



State of Louisiana

Louisiana Department of Health Office of Management and Finance

TO: Jay Dardenne
Commissioner of Administration

FROM: Monique Cross
Director of Planning and Budget

DATE: July 1, 2022

RE: Five-Year Strategic Plan

Monique Cross

This memo serves to provide a notice of the availability and web address of the FY 2022-2023 thru 2027-2028 Louisiana Department of Health's 5-Year Strategic Plan. The Department's plan can be viewed on the LDH's website under the Office of Management and Finance, Division of Planning and Budget. The official domain is <http://dhh.louisiana.gov/index.cfm/page/25>.

We believe this plan will articulate our efforts of targeting resources to deliver health care services that are efficient and effective, comprehensive, accessible, community-based and individualized. Furthermore, we believe this plan will provide a basis to evaluate and improve our overall performance and enable us to manage our future, rather than be managed by it.

If you need assistance navigating our website or have questions about agency strategic plans, you may contact Liz Davis at 225-342-5608 or Liz.Davis@la.gov.

c: House Fiscal Division
Senate Fiscal Services
House Health and Welfare Committee
Senate Health and Welfare Committee
Legislative Fiscal Office
Performance Audit Division of the Office of the Legislative Auditor

5-Year Strategic Plan
FY 2022-2023 through FY 2027-2028

LDH Agency Listing

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The Louisiana Department of Health Strategic Plan

FY 2023-2024 through FY 2027-2028

Vision

The vision of the Louisiana Department of Health is a future where all the people of Louisiana will have the opportunity to grow, develop, and live in an environment that is nurturing, supportive and safe, and that promotes and supports the physical, mental and social health of individuals, families, and communities.

Mission

The mission of the Louisiana Department of Health is to protect and promote health and to ensure access to medical, preventive and rehabilitative services for all citizens of the State of Louisiana.

Philosophy

LDH has four major categories in which we are committed to making measurable improvements:

- Improve the Health and Well-being of Louisianans with an Emphasis on Prevention
- Reshape #TeamLDH Culture
- Enhance Customer Service, Partnerships, and Community Relations
- Promote Transparency, Accountability, and Compliance
- Promote Health Equity

Organizational Goals

In order to fulfill its mission, the Louisiana Department of Health intends to:

- Provide quality services
- Protect and promote health practices
- Develop and stimulate services by others
- Utilize available resources in the most effective manner

Jefferson Parish Human Services Authority**Vision**

Jefferson Parish Human Services Authority (JPHSA) aspires to meet the integrated care and support needs of individuals and families by providing effective and responsive services, now and in the future.

Mission

Individuals and families in Jefferson Parish affected by Mental Illness, Addictive Disorders and/or Developmental Disabilities shall live full, healthy, independent and productive lives to the greatest extent possible for available resources.

Philosophy/Values

Jefferson Parish Human Services Authority (JPHSA) embraces the shared philosophies of person-centered, comprehensive, and integrated service planning and delivery within a culture committed:

- To support the individuals we serve with overcoming barriers to achieving full potential;
- To provide effective and responsive services representative of best and evidence-based practices with a focus on positive outcomes;
- To maintain supports and service delivery environments that are welcoming, safe, and encompass full access for the diverse population we serve, regardless of age, gender, and/or disability; and,
- To practice JPHSA's Service Statement – we promise courtesy, empathy, and respect in meeting the expectations of those we serve and each other – during daily interpersonal interactions.

Executive Summary

Jefferson Parish Human Services Authority (JPHSA) is organized under the following provisions of the Louisiana Revised Statutes (LSA-RS): R.S. 28:771 (C); R.S. 36:254 (E); Act 73 of the 2017 Louisiana Regular Legislative Session (R.S. 28:910 *et. seq.*); and, related statutes. JPHSA offers behavioral health, developmental disabilities and primary care services to the residents of Jefferson Parish, Louisiana. As a Local Governing Entity, JPHSA is a political subdivision of the State of Louisiana and a Special Parish District with all the powers and duties of a corporation.

Governance is by a 12-member Board of Directors with nine members appointed by the Jefferson Parish Council and three members appointed by the Governor of Louisiana. Each member represents a specific area of expertise and experience. All members are volunteers and serve without compensation.

The Board operates under a policy governance model with an ends statement, i.e. mission and means limitations policies in place for its chosen Executive Director to follow. The Board governs with an emphasis on: outward vision rather than an internal preoccupation; encouragement of diversity in viewpoints; strategic leadership more than administrative detail; clear distinction between Board and Chief Executive roles; collective rather than individual decisions; future rather than past or present; and, actively rather than reactively.

The Executive Director and his/her leadership team strive to foster a culture of accountability and collaboration in an environment focused on evidence-based, best and promising practices, ongoing assessment of needs, and continuous performance and quality improvement. Positive outcomes and “customer” satisfaction along with work flow efficiency and cost-effectiveness in the provision of services and supports define success. JPHSA holds full and organization-wide accreditation from the Council on Accreditation and National Committee on Quality Assurance Level 3 Patient-Centered Medical Home Recognition for both of its Health Centers.

As mandated by the Board of Directors, JPHSA allocates its resources according to the following priorities:

- **First Priority:** Persons and families in crisis related to mental illness, addictive disorders and/or developmental disabilities shall have their crisis resolved and a safe environment restored.
- **Second Priority:** Persons with serious and disabling mental illness, addictive disorders and/or developmental disabilities shall make use of natural supports, health care, community resources, and participate in the community.
- **Third Priority:** Persons not yet identified with specific serious or moderate mental illness, addictive disorders, developmental disabilities and/or health needs but, who are at significant risk of such disorders due to the presence of empirically established risk factors or the absence of the empirically established protective factors, do not develop the problems for which they are at risk.
- **Fourth Priority:** Persons with mild to moderate needs related to mental illness, addictive disorders and/or developmental disabilities shall make use of natural supports, health care, community resources, and participate in the community.

