to develop the cost participation system. The CFO has assisted other states in utilizing the process. Stakeholders were involved regularly in the implementation of the changes through regional meetings and regular updates. Materials were developed to assist in implementation, and reviews of implementation are ongoing.

E. **Does this accomplishment contribute to the success of your strategic plan?**

1. Yes, this accomplishment contributes to Office Goal III (To increase the capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings.) Reaching/exceeding the targets set for this accomplishment demonstrates the benefit of the program in that a significant number of children exiting EarlySteps improved in their development such that they were functioning at the level of their typical peers at exit of the program.

2. Yes, a major focus for EarlySteps is providing quality services and reducing costs. The eligibility change allowed EarlySteps to reduce costs for services. Additional revenue generated from cost participation will support program operations moving forward.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes.

1. The training model used for regional training was based on nationally available content,

which was individualized for EarlySteps. The training included features of Implementation Science, which incorporates follow-up activities to sustain changes in performance.

2. Yes, EarlySteps used the model from other states and worked with the Office of Special Education Programs to accomplish the development and implementation of cost participation.

Accomplishment #5: Expansion of Employment First Foundation Building

A. **What was achieved?** In FY 2015-2016, OCDD expanded foundation building for Louisiana's Employment First Initiative. The following successes were achieved:
- Retained the expectation that at least ten percent of individuals supported by each Support Coordination Agency will become employed in the community.
- Conducted various trainings with vocational providers, Local Governing Entities (LGE), Support Coordinators (SCs), and various stakeholder groups regarding changes that will be taking place over the next several years regarding employment as per the Home and Community Based Services (HCBS) Settings rule.
- Facilitated Employment Roundtables in each region to discuss the HCBS Settings rule and necessary changes, as well to promote discussions among providers.
- Implemented the quarterly completion of the "Path to Employment" Form for all individuals who are supported in the waiver and are at least 16 years of age and older.
- Participated in Employer Summits in Shreveport and Baton Rouge.
- Developed a Memorandum of Understanding (MOU) with Louisiana Rehabilitation Services, Office of Behavioral Health, and Medicaid to affirm a working partnership to improve competitive and integrated employment outcomes for individuals with disabilities.
- Provided technical assistance, including onsite visits, to vocational providers in each region around the state to provide insight into changes that could be made to become more employment driven.
- (Vocational providers) completed self-assessments that evaluated their program status regarding the HCBS Settings rule, as well as with integration and individualization.
- Conducted a ten percent sample of onsite validation visits with vocational providers. (Note: By March, 2017 all vocational providers will have received an onsite validation visit of the provider self-assessment.)
- Worked in conjunction with other agencies to provide information to vocational providers on relevant topics such as Social Security Benefits.
- Met with family/parent groups and individuals to discuss the expectations regarding employment that will take place as vocational providers align with the new HCBS Settings rule.
- Joined the effort to form an Employment First Task Force which is being headed up by the Governor's Office of Disability Affairs.
- Presented information to various stakeholder/advocacy groups regarding OCDD's employment initiative.

B. **Why is this success significant?** System changes related to employment services are critical to individuals who receive OCDD services achieving employment outcomes and realizing their visions. This cannot be accomplished without development of a strong Employment First Foundation; the success of this achievement moves the system closer to making this a reality. OCDD continues to strongly emphasize employment and to provide education to those involved. It is believed that when everyone fully understands the importance of employment for those who have the ability and desire to work, we will see more people working and living fulfilled lives.

C. **Who benefits and how?** Individuals with developmental disabilities who want to work and achieve employment will benefit from the improvement of employment services as they will be able to obtain and maintain employment thereby increasing their independence and enriching their lives. Families benefit by the increased independence of their family members and through a decreased level of financial responsibility. The state will benefit as these individuals will pay taxes and spend money, thereby improving the economy.

D. **How was the accomplishment achieved?** This was achieved by OCDD listening to advocates, parents, and individuals who want to work and following up on these discussions by making community employment a major Office focus. OCDD will continue to make changes to employment services that are offered in the waivers, as well as continue to focus on the need for employment for individuals with developmental disabilities. Additionally, to maintain the successes and to continue to make strides in employment, OCDD will continue to facilitate meetings and trainings with partner agencies partner, such as Louisiana Rehabilitation Services, Department of Education and Louisiana Workforce Commission, as well as individuals/families who are served through the developmental disabilities services system. This will allow opportunities to get further feedback on the changes and to be responsive to what is being asked of OCDD in the way of employment.

E. **Does this accomplishment contribute to the success of your strategic plan?** Yes, this accomplishment contributes to Office Goal III (To increase the capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings.), as well as Program B Goal I (To develop and manage in a fiscally the delivery of an array of community-based supports and services so that people with developmental disabilities achieve their person-centered or family-driven outcomes in the pursuit of quality of life, well-being, and meaningful relationships.) Development of policies and procedures to provide pathways to community employment is a strategy in OCDD's current strategic plan.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes. This process will continue to be implemented in order to continue the outreach and education specific to employment. Changes will continue to be made within OCDD to increase the number of individuals in community employment. Employment should be a focus for all agencies that serve individuals with any type of disability, not just developmental disabilities. Employment for people with the most significant disabilities has been in the national spotlight for the last ten years and individual, integrated employment is highlighted

in the new Centers for Medicare & Medicaid Services (CMS) HCBS Settings rule and the new Workforce Innovation Opportunity Act (WIOA).

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

◆ **Please provide a brief analysis of the overall status of your strategic progress.** OCDD is making significant progress in its five-year Strategic Plan/Business Plan particularly with those initiatives that support the following strategic plan goals: 1) To provide a Developmental Disabilities Services System that affords people access to information about what services and supports are available and how to access the services; 2) To provide a person-centered system that supports person-centered thinking and planning approaches such that supports identified via needs-based assessments are provided in a manner that focuses on the person's goals and desires and addresses quality of life; 3) To increase the capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings; 4) To increase the capacity of the Developmental Disabilities Services System to support people with complex behavioral, mental health, and/or medical needs in all service settings; 5) To implement an integrated, full-scale data-driven quality enhancement system; and 6) To rebalance the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs. These initiatives also support OCDD's Business Plan Priorities which relate to system transformation. Progress on objectives has been steady, and the Office continues to build on successes in the areas of rebalancing, person-centered thinking, early intervention, waiting list prioritization, supports for people with complex behavioral needs, and employment. The success of these initiatives in FY 2015-2016 has moved the Office toward goals/objectives outlined in both OCDD's Strategic Plan and Business Plan.

◆ **Where are you making significant progress?**

Consolidated Tiered Waiver Development

OCDD currently operates four Home and Community-Based Services Waivers, including the New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Children's Choice Waiver (CCW), and Supports Waiver (SW). There are approximately 11,000 individuals receiving services through these four waivers.

Through stakeholder engagement efforts, it was identified that it is difficult for individuals and providers to navigate the four separate waivers, and it was proposed that there be a consolidation of the four developmental disability waivers. Therefore, Louisiana is proposing consolidation of the four current waivers into one comprehensive New Opportunities Waiver (NOW) with a target implementation date of July 2019. (See Section III: *Management of four separate Developmental Disability Waiver Services*.) OCDD has developed a process to modify the current Home and Community-Based Services waivers and establish a "tiered" waiver system, which will result in people

receiving the most appropriate waiver for their needs, rather than initially moving to the most expensive NOW waiver. These modifications will facilitate moving to the prioritization of the RFSR in that more people will be served in a more fiscally responsible manner. Rule changes and waiver amendments will be submitted related to these options in FY 2016-2017, and OCDD will seek Centers for Medicare and Medicaid Services (CMS) approval following public input.

The current proposed modifications include: 1) modifying the method for distribution of waiver opportunities (slots) [i.e., Children will receive Children's Choice Waiver option only and adults will be considered in the following order for waiver services: Supports Waiver (employment), Residential Options Waiver (shared support and/or living with family or host family), New Opportunities Waiver (for those with most complex support needs requiring intensive supports).]; 2) adding ten hours of Personal Care Attendant services to the SW in order to assist more people with remaining at this lower cost waiver; 3) increasing the age for children to remain in Children's Choice Waiver to age 22, which is consistent with current Early Periodic Screening and Diagnostic Treatment (EPSDT) services available in Medicaid, with individuals having an option to move to the Supports Waiver or remain in Children's Choice at age 19. As noted above, these proposed modifications must be published for public comment, which will occur in FY 2016-2017 and receive CMS approval prior to implementation.

1. To what do you attribute this success? OCDD has continued to work closely with all involved stakeholders with a focus on development of processes that will ultimately have the best outcomes for individuals receiving services. Historically, advocates for people with developmental disabilities have focused efforts on receiving additional New Opportunities Waiver slots to support people who are waiting. Because the average cost of this waiver is approximately $51,000/year, it is not reasonable to work toward providing this waiver to the over 14,000 people who are waiting for services. Additionally, analysis of waiver expenditures for individuals receiving the NOW indicate that many individuals do not need this comprehensive waiver and all supports available and that they could likely be supported in a lower cost waiver. Therefore, modifications are needed to the current process that will be fiscally responsible but continue to support people based on their needs. OCDD and involved stakeholders believe that the initial phased-in approach to a tiered waiver concept and the ultimate movement to a consolidated tiered waiver will accomplish this goal.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? This is not a result of a one-time gain; it is the accumulation of years of research and work with stakeholders to make significant system transformations that are responsive to all parties. A dedicated work plan with specific time frames has been outlined for this process, and we anticipate meeting set timeframes for implementation of phased-in approach to tiered waiver by October 2017 and implementation of consolidated tiered waiver by October 2019.