JPHSA Goals

Goal I: Support sustainability of resources through implementation of evidence-based, best and promising practices.

Goal II: Attract and retain a qualified workforce committed to Mission and to achieving Vision.

JPHSA has one program: Jefferson Parish Human Services Authority.

The Jefferson Parish Human Services Authority program includes the following activities: Behavioral Health Community Services, Developmental Disabilities Community Services, JeffCare, and Compliance & Performance Support/Business Operations.

Behavioral Health Community Services

JPHSA’s Behavioral Health Community Services activity provides community-based treatment and support services for adults, children and adolescents with serious mental illness, emotional

and behavioral disorders, and/or addictive disorders. Treatment and support services include the development, expansion, and provision of housing, employment, mobile crisis services, in-home treatments and supports, and peer support services as well as linkage to additional community resources. Services prevent psychiatric hospitalization, facilitate independence, and maximize individual recovery and resiliency.

Developmental Disabilities Community Services

JPHSA's Developmental Disabilities Community Services (DDCS) activity serves as the Single Point of Entry for individuals with developmental disabilities who live in Jefferson Parish. Supports and services are person-and family-centered and planned to assist individuals with developmental disabilities with achieving full participation and inclusion in their community. DDCS encourages full community participation and inclusion by focusing on increasing independence, promoting equal employment, supporting educational goals, assisting with increasing skill development, and decreasing challenging behaviors that may lead to institutionalization or services in a more restrictive setting.

JeffCare

JPHSA's JeffCare activity provides individuals of all ages with health-center-based behavioral health and/or primary care services utilizing an integrated universal design model to ensure ease of access to services and coordination of care. JeffCare believes individuals are able to live full and productive lives even with behavioral health and primary care issues. Providers render treatment, services, and supports to individuals impacted by physical health, mental health, developmental disability, substance use, and co-occurring disorders. A multidisciplinary team, including the individual receiving services and his/her family, provides personalized treatment and services, based on best practices.

Compliance & Performance Support/Business Operations

JPHSA's Compliance & Performance Support/Business Operations activity provides quality management (monitoring, auditing, correction and/or improvement activities), legal and regulatory compliance services, decision support (data collection, mining and analysis), outcomes reporting, accreditation maintenance, centralized care coordination, managed care contracting, provider credentialing, revenue cycle management for billable services, denial management, contract and grants administration, fiscal/accounting services, risk management, and infrastructure support and management.

Objective I:

Through the Behavioral Health Community Services activity, provide a continuum of services to individuals of all ages, and retain or acquire resources needed to sustain such programs through the end of FY2027-2028.

Strategies:

- 1.1 Monitor community-based employed and contracted providers to ensure adherence to evidence-based and best practices.
- 1.2 Provide intensive technical assistance to maximize community-based provider effectiveness and facilitate linkages to available resources.
- 1.3 Ensure community-based providers implement improvement activities to ensure outcomes are met.
- 1.4 Practice aggressive management of payor denials.

Performance Indicators:

- Percent of payor denials for Functional Family Therapy, Multi-Systemic Therapy, and Community Psychiatric Supportive Treatment services. (Key).
- Percent of adults receiving community-based services who remain in the community without a hospitalization. (Supportive)
- Percent of adults receiving community-based services who remain in stable housing. (Supportive)
- Percent of individuals completing Multi-Systemic Therapy living in the home. (Supportive)
- Percent of individuals completing Functional Family Therapy living in the home. (Supportive)
- Percent of individuals participating in Supported Employment engaged in paid employment within 90 days. (Supportive)
- Percent of youth showing a decrease in positive attitude and an increase in perception of harm toward substance use/abuse. (General)

Objective II:

Through the Developmental Disabilities Community Services activity, provide a continuum of services to individuals of all ages, and retain or acquire resources needed to sustain such programs through the end of FY2027-2028.

Strategies:

- 2.1 Maintain person/family-centered planning, team functioning and leadership.
- 2.2 Maintain the development, implementation and quality of comprehensive plans of support via service monitoring and ongoing plan evaluation.
- 2.3 Monitor community-based providers to support implementation of improvement activities to ensure outcomes are met.

Performance Indicators:

- Percent of new system entry applications received and completed within 45 calendar days. (Key)
- Total unduplicated number of individuals receiving developmental disabilities community-based services. (Key)
- Percent of Individual and Family Support recipients who remain living in the community vs. institution. (Supportive)
- Percent of available home and community-based waiver slots utilized. (Supportive)
- Percent of individuals participating in home and community-based waivers utilizing self-direction. (General)

Objective III:

Through the JeffCare activity, provide a continuum of services to individuals of all ages, and retain or acquire resources needed to sustain such programs through the end of FY2027-2028

Strategies:

- 3.1 Increase capacity for integrated care services.
- 3.2 Continue training and skills development required for fidelity to evidenced-based and best practices.
- 3.3 Practice aggressive management of payor denials.

Performance Indicators:

- Number of adults who receive behavioral health services. (Key)
- Number of children and adolescents who receive behavioral health services. (Key)
- Number of adults who receive primary care services. (Supportive)
- Number of children and adolescents who receive primary care services. (Supportive)
- Percent of individuals who report improvement in or maintenance of depressive symptoms. (Supportive)
- Percent of adults who report improvement in or maintenance of recovery behaviors of goal setting, knowledge of symptom control, and responsibility for recovery. (Supportive)
- Percent of children and adolescents who report improvement in or maintenance of attention deficit symptoms. (Supportive)
- Number of individuals assisted with submission of applications through the Health Insurance Marketplace or the Louisiana Medicaid portals. (General)

Objective IV:

Through the Compliance & Performance Support/Business Operations activity, ensure efficient utilization of resources in support of Mission, as well as sound business practices that meet legal, regulatory, ethical, and accreditation requirements and promote continuous performance and quality improvement through FY2027-2028

Strategies:

- 4.1 Increase revenue by decreasing the number of days to submit claims for billable services.
- 4.2 Utilize detailed and engaging onboarding and supervisory practices to promote ongoing communication and retention of staff.
- 4.3 Demonstrate fidelity to the “No Wrong Door” philosophy, whereby individuals receive fully integrated care and supports regardless of their point of entry.
- 4.4 Meet or exceed Council on Accreditation standards.

Performance Indicators:

- Number of individuals who have documented contact with a care coordinator. (Key)
- Average number of days from date of service to claim submission. (Supportive)
- Percent compliance with completion of intensive First Thirty-Day Orientation for new staff members per internal procedure guidelines. (Supportive)
- Percent of JPHSA Annual Performance & Quality Improvement Initiatives achieved. (General)
- Percent compliance with recommended frequency of documented individual supervision per Staff Development & Supervision Guidelines. (General)

09-301

Florida Parishes Human Services Authority

Note: This budget unit is comprised of one program; therefore, the mission and goals for the budget unit and the program are identical and not reported separately.



Vision

That all people of Florida Parishes will be empowered to lead meaningful and productive lives among friends, relatives, and neighbors regardless of behavioral health needs or developmental disabilities.

Mission

Florida Parishes Human Services Authority (FPHSA) is lighting the path forward by offering services in our communities to help people reach their fullest potential in health and wellness.

Philosophy

To ensure that services provided are responsive to client concerns, integrated in service delivery methods and representative of best practices, in the most cost-effective manner.

Florida Parishes Human Services Authority exists to support each consumer, to the full extent that resources permit, to live productively in the location and environment of their choosing, within appropriate and fiscally responsible parameters.

Executive Summary

The Florida Parishes Human Services Authority Program is a local governing entity/political subdivision of this state created by the Louisiana Legislature to directly operate and manage community-based behavioral health disorders and developmental disabilities in the parishes of Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington. Functions and funds relative to the operation of these services were transferred to FPHSA from the Louisiana Department of Health (LDH). Some funds relative to these functions are also appropriated directly to FPHSA. To increase responsiveness to local human service needs, FPHSA is governed by a board composed of members appointed by the respective parish governing authority and ratified by a plurality of the legislative delegation representing the five parishes which are included in the authority. The program has two major activities: Behavioral Health Services (BHS) and Developmental Disabilities Services (DDS). Also included is the activity of Executive Administration.

Goals:

Goal I

To assure comprehensive services and supports which improve the quality of life and community participation for persons with behavioral health disorders (substance use and serious/persistent mental illness) and developmental disabilities, while providing effective limited intervention to individuals with less severe needs.

Goal II

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.

Goal III

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.

Program A: Florida Parishes Human Services Authority

The Florida Parishes Human Services Authority has one program: Florida Parishes Human Services Authority. The two major activities are: Behavioral Health Services (addictions/substance use and serious/persistent mental health disorders) and Developmental Disabilities Services. Also included is the activity of Executive Administration.

Note: The FPHSA Board of Directors and administration assure consistency of its goals with LDH in the areas of prevention, treatment, support, and advocacy for persons with behavioral health disorders and developmental disabilities.

The Florida Parishes Human Services Authority Program includes the following activities:

- **Activity 1 – Behavioral Health Services** - Behavioral Health Services (BHS) provides an accessible system of prevention and treatment services for addictions/substance use and mental health disorders, as well as home and community-based services. These services are available for persons residing in all five parishes served by FPHSA.

Primary Prevention

Prevention is the proactive outcome-driven process of promoting healthy lifestyles and improving quality of life by empowering individuals, families, and communities through an integrated system of evidence-based policies, programs and practices. Ideally, prevention is intended to prevent or reduce the risk of developing a behavioral health problem such as underage drinking, prescription drug misuse and abuse, and illicit drug use. Early intervention is the key to preventing the onset of substance abuse usage issues. Community involvement is vital to ensure that the issue of prevention is being tackled at every level. It is our belief that prevention works. Furthermore, it provides hope for effecting change to support healthy behaviors.

Addictions/Substance Use Disorders and Gambling Treatment

FPHSA promotes and supports healthy lifestyles for individuals, families, and communities by providing treatment for addictions/substance use disorders and compulsive problem gambling. Levels of care include:

- Outpatient clinics provide intensive and non-intensive outpatient treatment. Intensive outpatient treatment consists of a minimum of nine hours per week at a minimum of three days per week for adults 18 years and older. Non-intensive treatment includes aftercare, counseling and supportive services. The primary mode of treatment for substance use and compulsive problem gambling is group counseling.
- Residential Treatment (Alcohol Drug Unit/Fontainebleau Treatment Center) is a twenty-four hours a day, seven days a week residential treatment modality providing non-acute care. It includes a planned and professionally implemented treatment regime for persons experiencing alcohol and/or other substance use problems.
- FPHSA will maintain a commitment to supporting, providing, and/or facilitating through referral any available FDA approved MAT treatments for substance use disorders including tobacco, opioids, alcohol, and other addictive disorders for which MAT has proven effective.