Request for Services Registry Prioritization Project

As noted in Section I. *Research/Planning for Request for Services Registry (RFSR)*, OCDD has completed development of a tool (Screening of Urgency of Need tool) to

assess all individuals on the RFSR to determine if they have met or unmet needs and the urgency of any identified unmet needs. Rule changes are in process to modify the current emergency waiver process to utilize this tool and developed processes with the current NOW waiver, and it is anticipated that final approval will be given early FY 2016-2017. A pilot process was initiated in FY 2015-2016 and continues into FY 2016-2017 to complete a Screening of Urgency of Need (SUN) on all individuals receiving the Supports Waiver and on the RFSR "waiting list" for the NOW. Findings from approximately half of screenings completed indicate that only 6% of individuals screened have unmet needs that are *emergent* or *urgent* in nature, meaning they will need supports within the next six months. The remaining 94% of individuals screened either have no unmet needs or have unmet needs that will require supports in the next 1 to 5 years. OCDD received funding in the FY 2016-2017 budget to allow for screening of all individuals on the NOW RFSR utilizing the SUN tool. Information received from these screenings will inform further development of the consolidated tiered waiver noted above, as well as future funding requests that will be tied to individuals' needs.

1. To what do you attribute this success? OCDD has worked closely with all involved stakeholders in the development of the RFSR screening process over the past 2 to 3 years. Stakeholders were closely involved in development of the SUN tool, and many advocates have provided written statements showing support for this modified process, including the Developmental Disabilities Council, self-advocates, and family members of individuals with developmental disabilities. Additionally, OCDD has dedicated significant staff resources to development, training, and ongoing data collection/monitoring of this process in order to ensure success.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at an accelerated pace. OCDD will be receiving monthly data related to individuals screened on the RFSR and will provide ongoing data analysis through the Business Analytics section to begin immediately informing future process development. This is one step in our overall System Transformation, and OCDD resources will continue to be dedicated to this project.

Supporting Transition from Institutional Services to Home and Community-Based Living

OCDD Resource Centers designate transition and technical support staff to assist Pinecrest Supports and Services Center and Cooperative Endeavor Agreement agencies to transition individuals from these facility-based settings to home and community-based living situations. The transition and technical support staff act as a bridge between the facility teams and the community teams and follow the individual for at least one year post-move to ensure needed supports are in place. A performance indicator (#24699) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative. This FY, 93% of individuals transitioning indicated satisfaction with their new living arrangements.

1. To what do you attribute this success? OCDD has utilized a person-centered approach and tools as individuals transition from a large Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) setting into less restrictive community

settings to ensure individuals' support needs are met and to assist with improving quality of life in the less restrictive environment. The Partners in Quality (PIQ) process allows ongoing oversight for a minimum of one year after transition from a large ICF/DD to ensure that supports are being met and that the inter-disciplinary team is actively responding if issues are identified.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at an accelerated pace. OCDD will continue to refine activities in FY 2016-2017 to further improve the oversight process following transition from a large ICF/DD to ensure quality of life and support needs being met.

Supporting Individuals with Complex Behavioral Health Needs to Live in their Community

OCDD Resource Center Community Support Teams (CSTs) and Community Psychologists have continued to shift services to supporting individuals with the most complex behavioral needs and currently act as a service of last resort. Presentation of behavioral health needs and/or legal involvement represent the primary reason for high cost institutionalization within the OCDD system. A performance indicator (#24259) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative. This year the efforts of the OCDD CSTs and Community Psychologists to support individuals referred with complex behavioral health needs resulted in maintenance of community living for 96% of the individuals supported. These results represent significant positive outcomes for these individuals and speak to the success and importance of this OCDD effort.

1. To what do you attribute this success? The OCDD Resource Center employs clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral/medical support needs and utilizes a multi-disciplinary approach to providing consultation, training, and services that improves the ability of caregivers and providers to achieve positive outcomes for persons with complex needs.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue. With implementation of triage initiatives, Resource Center staff can provide services to a greater number of individuals and provider agencies. With implementation of crisis/diversion initiatives, Resource Center professionals in collaboration with the Local Governing Entities can initiate a consultation prior to escalation of a crisis such that one's community connection is maintained, or within a timeframe that increases the likelihood of diversion to the most integrated setting.

Enhanced Training for Community Professionals and Providers to Improve Capacity to Support Individuals with Complex Needs

The OCDD Resource Center utilizes the professional expertise of staff to develop and conduct training and technical assistance activities with community providers and professionals to enhance the ability of these providers and professionals to support

individuals with complex medical and behavioral support needs. These activities are offered at the initiation of both the Office and actual provider/professional request. A performance indicator (#24696) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative. This fiscal year's efforts resulted in 98% satisfaction from the providers and professionals.

1. To what do you attribute this success? The OCDD Resource Centers employs clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral and medical support needs. The training is provided utilizing a multi-disciplinary approach working to improve the ability of caregivers and providers to achieve positive outcomes for persons with developmental disabilities and complex needs.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at this accelerated pace. Feedback is obtained from customers at the time of each training event.; this feedback and suggestions for additional training allows OCDD to be responsive to customers' training needs.

EarlySteps' Success in Exceeding Performance Standards related to Development and Implementation of Individual Family Services Plans

One of the primary program purposes of EarlySteps is to enhance the capacity of families to meet the needs of their infants and toddlers with disabilities. A key measure of success for meeting this need is timely service delivery to eligible infants and toddlers. Performance is measured through two indicators:

Development of Individual Family Service Plans (IFSPs) within 45 days of referral:

A focus on improving the State's compliance related to this requirement has been in place since 2008. A performance indicator (#24664) is included in OCDD's Strategic Plan and Operational Plan to monitor compliance with this requirement. The current performance standard for this indicator is 97%. In FY 2015-2016, this standard was exceeded with achievement of 99%.

1. To what do you attribute this success? EarlySteps can generate reports from its data system and closely track timelines for completion of IFSPs by its entry offices. When performance is less than 100%, monitoring is triggered to determine the reason for the delay. The system now tracks delays which are due to family reasons as compared to system or internal office reasons; if the delay is due to a system reason, a finding is issued and the entry office receives technical assistance in managing its timelines.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress has been steady and is expected to be maintained.

Implementation of Individual Family Services Plans within 30 days of parent consent:

A focus on improving the State's compliance related to this requirement has been in place since 2008. A performance indicator (#24665) is included in OCDD's Strategic Plan and

Operational Plan to monitor compliance with this requirement. The current performance standard for this indicator is 94%. In FY 2015-2016, this standard was exceeded with achievement of 95%.

1. To what do you attribute this success? Since 2007, EarlySteps has conducted provider recruitment and enrollment activities to increase the availability of providers around the state. Lack of provider availability is the main reason for a delay in meeting the 30-day timeline. Availability impacts regions in central and north Louisiana specifically. In addition, support coordinators are required to have team meetings and contact the regional coordinator if there are problems with provider availability. With an increased number of providers in place and the addition of the follow up by the support coordinator, the performance standard has been met. Early in FY 2014-2015, EarlySteps formed a workgroup to specifically address this need. Provider recruitment and policy changes to support alternate means of meeting child/family outcomes (such as a telehealth model) are being explored. A data system update and training materials have been developed to better support the activity and provide effective measurement to monitor continued progress.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Since 2004 when EarlySteps began collecting data for this indicator, steady progress has been shown; it is expected to continue due to increased availability of providers.

Person-Centered Initiative

OCDD's planning values are consistent with person-centered thinking, and OCDD has been recognized nationally as an example of best practice in terms of its published Guidelines for Support Planning. Louisiana OCDD's ability to implement a person-centered approach to planning inclusive of resource allocation was a major factor in the invitation to the National Home and Community-Based Services (HCBS) conference last year. OCDD developed the *Guidelines for Support Planning* in conjunction with Resource Allocation to ensure that person-centered values drove planning for individuals rather than simple cost. Person-centered planning determines the individual's vision and goals and sets how he/she spends his/her time and the people and places important to the individual. Resource Allocation assists in determining and planning for the amount and type of support the individual needs to see the important people, do the important things, go the important places, and move closer to his/her vision and goals. OCDD identified challenges in implementation of person-centered thinking and planning approaches and drift from the Guidelines for Support Planning requirements in its Systems Transformation initiative which begin in 2012. This effort was shortly after merged with the exploration of Managed Long-Term Supports and Services (MLTSS). OCDD did not undertake any outside efforts to address support coordination or person-centered issues due to the changes that would occur in these areas in any implementation of MLTSS (i.e., It was not prudent to invest resources into correct a problem in a system that at the time was targeted for a major reformation.). With the decision to halt and re-evaluate MLTSS, OCDD has engaged stakeholders across LGEs, providers, support coordination, advocacy groups, and participants/families to evaluate the current implementation of its person-centered approaches and to develop actions to address any needed changes, training/competency building, and accountability.

1. To what do you attribute this success? OCDD has initiated a formal Person-Centered Workgroup composed of stakeholders including advocates, providers, LGE staff, and support coordination. Family informational sessions and input have also occurred. The workgroup is using information including data about program outcomes and challenges, participant and family input, and new federal requirements to develop the following: 1) an improved needs-based assessment process, 2) a more person-driven planning process and document, and 3) a training, certification and mentoring process to infuse the developmental disabilities service system with person-centered thinking skills and tools. Louisiana has received national recognition for its *Guidelines for Support Planning* in the New Opportunities Waiver which sets a good foundation for improvements in this arena. The new initiative and workgroup provide additional resources and focus to ensure ongoing quality improvements as well as improved implementation and sustainability of person-centered practices.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at an accelerated pace.

- **Where are you experiencing a significant lack of progress?**

Reducing the Waiting Time on the Request for Services Register (RFSR)

The current OCDD Request for Services Registry (RFSR) includes individuals who have requested and are waiting for the New Opportunities Waiver (NOW). The RFSR has remained lengthy despite efforts to fund additional opportunities and repeated reform initiatives over the past several years. Performance Indicators (#24648, 24649, and 24650) are included in OCDD's Strategic Plan and Operational Plan to monitor progress related to established standards. The Office has been unable to reach Performance Standards related to these indicators for many years, and unless significant process changes occur, including addition of waiver slots and modifications to lower cost waivers that will have a fiscal impact, the waiting time will continue to escalate.