Mental Health Services

FPHSA provides services to adults with severe and persistent mental health disorders, as well as services for children and adolescents. Clinic-based services, as well as outreach and home and community-based services, are provided in the five parish service area in order to enhance accessibility. Services provided are individualized, educational, and supportive to assist individuals in their recovery.

- Clinic-based services include crisis assessments, behavioral health assessments, psychiatric evaluations, individual, family and group therapy, medication management, case management, and provision of psychiatric medications to individuals. In addition, supportive services are provided through contract providers in the community as an extension of clinic services. Some of these services offered include a crisis phone line for after-hours access, consumer care resources, flexible family funds and peer support services.
- FPHSA clinics refer persons served to its Home and Community-based services when it is deemed appropriate and that the person may benefit from case management services. These individuals often have difficulty with daily functioning and may benefit from supports being provided in their home or community. Supportive services are also provided to individuals who are in the Permanent Supportive Housing initiative. These services are accepted on a voluntary basis and the program is based on the Housing First philosophy. FPHSA also provides in-home treatment for families through the evidence-based Functional Family Therapy – Child Welfare (FFT-CW) program. The FFT-CW program provides Low-Risk Interventions and High-Risk Treatment services to program participants based on a comprehensive assessment of client need.

Primary Care Services

FPHSA will be expanding services to integrate primary care into the existing continuum of services. Integrated primary care will result in better outcomes for individuals served with respect to traditional physical health outcomes as well as behavioral health outcomes. Statistics show that individuals with severe and persistent mental illness die, on average, 25 years earlier than the general population. Integrated primary care and behavioral health services will allow for earlier detection and management of chronic conditions which are responsible for this statistic.

All services are coordinated, and every effort is made to avoid duplication of services, both within the agency and with other community service providers and stakeholders. This philosophy and promotion of coordination and collaboration of service delivery with other area public agencies and service providers helps to maximize use of limited resources, both staff resources and funding for contracted services.

Activity 2-Developmental Disabilities Services – Developmental Disabilities Services (DDS) provides supports and services which afford people with developmental disabilities and their families a seamless system that is responsive to both the individuals needs and desires.

- DDS is the single point of entry into community-based services which include Support Coordination, Individual and Family Support, Flexible Family Fund, Residential Living Option, and local oversight and operation of the Home and Community Based (HCBS) waivers. A developmental disability may be a physical and/or intellectual impairment, must occur prior to the age of 22, not solely attributed to mental illness, and results in substantial functional limitations in three or more areas of major life activities. The Entry Services unit determines whether the individual meets criteria for participation in the system.
 - Support Coordination assists individuals in obtaining needed services through an assessment of their needs, and development of a Plan of Support (POS) which identifies and provides access to natural community supports and system-funded services (such as Medicaid) to meet their needs. Information and referral to other agencies is provided on an ongoing basis.
 - Individual and Family Support services are provided to support those needs of individuals with developmental disabilities which exceed those that can be met by existing resources.
 - Diversion services include diversion funding, coordination for those involved in court and/or LDH custody, diversion admission to residential living options, transition coordination, and referral to immediate support services.
 - Flexible Family Fund is a flat monthly stipend provided to families of children from birth until age 18 with severe developmental disabilities. Funding assists these families meet the extraordinary cost of services and equipment to maintain a child with a developmental disability in the home.
 - Residential Living Options include a broad range of living options which provide 24-hour supports such as community homes.

- The DDS Home and Community Based (HCB) waivers include the New Opportunities Waiver (NOW), the Children’s Choice Waiver (CCW), the Supports Waiver (SW), and the Residential Options Waiver (ROW).
- Pre-admission Screening Resident Review (PASRR) is the review of all nursing home admissions within the FPHSA area of persons with developmental disabilities to determine appropriateness of nursing home environment in meeting their needs in the least restrictive setting and to identify their need for specialized services.

DDS strives to provide supports and services in order to maintain persons with developmental disabilities in the home with family or in a home of their own.

- **Activity 3-Executive Administration** - Florida Parishes Human Services Authority (FPHSA) is a local governing entity/political subdivision of this state with the mission to direct the operation and management of public community-based programs and services relative to behavioral health disorders (including Alcohol Drug Unit and Fontainebleau Treatment Center) and developmental disabilities in the FPHSA catchment area. FPHSA was created to pool funding dollars in the areas of behavioral health and developmental disabilities services and to bring spending and operational decisions down to the local level. FPHSA’s geographical service area includes the five parishes of Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington. The Authority is governed by a nine-member Board of Directors representing the five-parish area. FPHSA, through its Board, directs the operation and management of community-based programs. The Executive Administration oversees the budget, contracting, and purchasing processes, ensuring that the agency optimizes tax-payer dollars; develops, implements, and monitors agency compliance with policies and procedures modeled after state and national best-practices; assesses staff training needs and fosters workforce development by connecting employees with appropriate training opportunities; reduces or eliminates inefficiencies by analyzing and improving on agency processes; keeps pace with the rest of the state by early adoption of technological improvements; and ensures agency adherence to state and federal regulations. A goal of Executive Administration is to avoid duplication, to streamline service delivery, and to improve the quality of care and service delivery to the individuals who are served.

Objective I:

Through the Behavioral Health Services (BHS) activity, FPHSA will provide evidence-based treatment services for individuals with behavioral health disorders and prevention services while providing them in a cost-effective manner.