1. To what do you attribute the lack of progress? No new state appropriations for waiver opportunities (slots) have been funded by the Louisiana legislature for several years. Thus, as more individuals request waiver services and are added to the RFSR without any new opportunities being offered, the natural trend is for more persons to wait longer and the overall average wait time for the RFSR to increase over time. This is the trend which has been demonstrated in the data for the three performance indicators listed above. In FY 2015-2016, the trend continued with no more developmental disabilities waiver slots being funded/allocated and, consequently, the wait time increasing for persons on the registry who were waiting for developmental disabilities waiver services. Additionally, most of the individuals who are "waiting" for services are waiting for the NOW, when other less costly waivers may meet their needs. Without system reform, the requests were primarily for additional NOW slots, which have the highest average annual cost, making it difficult in fiscally difficult times to provide waiver opportunities.
2. Is this lack of progress due to a one-time event or set of circumstances? The lack of progress is due to a set of circumstances which are described above in question

number 1. As noted in Section II. narratives related to a consolidated waiver and the Request for Services Registry, OCDD is recommending systems changes to most appropriately address the RFSR and provide services to individuals who need more timely support.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?** Yes. OCDD's Strategic Plan was recently updated for FY 2018 through 2022. Updates include revisions to program objectives, strategies and indicators to reflect Office direction, to build on successes, to provide strategies in areas where success has not been as substantial or where changes in program direction indicate such, and to improve performance assessment.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**

  On a Department-wide level, Performance Based Budgeting activities (including, but not limited to, strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. Recommendations are made directly to the Assistant Secretaries or the Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

  Within OCDD, objectives are assigned to specific staff members who are responsible for management and oversight of the accomplishment of each objective and related performance indicators. Additionally, a variety of management tools (i.e., databases, project charters, etc.) and task/initiative specific workgroups/committees are utilized to track, review, and provide feedback for utilization in decision making and resource allocation. Progress or lack of progress (along with support/resources needed to achieve assigned objective) is reported to OCDD Executive Management. Performance data is also reported in Louisiana Performance Accountability System (LaPAS) and available for both management and stakeholder review.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

Management of four separate Developmental Disability Waiver Services

A. Problem/Issue Description

1. What is the nature of the problem or issue? Current Developmental Disability Waiver Services are distributed across four 1915 (c) waivers with different services in each

waiver. This design is confusing for participants and unwieldy for staff.

2. Is the problem or issue affecting the progress of your strategic plan? Yes. One of the goals of the OCDD Strategic Plan is to afford people with information about available services and supports and how to access the services system. The four different waiver options make it difficult to provide clear information and often cause confusion for those seeking services and supports in that applicants are uncertain of which option will best meet their specific needs.
3. What organizational unit in the department is experiencing the problem or issue? OCDD and Local Governing Entities are affected by this problem.
4. Who else is affected by the problem? Individuals who are applying for services or already participants and their families, support coordinators, private providers and stakeholder groups are impacted by this problem.
5. How long has the problem or issue existed? The first waiver was titled the Mentally Retarded and Developmentally Disabled Waiver (MRDD Waiver). The Children's Choice Waiver was added in February 2001; the New Opportunities Waiver (NOW) replaced the MRDD Waiver in April 2003. The Supports Waiver followed in July 2006, and the Residential Options Waiver (ROW) in October 2009. As new waivers were added and existing waivers amended to add new services, the problems began and have continued to escalate.
6. What are the causes of the problem or issue? How do you know? Four different Home and Community-Based Services (HCBS) waivers serving one population (individuals with developmental disabilities) without the consistency needed to maximize services, simplify service coordination, and avoid confusion has caused the problem. It is evident through observation of day-to-day coordination/delivery of waiver services in Central Office and Local Governing Entities, as well as feedback from applicants/families and other stakeholders.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Consequences include continued confusion about services offered by the four waivers, improper utilization of available services, along with continued difficulty in management of waiver services.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes
2. What corrective actions do you recommend to alleviate or resolve the problem or issue? Consolidation of the four Developmental Disability Waivers into a single tiered waiver.
3. Has this recommendation been made in previous management and program analysis reports? Yes
4. Are corrective actions underway? Yes. OCDD is working to develop a tiered HCBS waiver system which will modify service packages to allow individuals to be supported in the most appropriate waiver. The target for FY 2016-2017 is to have waiver amendments prepared for public comment and Centers for Medicare & Medicaid (CMS)

review that will modify the current four waivers and initially establish a tiered waiver system. Partial implementation of the tiered system will occur in FY 2016-2017 and FY 2017-2018 based on funding available. The target for implementation of the full consolidated tiered waiver system is FY 2018-2019 pending funding. (See Section II: *Consolidated Tiered Waiver Development.)*

5. Do corrective actions carry a cost? Yes. The initial move to tiered waiver will involve increased costs to add ten hours of Individual and Family Support (IFS) to the Supports Waiver. Funding for these services has been included in the FY 2017-2018 budget request. This increased cost would allow many individuals to be successfully supported in the Supports Waiver, rather than moving to the costlier NOW. There is an expected cost avoidance over time because the average waiver cost per person would be expected to decrease following implementation making the program more sustainable.

Unmanageable Number of People on the Request for Services Registry (RFSR)

A. Problem/Issue Description

1. What is the nature of the problem or issue? The Developmental Disability Request for Services Registry (RFSR) has an unmanageable number of people waiting for services and has no prioritization system to allow individuals with the most immediate needs to be served most quickly.
2. Is the problem or issue affecting the progress of your strategic plan? Yes.
3. What organizational unit in the department is experiencing the problem or issue? OCDD and Local Governing Entities are experiencing the problem.
4. Who else is affected by the problem? Individuals who are applying for services and their families, support coordinators, private providers and stakeholder groups are impacted by this problem.
5. How long has the problem or issue existed? This has been a problem for many years. The RFSR (also known as the waiver "waiting list") has been the subject of repeated reform initiatives over the past several years attempting to reduce time spent waiting for waiver services.
6. What are the causes of the problem or issue? Insufficient funds to increase the number of waiver opportunities (slots) needed to provide additional services and reduce the waiting list. Additionally, not having a process for evaluation and prioritization of those currently on the waiting list makes it likely that the numbers are not accurate. Once put in place such a system will likely result in lower numbers and a better system of serving those with the greatest need first.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Individuals and their families continue to wait for needed services while the "waiting list" continues to grow. This is a particularly significant problem for those individuals/families who are experiencing urgent situations and who are at risk of institutionalization or hospitalization due to lack of services availability.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes
2. What corrective actions do you recommend to alleviate or resolve the problem or issue? Improving processes/tools for managing the RFSR to include re-evaluation/ prioritization of individuals currently on the waiting list and periodic updates to maintain accuracy are recommended. These actions will result in a more accurate list which will likely result in lower numbers and, more importantly, result in those with greatest need receiving services first.
3. Has this recommendation been made in previous management and program analysis reports? The unmanageable number of individuals on the RFSR waiting for developmental disability services has been a long-standing problem. While strides have been made over the years with the addition of new waivers and validation of waiting list information, the problem continues to the dismay of both OCDD and the people waiting for services. The problem has been addressed in different ways in annual reports in the past several years.
4. Are corrective actions underway? Yes. During a RFSR re-evaluation, OCDD discovered that one-third of individuals on RFSR were already receiving other Medicaid Long Term Supports and Services (LTSS) or comparable alternatives and over eighty percent were Medicaid eligible and could qualify for in-home supports through the Medicaid State Plan but were not accessing them. This re-evaluation, along with input from the Core Stakeholder group, formed the basis for the creation of a RFSR prioritization tool, which will assist with identification of met or unmet needs for individuals who are waiting. The Screening of Urgency of Need (SUN) tool has been developed and is in pilot stage for people who already have a Support Coordinator. Based on funding in FY 2016-2017 budget, OCDD will complete screening for individuals on the RFSR. (See Section II: *Request for Services Registry Prioritization Project*.)
5. Do corrective actions carry a cost? Yes. The cost of conducting a prioritization screening for all individuals on the RFSR ($3.5 million) was allocated in the current FY 2016-2017 budget. Funding in the amount of $837K has been requested for FY 2017-2018 (and will be included in subsequent budgets) for screening of individuals who are added to the RFSR and for individuals on the registry whose needs/status change. All individuals on the RFSR must be screened for full implementation of the process to occur. While there are upfront costs, the goal and expectation is cost savings/avoidance in years to come, more cost-effective options, and a more sustainable waiver.

Maintenance associated with facilities in which the campuses have been vacated

A. Problem/Issue Description

1. What is the nature of the problem or issue? Over the past ten years, eight former supports and services centers have been privatized or closed, and OCDD continues to be responsible for costs associated with six of these eight facilities. These costs may include acquisitions and major repairs, risk management fees, building and grounds maintenance, utilities, and/or loss prevention/security. In addition, OCDD remains

responsible for risk management fees at three privatized facilities and for major repairs and identified maintenance costs per the Cooperative Endeavor Agreement for operation of the former Northlake Supports and Services Center facility. OCDD will continue to be responsible for these costs as long as the properties belong to LDH/OCDD and will continue to be responsible for the risk management fees for two (2) years after the properties no longer belong to OCDD.