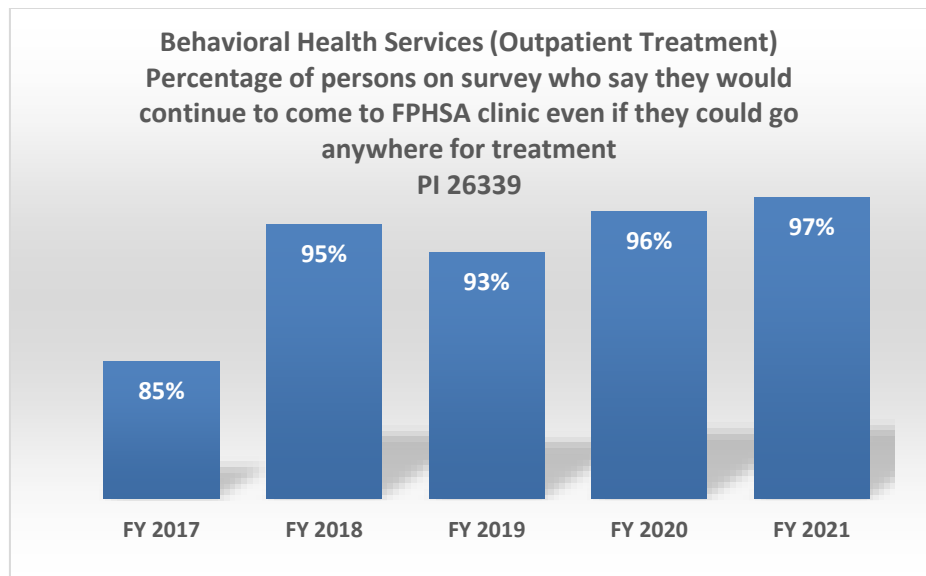
Strategies:

- 1.1: Meet monthly with facility managers and service providers to review performance indicators to identify areas of success or needs for improvement. Develop action plans to facilitate improvement and/or continued success.
- 1.2: Annually seek input from stakeholders and consumers to identify service gaps and initiate program modifications if indicated or initiate collaborations/partnerships in response to survey results.

- 1.3: Provide evidence based and person-centered services that result in positively impact the service recipient's ability to maintain in the community.
- 1.4: Monitor service type, frequency of services, and reimbursements in order to make cost effective adjustments.
- 1.5: Increase the use and accessibility of medication assisted treatment (MAT).
- 1.6: Integrate primary care services in to the current continuum of services.

Performance Indicators:

- 21038/Outcome: Percentage of individuals successfully completing the Level III.5 Adult residential treatment program (ADU/FTC).
- 21039/Outcome: Average daily census- Level III.5 Adult residential treatment program (ADU/FTC).
- 26338/Output: Total unduplicated number of persons served in outpatient behavioral health clinics, includes screening, assessment, and treatment of persons seeking services for substance use, mental health, and compulsive gambling.
- 25954/Output: Total unduplicated number of individuals served in the Level III.5 adult residential treatment program (ADU/FTC).
- 25517/Output: Total number of persons registered in evidence-based educational (prevention) programming (enrollees).
- 21045/Efficiency: Average cost per client day (Level III.5 Adult residential treatment) (FTC/ADU).
- 23829/Efficiency: Average cost per individual served in Level III.5 Adult substance use disorders residential treatment services (ADU/FTC).
- 23830/Efficiency: Average cost per individual served in prevention substance use disorders and prevention gambling programs.
- 23825/Output: Total number of individuals served in prevention programs (includes social media and billboards).
- 23831/Output: Total number of merchants educated through Synar services.
- 26339/Quality: Percentage of persons on survey who say they would continue to come to FPHSA clinic even if they could go anywhere for treatment.



- 26340/Efficiency: Average cost per individuals served in outpatient Behavioral Health Services.
- 25848/Outcome: Percentage of Mental Health Services/Flexible Family Fund Recipients who remain in the community (vs. institution)
- 25516/Output: Number of unduplicated persons participating in evidence-based treatment groups in FPHSA's outpatient clinics.
- 23832/Efficiency: Cost per registered enrollee in evidence-based educational (prevention) programs.
- NEW/Output: Total number of persons registered in evidence-informed educational (prevention) programming (enrollees)

Objective II:

Developmental Disabilities Services (DDS) are designed to support people to remain in their communities or location of choice, support people to achieve valued outcomes, develop meaningful relationships, and attain quality of life as defined by the person. Individualized supports for each person are developed to meet the personal outcomes and goals.

Strategies:

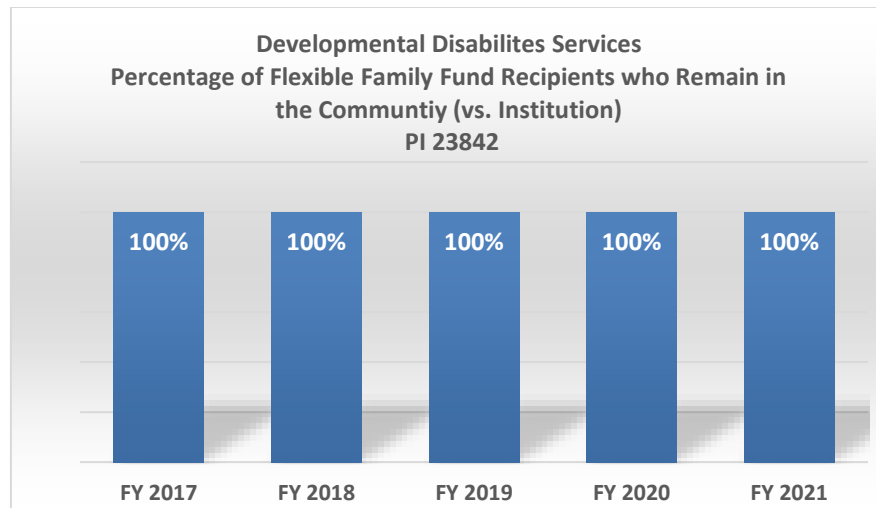
- 2.1: Utilize person-centered planning to assist individuals and families in identifying supports and services needed to live and work in a setting selected by the individual or their family.