2. Is the problem or issue affecting the progress of your strategic plan? Yes. Although indirectly, this problem is affecting OCDD's progress in implementing its strategic plan in that the fiscal resources required to maintain the vacated properties could be better utilized to further OCDD's progress toward one or more of its strategic plan goals. In addition, the opportunity to utilize state-owned property as revenue-generating property as campuses are vacated has been explored; however, there are current legislative rules in direct opposition to this course of action.
3. What organizational unit in the department is experiencing the problem or issue? OCDD is managing the problem by continuing to allocate necessary resources to manage the costs associated with maintaining the properties and fulfilling Office of Risk Management (ORM) and other state requirements.
4. Who else is affected by the problem? The OCDD budget authority and the employees fulfilling the duties are affected by this problem. There are also additional indirect impacts of these required expenditures on participants/families in that resources are diverted away from service delivery.
5. How long has the problem or issue existed? It was identified in FY 2009-2010.
6. What are the causes of the problem or issue? The problem is caused by mandatory duties related to state-owned property insured by ORM. Also, though vacated, the properties remain the property of the State and efforts must be made to keep the physical plant in good condition and to prevent theft or destruction of property.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? The consequence of this issue is a continued expenditure of funds to maintain properties that are no longer used by OCDD. These expenditures may cause shortfalls in future fiscal years.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue? LDH/OCDD should secure permission and/or an exception to the Legislative rules and regulations for alternate use of the facilities, including but not limited to the following: 1) sale of state-owned property at a reasonable rate (Note: Sections of all facilities contain asbestos which impacts ability to remove buildings at a reasonable cost which impacts ability to sell property.); 2) transfer of state-owned property to other state, parish, or local governing departments / offices; and 3) utilization of state-owned property as revenue generating property or amend existing legislation.
3. Has this recommendation been made in previous management and program analysis

reports? If so, for how long (how many annual reports)? Yes. This recommendation was made in this annual report since 2009-2010; however, additional recommendations have been added for this year.

4. Are corrective actions underway? Yes. The Office is working to identify potential alternate use for all properties not occupied or planning to be unoccupied due to downsizing efforts.
5. Do corrective actions carry a cost? No. There would be no direct costs related to researching and developing amendments to existing legislation as these actions would be completed by existing staff. However, as mentioned above, failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings/facilities.

Development of an integrated, full-scale data-driven quality enhancement system

A. Problem/Issue Description

1. What is the nature of the problem or issue? Quality service delivery should be a thread that is embedded throughout the OCDD. The Office should always strive to improve the way it provides services and supports to participants and their families. Key to achieving desired program outcomes is an integrated quality management/ enhancement system that relies on the availability of high-quality data. This is one of the short falls of OCDD's quality system; data must be current, available, and integrated. There are currently data mandates for the Home and Community-Based Services waivers, the Louisiana Performance Accountability System (LaPAS), the EarlySteps Program, and the Accountability and Implementation Plan (AIP). Within the current OCDD Quality Enhancement System, the Office collects data from various sources [i.e., Online Tracking Incident System (OTIS), Medicaid, Statistical Research, Inc. (SRI), Participant Services Database, Local Governing Entities (LGE), Covansys, complaints database, auditing reports, surveys, and census database]. Data collected from these different sources is stored in a variety of places (i.e., on shared drives, OCDD staff computers, in binders, in the complaints database, and in an access database). Some of the data collected and reported is Centers for Medicare & Medicaid Services (CMS) performance data, Level of Care/Plan of Care (LOC/POC) Quality Review data, Provider Quality Process and Plan Review data, Transition Tracking data, EarlySteps Performance data, Support Coordination Monitoring data, LaPAS data, AIP data, National Core Indicators Project data, mortality data, National Association of State Directors of Developmental Disabilities Services (NASDDDS) data, Minnesota Survey data, and State of the State data (Braddock). The problem is that there is no single place for collection/storage or analysis of OCDD quality data.
2. Is the problem or issue affecting the progress of your strategic plan? Yes. Goal V of the Strategic Plan is to implement an integrated, full-scale data-driven quality enhancement system. To implement such a system that is directed toward responsiveness to individuals and their families, OCDD will need to develop a web-based integrated database which can collect, store, and track all OCDD quality data. This database will consist of standard reports that can be used to respond to requests for data and can be used by OCDD management in decision making and program

planning. This information that will be stored in the database will be easily accessible to all OCDD staff and all LGE staff, with the capacity for accessibility to OCDD providers if this is deemed necessary. Information gathered from this database can be analyzed to look at trends and patterns and can be used to assess training needs of staff. When the integrated database is developed, the OCDD/LGE staff will be trained on how to use the database. The OCDD Performance Review Committee and the Regional Quality Review Committees will have a mechanism to gather/analyze data and use the information for improving OCDD quality service delivery, improving the monitoring process, and providing technical assistance/ training when needed.

3. What organizational unit in the department is experiencing the problem or issue? Community Services, Business Analytics/Information Technology (IT), Clinical Services, and Administration are all affected because there is no holistic data analysis which affects the decisions that are made relative to program planning and policy development. The sections mentioned above are formulating their own analysis and making/submitting individual unit decisions/recommendations rather than the OCDD Executive Management Team receiving recommendations from one entity, such as a quality committee with representation from each section, regarding the quality of the services being delivered.
4. Who else is affected by the problem? Those affected include participants/their families, external and internal stakeholders, LGEs, OCDD Central Office, providers, and support coordinators.
5. How long has the problem or issue existed? Over the past ten years as components of a qualify management/enhancement system were being established, the Office developed/refined a number of data sources specific to areas included in the quality system. Many of the components were new to the quality system and were not developed in a consistent, unified manner. As the quality system has expanded, the lack of centralized/integrated data has become more of a problem.
6. What are the causes of the problem or issue? How do you know? The previous organizational structure could have been a contributing factor to this issue. Silos existed because of the lack of integration among sections within OCDD.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Failure to resolve the problem will result in lack of integrated information, duplication of efforts, unnecessary data collection, and inability to share information within the agency.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes
2. What corrective actions do you recommend to alleviate or resolve the problem or issue? The development and the implementation of a centralized OCDD web-based Quality Integrated Database, which can be used by all OCDD staff and LGE staff, are recommended. The next steps to resolving this issue involve: (1) reinstating the OCDD Performance Review Committee, (2) identifying all data being collected across the

agency and evaluating the utility for operations, and (3) establishing the data system that ensures assessment of outcomes for individuals with developmental disabilities.

3. Has this recommendation been made in previous management and program analysis reports? No
4. Are corrective actions underway? Yes
    - What is the expected time frame for corrective actions to be implemented and improvements to occur? OCDD has developed a Quality Committee work plan that was initiated on July 1, 2016; this work plan outlines the goals and timelines for completion of the task with the end date of July 2017.
    - How much progress has been made and how much additional progress is needed? The progress has been delayed due to other competing priorities within OCDD.
5. Do corrective actions carry a cost? No. There would be no direct costs related to further development and integration of the OCDD quality system as these actions would be completed by existing staff and with current IT systems.

Community settings lack adequately trained professionals and direct support staff to deliver needed (1) behavioral services, including qualified persons to deliver applied behavior analysis to people with autism, and (2) services and supports, including skilled nursing services, to individuals who are medically fragile

A. Problem/Issue Description

1. What is the nature of the problem or issue? There continues to be a lack of adequately trained professionals and direct support staff to deliver needed behavioral and medical/nursing services to individuals with complex needs in community settings, including a lack of qualified professionals to deliver applied behavior analytic therapies to persons with autism. There is a shortage of trained staff to provide services and supports for individuals with significant medical needs, including skilled nursing services for individuals who are medically fragile and reside in community settings.

   Adequate behavioral supports can be very effective in improving quality of life and reducing behavioral symptoms/challenges for individuals with intellectual and developmental disabilities. Applied behavior analysis can be very effective and can significantly alter the course of autism for many individuals. Complex medical support needs, particularly those requiring nursing supports throughout significant periods of the day, can be managed in community settings; however, it is very difficult to locate and secure trained staff to meet these needs. Continued challenges in this area contribute to institutional admissions, hospital admissions, emergency room use, increased illnesses, increased medication usage and costs, and other negative health outcomes.

   While specific departmental and OCDD initiatives have been implemented this fiscal year to continue addressing this barrier and improvements have occurred in some

areas, a general problem continues to exist. It is believed that a multi-faceted and multi-year approach is required to resolve the problem.

2. Is the problem or issue affecting the progress of your strategic plan? Yes. Lack of professional supports in community settings has continued to be the primary contributor to admissions to the supports and service center and other more restrictive settings, with requests for admissions resulting when community providers are unable to meet behavioral and psychiatric needs of people whom they are serving in community settings and in smaller numbers those with complex medical needs. Lack of trained autism professionals negatively impacts the ability to develop new autism services, which can prevent more severe negative developmental outcomes. The inability to teach functional behavioral skills adequately detracts from community participation objectives (i.e., that individuals with disabilities are participating fully in communities). Continued movement from Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) settings to community-based living arrangements is also hampered due to the challenges in securing needed behavioral and medical/ nursing supports for individuals with complex needs.

3. What organizational unit in the department is experiencing the problem or issue? OCDD and the Local Governing Entities have been impacted by this problem for many years. The Office of Behavioral Health (OBH) and Medicaid are also experiencing some impact due to this problem.

4. Who else is affected by the problem? Individuals supported and their families, support coordinators, and private providers who serve persons with developmental disabilities in community homes, family homes, and supported independent living settings are impacted by this problem. Hospitals are impacted when individuals with co-occurring needs present at the emergency room due to difficulty accessing other needed services.