- 2.2: Provide quarterly review of supports to the individual to discuss goals and supports and to resolve barriers to achieving their personal goals.
- 2.3: Identify methods of facilitating the opportunity for individuals to gain employment in the community.

Performance Indicators:

- 21022/Output: Total unduplicated number of individuals receiving community-based developmental disabilities services.
- 21023/Output: Total unduplicated number of individuals receiving Individual and Family Support services.
- 23833/Output: Total unduplicated number of individuals receiving Flexible Family Fund services.
- 23834/Output: Total unduplicated number of individuals receiving Individual and Family Support Diversion services.
- NEW/Output: Total unduplicated number of individuals completing the Preadmission Screening and Resident Review (PASRR) services determination process
- 23837/Output: Average value of services per individual receiving Individual and Family Support services.
- 23838/Output: Average value of services per individual receiving Flexible Family Funds.
- 23839/Output: Average value of services per individual receiving Individual and Family Support Crisis services.
- 23840/Output: Average cost per individual receiving Preadmission Screening and Resident Review (PASRR) services.
- 26546/Outcome: Percentage of Waiver participants that remain in the community (vs. institution).
- 23843/Outcome: Percentage of Individual and Family Support recipients that remain in the community (vs. institution).
- 24950/Input: Percentage of Waiver participants with a current Statement of Approval.
- 25073/Output: The total unduplicated number of individuals served through waiver supports and services including New Opportunities Waiver (NOW), Children's Choice Waiver (CC), Supports Waiver (SW), and Residential Options Waiver (ROW).

- 26547/Input: Percentage of Waiver participants with a Level of Care redetermination made within 12 months of initial or last annual evaluation.
- 23842/Outcome: Percentage of Flexible Family Fund recipients who remain in the community (vs. institution).



Objective III:

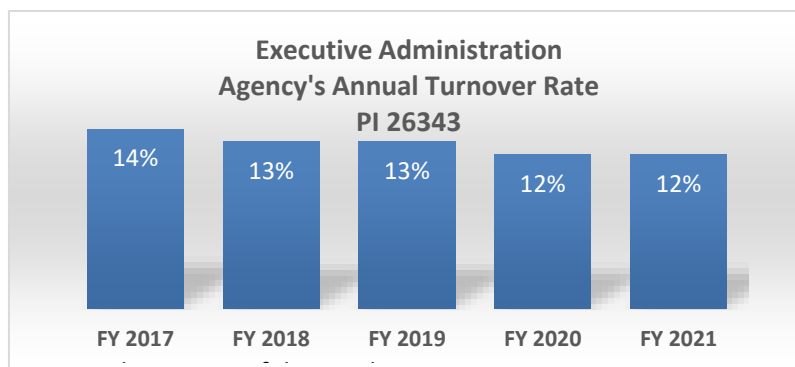
Through the Executive Administration activity, FPHSA will work to continuously improve the effectiveness and efficiency with which the previous objectives are accomplished through the management of available resources in response to the needs to the communities served.

Strategies:

- 3.1: Monitor performance indicators reported in the Louisiana Performance Accountability System (LaPAS) and address any deviations from the assigned target.
- 3.2: Audit agency processes related to activities that affect efficient use of available resources.
- 3.3: Strengthen and improve current workflow processes by internal analyses of established agency policies and procedures to maximize the production and efficiency of FPHSA activities.

Performance Indicators:

- 25534/Efficiency: Percentage of information technology (IT) work orders closed within 6 business days of work request.
- 25535/Efficiency: Percentage of contract invoices for which payment is issued within 30 days of agency receipt.
- 23847/Efficiency: Percentage of new employees completing mandatory online training courses within 90 days of employment.
- 26341/Outcome: Percentage of agency's Performance Indicators within the + / - 5 percent of target.
- 26342/Output: Percentage of contract performance evaluations completed annually.
- 26343/Output: Agency's annual turnover rate.



- 23850/Efficiency: Executive Administration expenditures as a percentage of agency's budget.
- 23851/Quality: Percentage of agency's moveable property accounted for annually.
- 23852/Output: Total number of individuals served by Florida Parishes Human Services Authority.
- 23844/Outcome-Efficiency: Percentage of Performance Evaluation System (PES) completed annually.

09-302

Capital Area Human Services District



Vision

We excel at making lives better.

Mission

The mission of the Capital Area Human Services District (CAHSD) is to deliver caring and responsive services, leading to a better tomorrow.

Philosophy/Values

CAHSD commits to the philosophy that all individuals are valuable members of the community. The District exists to support each person served, to the full extent that resources permit, to live productively in the location and environment of their choosing (within appropriate parameters). The services and supports provided by the District are those determined by the person served to be important to their success and stability. Our staff works with each person served to facilitate attainment of their goals.

Executive Summary

The CAHSD provides mental health, addictive disorders, and developmental disabilities services in Region 2. The agency directs the operation and management of public, community-based programs and services in the parishes of Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge and West Feliciana.

We envision a community network which provides a continuum of supports and services that respond, in a practical manner, to the unique needs of the persons served who live with mental illness, addictive disorders, and developmental disabilities. This coordinated network will allow each individual to develop their potential for living a satisfying and productive life within the community. We continuously strive for greater resource efficiency to expand our capability for innovation and to provide access to more decentralized services.