5. How long has the problem or issue existed? The problem is longstanding.

6. What are the causes of the problem or issue? How do you know? Many factors contribute to the problem beginning with a historic lack of training of persons equipped to deliver these services. Many professional training programs offer no training in developmental disabilities. National reports continue to indicate that there is a general shortage of behavioral health professionals in many areas of the country with access for those with co-occurring developmental disabilities and behavioral health needs even more challenging. The cost of providing nursing services in individual settings and challenges in terms of isolation in these arrangements negatively impact the access to needed medical/nursing supports. Both the increasing number of persons with developmental disabilities now being served in the community and the downsizing of institutional services, generally considered to be positive and progressive developments in developmental disabilities services, have contributed to an increased need for medical/nursing and behavioral/psychiatric supports in the community. In addition, private Supported Independent Living (SIL) providers serving persons in waiver settings and private community home providers generally conduct and are required to conduct very little training with direct support staff on positive behavior supports and medical/nursing needs.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Consequences include a significant number of people with developmental disabilities having unmet needs, a continued need for costly institutional admissions to the higher treatment cost supports and service center, continued high utilization of high cost acute services, and an inadequate number of practitioners to positively impact the developmental trajectories of children with autism, other behavioral challenges and/or complex medical needs leading to increasing service costs over the course of their lifespan.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue? The following are recommended actions to alleviate the problem:

   - Engage in Partnership with the Louisiana Developmental Disabilities Council to offer a formal incentive-based training, technical assistance and consultation opportunity to community waiver providers supporting individuals with complex needs.
   - Explore enhanced Individual and Family Support (IFS) services and the associated rate for individuals with complex needs. Evaluate benefits of inclusion of behavioral and medical therapeutic respite options via the OCDD consolidated waiver and research development of specialized shared living waiver models for individuals with complex medical and behavioral needs.
   - Continue implementation of opportunities for partnering with university programs that provide training as well as individual clinicians resulting in additional needed professionals, growing the service provider pool.
   - Continue implementation of statewide access to training for direct support workers through the Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana) program with additional development of specialized/customized approaches for providers and evaluate opportunities for expansion of access to needed training.
   - Continue OCDD developed and sponsored professional continuing education opportunities.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? Yes. A recommendation has been included in this annual report for the last few years. Some recommendations have been implemented, while others remain and new recommendations are included.

4. Are corrective actions underway? Yes. The following actions are underway:

   - Partnership with the Louisiana Developmental Disabilities Council began in June, 2016 and will continue through two FYs.

- OCDD's statewide Positive Behavioral Supports (PBS) curriculum for direct service workers has been expanded to include statewide certified trainers and has been incorporated into the OCDD Resource Center transformation as an ongoing option with local accessibility.
- OCDD continues its statewide offering of Medical/Nursing Direct Service Worker (DSW) training via Money-Follows-the-Person (MFP) Rebalancing Demonstration.
- OCDD continues to offer Board Certified Behavior Analysts (BCBA) continuing education opportunities as well as other behavioral and psychological continuing education options.
- OCDD continues to provide consultation and technical assistance via the OCDD Resource Center.
- OCDD continues to work with Medicaid to support Applied Behavior Analysis (ABA) services via the State Plan.

5. Do corrective actions carry a cost? Most of these actions do not carry a cost. Implementation of training and capacity building efforts approved in the MFP Rebalancing Demonstration (My Place Louisiana) Operational Protocol are funded with federal demonstration dollars through 2020. While other corrective actions could carry a cost in so far as additional clinicians and/or technical assistance staff are recruited into state service systems, they do not carry a cost as most new positions in OCDD are existing positions diverted from institutional services. They do not incur a cost when the focus is on community, non-public capacity building. Costs are associated with new services such as ABA. However, costs are likely offset by costs associated with failure to implement corrective actions as: 1) failure to intervene at the community level can result in extensive additional institutional treatment costs and 2) failure to intervene with persons with autism at an early age does result in extensive lifelong service costs that are estimated at over one million dollars per person and incurred by families and the taxpayer. The DD Council partnership is funded solely through funds dedicated to this purpose by the DD Council.

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
The Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste & abuse by conducting risk-based audits and compliance investigations. The Internal Audit

function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

Internal Audit also provides management with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

Within OCDD, the agency provides ongoing monitoring of its administrative and fiscal functions through a variety of audit/monitoring tools; as appropriate, results are reported to Executive Management Team (EMT).

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The Louisiana Department of Health (LDH) has a designated Audit Coordinator for financial audits. The LDH Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

☒ **Policy, research, planning, and/or quality assurance functions in-house**
OCDD quality and clinical staff review best practices on an on-going basis in addition to performing on-going review of Office's practices and performance; the OCDD Performance Review Committee provides oversight of Office's quality management/assurance processes

☒ **Policy, research, planning, and/or quality assurance functions by contract**
Through contract, Mediware provides a critical incident data management system.

☒ **Program evaluation by in-house staff**
OCDD provides ongoing monitoring of its clinical and programmatic functions through a variety of audit/monitoring tools; as appropriate, results are reported to Executive Management Team. LGEs provide OCDD with Monthly Performance Data Reports (e.g., service requests, persons served, referrals/ consultations, and funding) specific to system participants. The EarlySteps program provides an Annual Performance Report Summary to the US Department of Education and in turn the state receives a status determination.

☒ **Program evaluation by contract**
The National Core Indicators (NCI) Project evaluates standard measures used across

states to assess the outcomes of services provided to individuals and their families; indicators address key areas of concern including employment, rights, service planning, community inclusion choice and health and safety (see section C. below).

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory Notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

☒ **In-house performance accountability system or process**
☐ Benchmarking for Best Management Practices

☒ **Performance-based contracting (including contract monitoring)**
Contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

☐ Peer review
☐ Accreditation review

☒ **Customer/stakeholder feedback**
Customer/stakeholder feedback is received from National Core Indicator (NCI) surveys to participants and families (see section C. below) and through periodic stakeholder meetings to solicit input on a variety of initiatives.

☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report? Yes

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

National Core Indicators Project - Since FY 2008-2009, the Louisiana Office for Citizens with Developmental Disabilities (OCDD) has participated in the National Core Indicators (NCI) Project. Currently, forty-six states and the District of Columbia participate in the NCI Project, which is co-sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and their families. Indicators address key areas of concern including employment, rights, service planning, community inclusion choice and health and safety. Annually, OCDD mails surveys to a random sample of the families of children and adults with developmental disabilities participating in various developmental disability programs. The number of surveys that are mailed is calculated to achieve a return

rate that provides a total of 1,200 completed surveys. Additionally, the OCDD Resource Centers deploy personnel to conduct face-to-face interviews with 400 randomly selected adults with developmental disabilities who consent to participate in the survey. OCDD has experienced a diminishing rate of return of surveys, which has resulted in this office pulling larger samples and mailing more survey packets in order to achieve the target of a minimum of 1,200 completed surveys. OCDD has sent a follow-up reminder postcard approximately two weeks after mailing the family surveys, with a phone number to call if the family has any questions or needs another copy of the survey. This strategy will be discontinued due to privacy concerns, and NCI has suggested alternate strategies, such as reaching out to stakeholder agencies and organizations to publicize the event, making NCI outcome reports more widely available to families and participants of services, and providing a web-based survey response site as an alternate to the paper survey.

1. Title of Report or Program Evaluation:

   Reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services:

   - *National Core Indicators Adult Consumer Survey 2014-15 Final Report*: This report provides an aggregated summary of the results of interviews with adults receiving any developmental disability services in any setting, and provides comparisons between Louisiana and the national average of other participating states.
   - *National Core Indicators Family Guardian Survey 2014-15 Final Report*: This report provides an aggregated summary of the results of the survey which was mailed to families of adults receiving developmental disability services in any setting other than the family home, and provides comparisons between Louisiana and the national average of other participating states.
   - *National Core Indicators Adult Family Survey 2014-15 Final Report*: This report provides an aggregated summary of the results of the survey which was mailed to families of adults receiving developmental disability services and who reside with their families, and provides comparisons between Louisiana and the national average of other participating states.
   - *National Core Indicators Child Family Survey 2013-14 Final Report*: This report provides an aggregated summary of the results of the survey which was mailed to families of children living and receiving developmental disability services in the family home and provides comparisons between Louisiana and the national average of other participating states.

2. Date completed: Surveys and interviews were completed between January and June 2015. Final reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services were published in December 2015.
3. Subject or purpose and reason for initiation of the analysis or evaluation: Surveys and interviews were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. Interview questions concerned satisfaction, quality of care and quality of life. Analyses compared Louisiana

statewide results with results of other states participating in the National Core Indicators Project.

4. Methodology used for analysis or evaluation: The primary tools used for this evaluation were family surveys and consumer interview questions. Analyses reported both the number and percentage of responses to each question. Comparisons were reported among the participating states.

5. Cost (allocation of in-house resources or purchase price): The family mail-out surveys were printed and mailed through a purchase order for $8,729. All other activities were performed using OCDD resources and personnel. Approximately 272 hours of staff time were used to obtain the random sample and verify contact information for families for the mail-out surveys and participant interviews. Scheduling interviews, completing background information, and interviewing individuals took approximately 1,400 hours of staff time. Entering family survey data and consumer interview data into the NCI database took approximately 184 hours of staff time. Postage cost for a Business Reply Permit and return postage cost were approximately $3,000. Finally, travel costs to conduct 400 interviews were approximately $6,000.

6. Major Findings and Conclusions: Overall, Louisiana was ranked within the average range for the *Child Family Survey*, *Adult Family Survey*, *Family Guardian Survey* and *Adult Consumer Survey*. The majority of responses were "Within Average Range" with a substantial number falling five or more percent above average. However, there were a few areas that were five or more percent below average.

7. Major Recommendations: Acquire information/explanations/causes related to areas that fell below average and develop/implement strategies to improve issues identified.

8. Action taken in response to the report or evaluation: Information from the surveys was cross-walked to Centers for Medicare & Medicaid Services (CMS) measures for the HCBS Settings rule, which addresses community participation and employment goals for persons with developmental disabilities who are receiving Home and Community-Based Services.