Agency Goals

Goal I

To provide needed mental health, addictive disorders, and developmental disabilities services for persons served, their families, and communities; in a manner that provides them quick and convenient access.

Goal II

To ensure that services provided are responsive to the concerns of persons served, integrated in service delivery methods, representative of best practice, and consistent with the values of the Louisiana Department of Health and its Program Offices.

Goal III

To promote healthy, safe lives 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.

Goal IV

To structurally and functionally operate clinics in a manner consistent with the needs of diverse payers that allows for quality service expansion and availability.

Program A: Capital Area Human Services District

Program A Mission

Note: This budget unit is comprised of one program, therefore, the mission and goals for the budget unit and the program are identical and not reported separately.

Program A Goals

Note: This budget unit is comprised of one program, therefore, the mission and goals for the budget unit and the program are identical and not reported separately.

Objective I. Through the Administration activity, CAHSD will support and oversee programmatic operations that improve health outcomes of the citizens served by ensuring that administrative functions are carried out in manner that safeguards state assets and protects state resources against fraud, theft and other illegal or unethical activity.

Strategy I.1

The Executive Director, in conjunction with the Executive Management Team, shall establish strategic goals and objectives, develop policy and procedures, provide direction, training & guidance, and monitor compliance with state and federal regulations, departmental directives and legislative mandates for Administration and in the provision of clinic-based services and supports for Adult and Child Behavioral Health, Developmental

Disabilities, Nurse Family Partnership, Prevention and Primary Care, Disaster Response and Emergency Services Continuum.

Strategy I.2 Perform the functions of accounting & fiscal management, budget development and implementation, purchasing & accounts payable, contract development, implementation and management, property control, fleet management, human resources, telecommunications management, travel, staff development and training, information technology, quality assurance and executive oversight that supports the District's employees, providers, and clients/consumers.

Strategy I.3 Monitor compliance with trainings that meet licensure and CARF standards through use of Accreditation Now, LEO (Louisiana Employees Online system), staff development, Office of Risk Management, CPTP, and other resources as needed.

Strategy I.4 Develop, monitor, and oversee implementation of the CAHSD work plan to meet CARF standards and policy requirements for behavioral health accreditation.

Strategy I.5 Continue to manage processes for CAHSD audits, reviews and performance monitoring by external entities (Louisiana Legislative Auditor, Office of Risk Management, Louisiana Property Assistance Agency, Department of Civil Service, LDH Bureaus of Health Standards, LaPAS, etc.).

Performance Indicators:

- Percentage of state assets in the Asset Management system located/accounted for annually
- Number of findings in Legislative Auditor Report resulting from misappropriation of resources, fraud, theft, or other illegal or unethical activity

Objective II. Through the Developmental Disabilities activity, CAHSD will arrange for services for persons with developmental disabilities in the least restrictive setting near their home or community and will ensure that at least 95% of the persons served will have satisfaction with the services they receive.

Strategy II.1 Work with LDH in transitioning persons into living environments of their choice, and in monitoring the quality of services provided to waiver recipients.

Strategy II.2 Continue to use the Office for Citizens with Developmental Disabilities (OCDD) data systems to maintain updated waiting lists for FFF and services being provided to consumers.

Strategy II.3 Continue to work with CAHSD/OCDD staff, providers, and consumers to develop and/or refine outcome-oriented performance indicators for developmental disability services.

Strategy II.4 Continue to conduct/host trainings to increase the knowledge of developmental disabilities services for area healthcare professionals.

Performance Indicators:

- Percentage of those surveyed reporting that they can choose or change agency providing services.
- Number of individuals receiving Family Flexible Fund services
- Percentage of available Family Flexible Funds slots utilized
- Percentage of those surveyed reporting they had overall satisfaction with the services received
- Percentage of those surveyed reporting that the Individual and Family Support services contributed to maintaining themselves or their family member in their own home
- Total persons served

Objective III. Through the Nurse Family Partnership activity, CAHSD will provide home visiting to 100% of participating first time, low-income mothers.

Strategy III.1 Provide Public Health Nurse Providers intensive initial and ongoing education through the NFP National Service Office in utilization of the Visit-to-Visit Guidelines, clinical consultation and intervention resources to translate the program's theoretical foundations and content into practice in a way that is adaptable to each family; and Infant Mental Health training to aid in the assessment of mother-child interaction which is unique to the Louisiana NFP.

Strategy III.2 Public Health Nurse Providers work with mothers to complete their education and provide life coaching for her and her family to make them more self-sufficient by staying in school, finding employment and planning for future pregnancies.

Strategy III.3 Public Health Nurse Providers support mothers after delivery in the adjustment to parenthood. Particular attention is paid to breastfeeding support and assessment of postpartum depression. Individualized parent coaching is aimed at increasing awareness of

specific child developmental milestones and behaviors as well as immunizations and well child exams.

Strategy III.4 Public Health Nurse Providers assist mothers in learning better coping strategies & non-violent techniques in interactions with family members and children.

Performance Indicators:

- Total number of sessions completed
- Number of families served in program

Objective IV. Through the Children's Behavioral Health Services activity, CAHSD will provide an integrated, comprehensive behavioral health system of care, prevention, and treatment services for at-risk youth and their families, ensuring that at least 90% of clients would continue to receive services at CAHSD clinics if given the choice to go elsewhere.

Strategy IV.1 Work closely with local governments, school systems, parents, and other child-serving agencies to identify local needs and patterns of gaps and deficiencies in care delivery systems.

Strategy IV.2 Work to develop new and sustain existing financial partnerships with local governments and other public systems that will allow locally-based service delivery.

Strategy IV.3 Develop funding strategies that combine multiple revenue sources (traditional and non-traditional) as needed for expansion.