   OCDD's quality improvement process includes review of NCI data as well as data from other sources such as: data on regional performance indicators as part of the Human Services Accountability and Implementation Plan and data from EarlySteps and HCBS waiver performance indicators. The data is reviewed by an OCDD workgroup consisting of programmatic and quality staff. When trends and patterns are noted, quality improvement projects are developed and implemented upon approval of the OCDD Assistant Secretary.

9. Availability (hard copy, electronic file, and website): Available in electronic file on the National Core Indicators website:

   www.nationalcoreindicators.org

10. Contact person for more information:

Name: Dolores Sarna
Title: Program Manager 2
Agency & Program: Office for Citizens with Developmental Disabilities, Quality Management Section
Telephone: 225-342-5714
E-mail: Dolores.Sarna@LA.GOV

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
375 Imperial Calcasieu Human Services Authority

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Tanya M. McGee**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

Accomplishment #1: Implementation of Primary Care in Lake Charles Behavioral Health Clinic

A. What was achieved?

In order to improve health outcomes by providing access to quality primary healthcare, ImCal opened their *ImHealthy Primary Care Clinic* within the Lake Charles Behavioral Health Clinic (LCBHC). Research has shown that persons diagnosed with a mental health condition are less likely to seek treatment for physical health problems in a primary healthcare setting. This clinic allows for the integration of services and enhanced access to healthcare for our clients. Our goal is to create a person-centered integrated health home for persons with severe mental illness and/or substance abuse problems that will address chronic illnesses such as diabetes, hypertension, obesity, and other preventable diseases. People with mental illness or substance abuse problems are at a much higher risk of developing these illnesses, and we hope to increase access in a way that will improve all-around health for our clients.

B. Why is this success significant?

This program is funded through a $1.6 million Primary and Behavioral Healthcare Integration (PBHCI) Grant award by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This is a highly competitive grant which has only been awarded to one other entity in the state of Louisiana since the grant program's inception in 2007. Three (3)

Local Governing Entities in Louisiana applied for the grant in 2015 and ImCal was the only one awarded. Historically, primary care facilities have attempted this integration of services by hiring a social worker within their practices. ImCal's program does the opposite which is to integrate primary care into an existing behavioral health clinic. Across the country, behavioral health providers who are recipients of the PBHCI Grant have accomplished this integration through community partnerships with local Federally Qualified Health Centers (FQHCs) whereas they provided the FQHC grant monies to hire staff to work in the BH clinic. Unfortunately, the trend has been that when the grant is complete the partnership ends. Due to this, ImCal took a different approach and hired staff directly to run the ImHealthy Program.

C. Who benefits and how?

The ImHealthy program serves adults, 18 years of age and older, residing in Calcasieu, Cameron and Jefferson Davis parishes, who receive treatment for mental health and/or substance abuse disorders at ImCal HSA's Lake Charles Behavioral Health Clinic (LCBHC) and have or are at risk for chronic health conditions. Services that will be available within the ImHealthy program include disease management, medication assistance, tobacco cessation, weight management and wellness, and care coordination. The services within this program will be provided to individuals who qualify, regardless of their ability to pay.

D. How was the accomplishment achieved?

This program is funded through a $1.6 million Primary and Behavioral Healthcare Integration (PBHCI) Grant award by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The ImCal Executive Management team wrote the grant application and the grant was awarded October 1, 2015. Construction on the medical exam rooms in the LCBHC began at that time. Staff were hired and primary care services began in March 2016.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes

Accomplishment #2: Opening of Jefferson Davis Behavioral Health Clinic

A. What was achieved?

In November 2015, ImCal opened the Jefferson Davis Behavioral Health Clinic (JDBHC) in Jennings. The JDBHC provides outpatient mental health, substance abuse, and co-occurring treatment to adults, ages 18 and older, and substance abuse treatment to adolescents, ages 12-17. Historically, residents of Jeff Davis had to either travel to receive services in Lake Charles or

they received very limited mental health services through the Jennings outreach program.

B. Why is this success significant?

Integrated mental health and substance abuse treatment services are now provided in Jeff Davis parish every week compared to historically whereas only limited services were provided once a month. Currently, the JDBHC is staffed with a licensed clinical social worker, certified addiction specialist, registered nurse and advanced practice psychiatric nurse practitioner. The JDBHC began as a one day per week clinic, then quickly grew to six times per month. Once additional staff are hired, JDBHC will be open for integrated BH services twice per week.

C. Who benefits and how?

Residents of Jefferson Davis Parish now have access to mental health and substance abuse treatment within their local community. These services improve their daily functioning and enhance their quality of life.

D. How was the accomplishment achieved?

For several years, ImCal contracted with a private provider for substance abuse services in Jeff Davis parish. This contract was not renewed for FY 2015-16. ImCal utilized those funds to secure the rental of a building in Jennings and to cover additional operational costs. At that time, 150 Jeff Davis residents were accessing services at the Lake Charles clinic. Clinic management adjusted schedules of the Lake Charles staff so that the Jeff Davis residents could be seen in the new Jeff Davis clinic. Currently, the Jeff Davis clinic is staffed with Lake Charles Behavioral Health Clinic (LCBHC) staff.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general

assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

ImCal HSA is on time and on target to meet the goals and objectives set within our 5-year strategic plan. The mission of ImCal HSA is that citizens with mental health, addictions, and developmental challenges residing in the parishes of Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis are empowered, and self-determination is valued such that individuals live a satisfying, hopeful, and contributing life. This mission is accomplished through ImCal's Administrative, Behavioral Health and Developmental Disability Activities. ImCal HSA makes use of best practices in implementing, evaluating, monitoring, modifying existing services so that quality is assured; services meet the needs of those served; and the variety of services available adequately address the range of behavioral health issues identified and are further developed to address service gaps.

ImCal Agency Goals:

I. Increase public awareness and to provide access to care for individuals and their families who are in need of behavioral health and developmental disabilities services.

II. To ensure that services provided are responsive to client needs, based on evidence-based best practices, and that programs afford the client a continuum of care taking into consideration cultural diversity and abide by all State and Federal guidelines.

III. To promote healthy, safe lives for people by providing leadership in educating the community on the importance of prevention, early detection and intervention, and by facilitating coalition building to address localized community problems.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

ImCal HSA continues to make steady progress in all three Program Activity areas. Outside of the two accomplishments described in Section I. above, while ImCal has not significantly exceeded any stated objectives and strategies, we have made steady and efficient progress in all objectives and strategies as indicated in our 5-year plan which gets more and more difficult to accomplish with continuous budget cuts every fiscal year.

1. To what do you attribute this success? For example:
   - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
   - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to

achieve economies or improve service delivery?)
- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
- Other? Please specify.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

1. To what do you attribute this lack of progress? For example:
   - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
   - Is the lack of progress due to budget or other constraint?
   - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
   - Other? Please specify.
2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

NONE

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

☐ Yes. If so, what adjustments have been made and how will they address the situation?
☒ No. If not, why not?

Because ImCal has made steady and efficient progress in all objectives and strategies as indicated in our 5-year plan despite budget cuts**.**

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

ImCal Executive Management Team utilizes the 5-year Strategic plan to develop ImCal HSA's annual operational goals and objectives within the Annual Business Plan as well as develop its annual budget. Performance measure data outlined within the 5-year Strategic Plan is collected quarterly and shared with the Executive Management Team. Performance measures are adjusted as needed.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

Recruitment and retention of professional and qualified staff

A. Problem/Issue Description

1. **What is the nature of the problem or issue?**
   ImCal HSA struggles with recruitment and retention of licensed professional staff and limited access to funds to compete with the private sector.

2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)** Not at this time.

3. **What organizational unit in the department is experiencing the problem or issue?** The Behavioral Health Division within ImCal HSA

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)** The individuals served by ImCal are affected by waiting lists to access services.

5. **How long has the problem or issue existed?** Since ImCal's inception.

6. **What are the causes of the problem or issue? How do you know?** In ImCal's labor pool, recruitment and retention of licensed professional staff and limited access to funds to compete with the private sector.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?** Will continue to struggle in filling vacancies and providing needed services to the community.

B. Corrective Actions

1. **Does the problem or issue identified above require a corrective action by your department?**

☒ No. If not, skip questions 2-5 below.
☐ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

4. Are corrective actions underway?

a. If so:
   - What is the expected time frame for corrective actions to be implemented and improvements to occur?
   - How much progress has been made and how much additional progress is needed?

b. If not:
   - Why has no action been taken regarding this recommendation?
   - What are the obstacles preventing or delaying corrective actions?
   - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:

a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
b. How much has been expended so far?
c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
d. Will additional personnel or funds be required to implement the recommended actions? If so:
   - Provide specific figures, including proposed means of financing for any additional funds.
   - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

- ☒ Internal audit
- ☒ External audits (Example: audits by the Office of the Legislative Auditor)
- ☒ Policy, research, planning, and/or quality assurance functions in-house
- ☐ Policy, research, planning, and/or quality assurance functions by contract
- ☐ Program evaluation by in-house staff
- ☐ Program evaluation by contract
- ☒ Performance Progress Reports (Louisiana Performance Accountability System)
- ☒ In-house performance accountability system or process
- ☐ Benchmarking for Best Management Practices
- ☐ Performance-based contracting (including contract monitoring)
- ☒ Peer review
- ☒ Accreditation review
- ☒ Customer/stakeholder feedback
- ☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

- ☒ Yes. Proceed to Section C below.
- ☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

Louisiana State Civil Service Audit

1. **Title of Report or Program Evaluation**
   Louisiana State Civil Service Audit

2. **Date completed**
   September 24-25, 2015

3. **Subject or purpose and reason for initiation of the analysis or evaluation**
   Mandated Civil Service Audit every 2 years

4. **Methodology used for analysis or evaluation**
   Review of personnel records, human resource policies and HR staff interviews.

5. **Cost (allocation of in-house resources or purchase price)**
   No cost to ImCal

6. **Major Findings and Conclusions**
   ImCal met 100% compliance on 19 of the 22 areas audited. ImCal's compliance is above the state compliance percentages in 20 of the 22 areas. ImCal was commended for 100% compliance within the employee Performance Evaluation System (PES).

7. **Major Recommendations**
   No major recommendations or areas of concern. Three suggested corrections:
   1. In three positions, no documentation of unclassified authority was provided.
   2. For one WAE appointment, documentation of DPRL check not provided.
   3. One promotional appointment not authorized in a timely manner in LA Careers.

8. **Action taken in response to the report or evaluation**
   Human Resource staff reviewed policy and procedures related to the appropriate documentation of certification of compliance, regular monitoring and review of the DPRL list, and implemented a check list to be completed for each personnel action.

9. **Availability (hard copy, electronic file, website)**
   Electronic file available upon request.

10. **Contact person for more information:**
    Name: Sheryl Meek
    Title: LDH Monitor, Corporate Compliance Officer
    Agency & Program: ImCal HSA
    Telephone: 337.475.3100
    E-mail: sheryl.meek@la.gov

CARF Accreditation

1. **Title of Report or Program Evaluation**
   Commission on Accreditation for Rehabilitative Facilities (CARF) Survey

2. **Date completed**
   June 6-8, 2016

3. **Subject or purpose and reason for initiation of the analysis or evaluation**
   Accreditation for ImCal HSA Behavioral Health Clinics

4. **Methodology used for analysis or evaluation**
   Review of ImCal administrative and behavioral health program policies and procedures, chart reviews, staff interviews, stakeholder interviews, client interviews, and facility walk through.

5. **Cost (allocation of in-house resources or purchase price)**
   $9,540.00

6. **Major Findings and Conclusions**
   ImCal HSA was awarded a 3-year Accreditation

7. **Major Recommendations**
   a. Conduct annual review of policy and scope of services
   b. Development of risk management plan
   c. Consistently communicate rights of persons served
   d. Collect data post discharge
   e. Follow-up on unplanned discharges
   f. Develop procedures on regular review of past medication use of persons served

8. **Action taken in response to the report or evaluation**
   ImCal Executive Management Team developed and submitted to CARF a Quality Improvement Plan (QIP) to address major recommendations in the survey. The QIP was approved by CARF on September 6, 2016.

9. **Availability (hard copy, electronic file, website)**
   Electronic file available upon request.

10. **Contact person for more information:**
    Name: Sheryl Meek
    Title: LDH Monitor, Corporate Compliance Officer
    Agency & Program: ImCal HSA
    Telephone: 337.475.3100
    E-mail: sheryl.meek@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department:	**Louisiana Department of Health (LDH)** 376 Central Louisiana Human Services District
Department Head:	**Rebekah E. Gee, MD, MPH** LDH Secretary
Undersecretary (or Equivalent):	**Jeff Reynolds** LDH Undersecretary
Executive Director:	**Michael R. DeCaire, Ph.D.**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Civil Service Audit

A. What was achieved?
Central La. Human Services District (CLHSD) Human Resources successfully completed its first Civil Service audit, since becoming a District.

B. Why is this success significant?
This success is significant because the Civil Service audit ensures that CLHSD is in

compliance with State Civil Service Rules and found that CLHSD only committed four documentation errors and no Rule violations.

C. Who benefits and how?
All former, current, and prospective employees of CLHSD benefit from this accomplishment, which in turn benefits all of the individuals and organizations we serve. CLHSD is ensuring that its employees possess the minimum educational and experiential qualifications and, by doing so, ensures its clientele that they are being provided services by competent employees. Furthermore, employees are being protected from unfair labor practices and the varying types of discrimination.

D. How was the accomplishment achieved?
Human Resources continuously exports data from both the LaGov and LaCareers systems to ensure compliance with all human resources actions. Employee records are constantly reviewed and audited for discrepancies.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, this achievement is a key factor in developing and accomplishing current and future goals and objectives. The Human Resources Department supports the ongoing staff development activity for the District in order to maintain appropriate credentials and ultimately provide support for provision of services.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Not applicable.

Accomplishment #2: Commission on Accreditation of Rehabilitation Facilities (CARF) International Accreditation Renewal

A. What was achieved?
CARF International Accreditation renewal for 3 years.

B. Why is this success significant?
This success is significant because it demonstrates to our clientele that we are providing services to them which meet the standards that CARF has established. CARF International is a non-profit organization with a mission to promote the quality, value, and optimal outcomes of services through the consultative accreditation process. The District continuously assesses and improves its services in order to achieve accreditation. As a result, our clients are provided a higher quality of care.

C. Who benefits and how?
All clients served in the CLHSD's eight-parish service area benefit: Avoyelles,

Concordia, Catahoula, Grant, LaSalle, Rapides, Winn, and Vernon. The District continuously assesses and improves its services in order to achieve accreditation; as a result, our clients are provided a higher quality of care.

D. How was the accomplishment achieved?
The accomplishment was achieved through the use of monitoring activities, collection of data, analysis of data, and feedback to clinicians.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, the accomplishment supports reliability and accuracy of reporting on progress for specific Goals, Objectives, and Strategies identified in the Strategic plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Not applicable

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

- **Please provide a brief analysis of the overall status of your strategic progress.**

CLHSD continues to proceed along the timeline for achieving the identified targets set for the Administrative, Behavioral Health, and Developmental Disabilities divisions of the agency. During the transition from FY14/15 (the "shadow" year) to FY15/16, CLHSD implemented the new electronic health record (ICANotes) and trained all clinical staff on its use. The clinical staff has continued to show improvement in their ability to accurately use ICANotes and have even developed "work-arounds," which enable them to overcome some of the built-in limitations of functionality of ICANotes. In addition, CLHSD began providing behavioral health services to all clients, whereas in previous years, those services were only provided to clients who met eligibility requirements. This greatly expanded the service provision to clients who did not have health benefits. Developmental disability services have continued to function at an optimal level.

- **Where are you making significant progress?**

Significant improvements were made:

- Adapting to and using the ICANotes electronic medical records system
- Transitioning from ICD-9 (International Classification of Diseases) to ICD-10 codes
- CLHSD becoming credentialed providers for the five Bayou Health Plans
- Realignment of duties within staff of Developmental Disabilities has allowed

for the Waiver Services area to handle increasing demands without increasing staffing costs

1.To what do you attribute this success?
This success can be attributed to the coordinated effort of CLHSD leadership and its behavioral health and developmental disabilities staff.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?
This success is a part of a larger trajectory that will continue to grow over the ensuing year(s) and then it should level out at or near optimal performance.

- **Where are you experiencing a significant lack of progress?**
We are not currently experiencing any significant lack of progress.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

☐ Yes. If so, what adjustments have been made and how will they address the situation?
☒ No. If not, why not?

This is the first year of implementation of the current strategic plan developed by the previous Executive Director. The Strategic Plan will be revisited by the current Executive Director during this fiscal year and it will be revised at that time as indicated.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation? Use as much space as needed to explain fully.**

The Strategic Plan is developed according to the priorities set by the Board of Directors of CLHSD and it is further delineated by the Executive Director along with the Executive Management Team, with input from our clinic managers and direct care staff, clients, and external stakeholders. Through all of our monitoring efforts, performance in the delivery of services is measured against the goals and objectives of the strategic plan, rules, and regulations, and adjusted accordingly.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as

demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

No significant department management or operational problems/issues exist.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   5. How long has the problem or issue existed?
   6. What are the causes of the problem or issue? How do you know?
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☐ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   4. Are corrective actions underway?
      a. If so:
         - What is the expected time frame for corrective actions to be implemented and improvements to occur?
         - How much progress has been made and how much additional progress is needed?
      b. If not:
         - Why has no action been taken regarding this recommendation?
         - What are the obstacles preventing or delaying corrective actions?
         - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of financing for any additional funds.
      - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit:**
CLHSD provides ongoing monitoring of clinical and administrative functions. Monitoring tools utilized and reviews conducted are in accord with Council on the Accreditation of Rehabilitation Facilities (CARF) standards and are designed to provide continuous improvements and corrective actions.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
CLHSD is audited by the Legislative Auditor, Department of Health and Hospitals Licensing, Louisiana Office of Risk Management, and Louisiana Department of Civil Service.

☒ **Policy, research, planning, and/or quality assurance functions in-house**
The CLHSD policy planning, development, and implementation is conducted by the Executive Management Team.

☐ Policy, research, planning, and/or quality assurance functions by contract

☒ **Program evaluation by in-house staff:**
Annually, each member of the Executive Team is asked to provide input to the Executive Director regarding the achievements and opportunities for growth for each of the functional areas of the District operations. The input is analyzed in relation to the strategic plan, operational plan, and performance improvement objectives. Adjustments to the strategic planning are made accordingly.

☐ Program evaluation by contract

☒ **Performance Progress Reports (Louisiana Performance Accountability System):**
Performance Indicators and required methodology is developed and approved by the Division of Administration.

☒ **In-house performance accountability system or process:**
CLHSD has an established Performance Improvement Committee.

☐ Benchmarking for Best Management Practices

☒ **Performance-based contracting (including contract monitoring):**
CLHSD Contracts have explicit performance measures and reporting. Contract monitoring is regularly conducted.

☒ **Peer review:**
Peer reviews are conducted annually for the Substance Abuse, Prevention and Treatment (SAPT) funded programs.

☒ **Accreditation review:**
CARF Accreditation

☒ **Customer/stakeholder feedback:**
Customer satisfaction is conducted utilizing the LDH/OBH developed C'est bon Surveys.

☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☒ Yes. Proceed to Section C below.
☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office

during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation:
    - **a. The Human Services Accountability and Implementation Plan (AIP) Annual On-Site Monitoring**
    - **b. Office of Risk Management Compliance Review**
    - **c. Louisiana Department of State Civil Service**
    - **d. Louisiana Performance and Accountability System (LaPAS)**
    - **e. Peer Review**
    - **f. CARF Accreditation**

2. Date completed:
    - **a.** August 5, 2015
    - **b.** February 27, 2015
    - **c.** May 5-6, 2015
    - **d.** Quarterly
    - **e.** December 9, 2015
    - **f.** April 4-5, 2016

3. Subject or purpose and reason for initiation of the analysis or evaluation:
    - **a.** Annual on-site monitoring is conducted to evaluate the Human Services District compliance with the Human Services Accountability and Implementation Plan (AIP).
    - **b.** Compliance review
    - **c.** Compliance review
    - **d.** Compliance with LaPAS requirements
    - **e.** Compliance requirements for the SAPT Block Grant Funding
    - **f.** Accreditation Re-survey

4. Methodology used for analysis or evaluation:
    - **a.** Site visits are conducted by an OCDD and OBH Office Team to validate documentation and support determining the accuracy and reliability of data submitted. A review is conducted to determine compliance with the performance standards in the AIP, and corrective action plans are developed to remediate any areas that do not meet the indicated level of performance expected.
    - **b.** Compliance Review completed by the ORM contractor Sedgewick LP Officer
    - **c.** La Department of Civil Service policy and rules
    - **d.** As required by DOA performance indicator and methodology development.
    - **e.** Peer monitoring visit
    - **f.** Site visit and monitoring by CARF accreditation survey team who visit each location of service provision being accredited.

5. Cost (allocation of in-house resources or purchase price):

a. None
b. None
c. None
d. None
e. None
f. $9,540.00

6. Major Findings and Conclusions:

a. 1. The CLHSD OBH services met 25 of the 25 deliverables monitored. The following are successes observed during the onsite visit that are related to deliverables found within the AIP document:

- In 2015 CLHSD has entered into a Cooperative Endeavor Agreement with the 9TH JDC to establish a Mental Health Court.

- CLHSD recently became a recipient of the Volunteer Generation Grant. The grant provides assistance for persons in need.

2. Developmental Disabilities: There are twenty-nine AIP performance indicators in effect for fiscal year 2014 through 2015. While Central Louisiana Human Service District (CLHSD) met the performance standard for 26 performance indicators (or 90%), the performance standard was not met for three performance indicators (or 10%).

b. None
c. Not applicable
d. None
e. Not applicable
f. None

7. Major Recommendations:

a. Developmental Disabilities:
i. The performance standard was not met for Performance Indicator 9 "Percentage of people employed in the community." The performance result is 5.45% although the target for fiscal year 2014 through 2015 was lowered to 20%. A Corrective Action Plan (CAP) should be developed to help improve performance.
ii. Complaint data should be added to the Complaints Database when complaints are received and/or addressed. With more than 1,078 individuals being served which include 103 individuals with Flexible Family Funds, 171 individuals with Individual and Family Supports and 804 individuals with Waivers during the 4th quarter of fiscal year 2014 through 2015, it is quite possible that complaints were received

and resolved and not entered into the Complaints Database.

b. None
c. None
d. Not applicable
e. Not applicable
f. Not applicable

8. Action taken in response to the report or evaluation:

a. Corrective Action Plans (CAP's) were developed for each performance area of concern. Each of the CAP's are reviewed and revised quarterly by District staff to maximize progress toward set performance standards. The District uses quarterly monitoring activities, collection of data, analysis of data, and feedback to staff and contractors as a method to improve outcomes and compliance.

b. Not applicable
c. Not applicable
d. Not applicable
e. Not applicable
f. Not applicable

9. Availability (hard copy, electronic file, website)
Yes

10. Contact person for more information:

Name: **Michael R. DeCaire, Ph.D.**

Title: **Executive Director**

Agency & Program: **Central Louisiana Human Services District**

Telephone: **318-487-5191**

E-mail: **Michael.DeCaire@la.gov**

Annual Management and Program Analysis Report

Fiscal Year 2015-2016

Department: **Louisiana Department of Health (LDH)**
377 Northwest Louisiana Human Services District

Department Head: **Rebekah E. Gee, MD, MPH**
LDH Secretary

Undersecretary (or Equivalent): **Jeff Reynolds**
LDH Undersecretary

Executive Director: **Douglas Efferson**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain:

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment: Increased Self-Generated Revenues

A. What was achieved?

Northwest Louisiana Human Services District increased self-generated revenue collections by 23% over the previous fiscal year.

B. Why is this success significant?

The dollars being realized are significant and on top of the 34% increase realized in fiscal year

2014-2015.

C. Who benefits and how?

The State of Louisiana benefits by having self-generated revenue collections that better match budgeted expectations. Northwest Louisiana Human Services District (NLHSD) benefits by better meeting budget expectations.

D. How was the accomplishment achieved?

This increase is the direct result of improving clinic billing processes, processing claims through the five Bayou Health plans instead of Magellan, and expanding our third-party billing.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)

Yes

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Yes

II. Is your department Five-year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

Northwest HSD is on time and on target to meet the goals and objectives set within our 5-year strategic plan.

- **Please provide a brief analysis of the overall status of your strategic progress.**

Key elements of the five-year Strategic Plan focus on the successful management of governance, leadership, and district processes so that available funding supports the most services possible to the parishes we serve. In this regard, NLHSD is meeting targets.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

    1. To what do you attribute this success? For example:

- Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
- Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
- Other? Please specify.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

NONE

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

1. To what do you attribute this lack of progress? For Example:
   - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
   - Is the lack of progress due to budget or other constraint?
   - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
   - Other? Please specify.
2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

NONE.

- **Has your department revised its strategic plan/business plan to build on your successes and address shortfalls?**

☒ Yes. If so, what adjustments have been made and how will they address the situation?
☐ No. If not, why not?

The NLHSD Five-year Strategic Plan was updated to reflect the Louisiana Department of Health name change and to better state the existing goals and strategies of the District. The performance standards are unchanged.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

The areas of focus for the strategic plan were developed based on stakeholder input and an update of the District's End Statement by the NLHSD Board of Directors. The NLHSD Senior Leadership Team then adjusted the goals and objectives of the plan based on input from management staff. The final draft has been disseminated to staff via e-mail and posted on the NLHSD shared folder for all staff to reference when needed. Review of the plan is set to occur twice a year with a summary report to the Board of Directors for their review and input.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question.

A. Problem/Issue Description
1. What is the nature of the problem or issue?
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
3. What organizational unit in the department is experiencing the problem or issue?
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
5. How long has the problem or issue existed?
6. What are the causes of the problem or issue? How do you know?
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

No significant department management or operational problems exist.

B. Corrective Actions
1. Does the problem or issue identified above require a corrective action by your department?

☒ No. If not, skip questions 2-5 below.
☐ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
    a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur?
- How much progress has been made and how much additional progress is needed?

b. If not:
- Why has no action been taken regarding this recommendation?
- What are the obstacles preventing or delaying corrective actions?
- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of financing for any additional funds.
      - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☐ Internal audit

☒ External audits (Example: audits by the Office of the Legislative Auditor)
Semi-Annual Legislative Audits and Annual Civil Service Audits

☒ Policy, research, planning, and/or quality assurance functions in-house
Performance Improvement Committee reviews

☐ Policy, research, planning, and/or quality assurance functions by contract

☒ Program evaluation by in-house staff
Behavioral Health Services Annual Performance Analysis Report

☐ Program evaluation by contract

☒ Performance Progress Reports (Louisiana Performance Accountability System)
LaPAS and C'est Bon Reports

☐ In-house performance accountability system or process

☐ Benchmarking for Best Management Practices

☒ Performance-based contracting (including contract monitoring)
Contract Monitoring

☒ Peer review
Medical Staff Review and OCDD Peer Review process

☒ Accreditation review
3-Year Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation with annual conformance review

☒ Customer/stakeholder feedback
I**nput solicited from surveys, during public forums, and requested during the NLHSD Board's annual strategic planning process.**

☒ Other (please specify):
Annual Human Services Accountability and Implementation Plan (AIP)
On-Site Monitoring by the Office of Behavioral Health and the Office for Citizens with Developmental Disabilities.

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☒ Yes. Proceed to Section C below.
☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. **Title of Report or Program Evaluation:**
   Northwest Louisiana Human Services District – Behavioral Health 2015-2016 Annual Performance Analysis Report

2. Date completed

August 26, 2016

3. Subject or purpose and reason for initiation of the analysis or evaluation

This report is generated to fulfill CARF accreditation standards. The report establishes specific, measurable goals and tracks the District's performance in an effort to determine the degree to which the District is achieving the desired service and business outcomes.

4. Methodology used for analysis or evaluation

A systematic annual review of Financial/Resource Allocation, Accessibility, Cultural Competency and Diversity, Risk Management, Human Resources, Technology, Health and Safety, Strategic Planning, Corporate Compliance, and Service Delivery System.

5. Cost (allocation of in-house resources or purchase price)

No direct cost. Used in-house resources.

6. Major Findings and Conclusions

- Transition from Magellan to 5 Bayou Health Plans completed.
- State deficit resulted in reduced State General Funds for behavioral health services.
- Self-generated revenues increased by 23%
- A better leased space for the Minden Behavioral Health Clinic space was recommended and identified.

7. Major Recommendations

- Move the Minden Behavioral Health Clinic into new leased space

8. Action taken in response to the report or evaluation

- The Minden Behavioral Health Clinic has been moved into the new leased space

9. Availability (hard copy, electronic file, website)

Electronic file is available on the District's shared folder

10. Contact person for more information, including

Name: Doug Efferson
Title: Executive Director
Agency & Program: Northwest Louisiana Human Services District
Telephone: (318) 676-5111
E-mail: Douglas.Efferson@la.gov