Strategy IV.4 Work to maintain school-based delivery of mental health treatment.

Strategy IV.5 Continue and enhance the provision of educational outreach programs targeting school professionals and parents, which are focused on prevention and early intervention.

Performance Indicators:

- Percentage of clients who indicate they would continue to receive services from CAHSD clinics if given the choice to go elsewhere
- Percentage of clients who indicate they would recommend CAHSD clinics to a friend or family member

General Performance Information

- Number of children/adolescents admitted per year for behavioral health services
- Number of child/adolescent substance abuse primary prevention programs offered
- Total children/adolescents served

Objective V. Through the Adult Behavioral Health Services activity, CAHSD will provide a comprehensive continuum of coordinated community-based services and ensure that at least 90% of clients would continue to receive services at CAHSD clinics if given the choice to go elsewhere.

- | | |
|---------------------|---|
| Strategy V.1 | Annually survey consumers to identify programmatic/supportive service gaps, and develop/modify programs in response to results. |
| Strategy V.2 | Expand psychosocial support and consumer education groups in response to results of consumer survey. |
| Strategy V.3 | Implement Evidence Based Practices for clinical outcomes improvement in mental health clinics. |

Performance Indicators:

- Percentage of clients who indicate they would continue to receive services from CAHSD clinics if given the choice to go elsewhere
- Percentage of clients who indicate they would recommend CAHSD clinics to a friend or family member
- Percentage of clients who rate the extent to which they felt better on the client satisfactory survey as agree

General Performance Information:

- Total adults served in CAHSD (Mental Health)
- Total adults served in CAHSD (Addiction Recovery Services)
- Number of persons provided Residential services (CARP)
- Number of persons provided Social Detoxification Services
- Number of persons provided Residential (28-day Inpatient) services
- Number of persons provided Community-Based Residential services
- Number of services provided Outpatient Addiction Recovery services

Objective VI. Through the Prevention and Primary Care activity, CAHSD will improve physical health and emotional well-being of the adult uninsured and underinsured population and ensure that at least 95% of new adult admissions in the three largest behavioral health clinics receive a physical health screen.

- | | |
|----------------------|--|
| Strategy VI.1 | New adult admissions who are linked to a primary care provider at the time of admission will receive education on the importance of having routine health check-ups. |
| Strategy VI.2 | Annually survey consumers to identify programmatic/supportive service gaps, and develop/modify programs in response to results. |
| Strategy VI.3 | Expand primary care services and consumer education groups in response to results of consumer survey. |

Strategy VI.4

Work cooperatively with other entities in the private and public physical health arena (OPH, local government officials, local hospitals and outpatient treatment providers, FQHCs and staff) to provide ongoing health screenings, referrals/connection to primary care and tobacco cessation.

Performance Indicators:

- Percentage of new adult admissions, in the three largest behavioral health clinics, receiving a physical health screen
- Percentage of new adult admissions, determined to be in the need of primary care during the physical health screen, who accept a referral to or agree to follow-up with a primary care-provider

Louisiana Developmental Disabilities Council**Louisiana Developmental
Disabilities Council****Vision**

We envision a system of services, supports and other assistance in Louisiana are provided in a manner that demonstrates respect for individual dignity, personal preference, and cultural differences and enable individuals with developmental disabilities to exercise self-determination, be independent, be productive and be integrated and included in all facets of community life.

Mission

The mission of the Louisiana Developmental Disabilities Council is to advocate for and support people with developmental disabilities to exercise control over their lives and participate fully in the community.

Philosophy

Individuals with developmental disabilities, including those with the most severe developmental disabilities, are capable of self-determination, independence, productivity, and integration and inclusion in all facets of community life, but often require the provision of community services, individualized supports, and other forms of assistance.

Executive Summary

All actions and efforts undertaken by the Developmental Disabilities Council will be directed to advocacy, capacity building and systems change activities to affect real and meaningful reform of Louisiana's system of services and supports to individuals with disabilities and their families. As such the Council will continue to function as Louisiana's premier advocacy organization for individuals with disabilities and their families. The Council will continue to advocate for the community services and supports desired by individuals with disabilities and their families, increased availability of those supports for Louisiana's citizens now waiting for those services, appropriate rebalancing of Louisiana's resources to better meet the needs of our citizens with disabilities and their families, and reasonable fiscal expenditures to support high quality community services.

Agency Goal

The goal of the Developmental Disabilities Council is to effectively implement the Developmental Disabilities Assistance and Bill of Rights Act of 2000 in Louisiana. The Council, through direct activity and funded projects with agencies, organizations, universities, other state agencies and individuals, shall facilitate advocacy, capacity building, and systemic change that contribute to increased community based services for individuals with developmental disabilities.

Program A: Developmental Disabilities Council

Program Description: The La. Developmental Disabilities Council engages in advocacy, systems change, and capacity building activities that contribute to a coordinated, individual and family-centered, individual and family-directed comprehensive system of community services, individualized supports, and other forms of assistance that enable individuals with developmental disabilities to exercise self-determination, be independent, be productive, and be integrated and included in all facets of community life.

Program Mission:

To advocate for and support people with developmental disabilities to exercise control over their lives and participate fully in the community.

Program Goal:

Pursue systems change (e.g., the way human service agencies do business so that individuals with developmental disabilities and their families have better or expanded services), advocacy (e.g., educating policy makers about unmet needs of individuals with developmental disabilities), and capacity building (e.g., working with state service agencies to provide training and benefits to direct care workers) to promote independence, self-determination, productivity, integration and inclusion of people with developmental disabilities in all facets of community life.

Objective I:

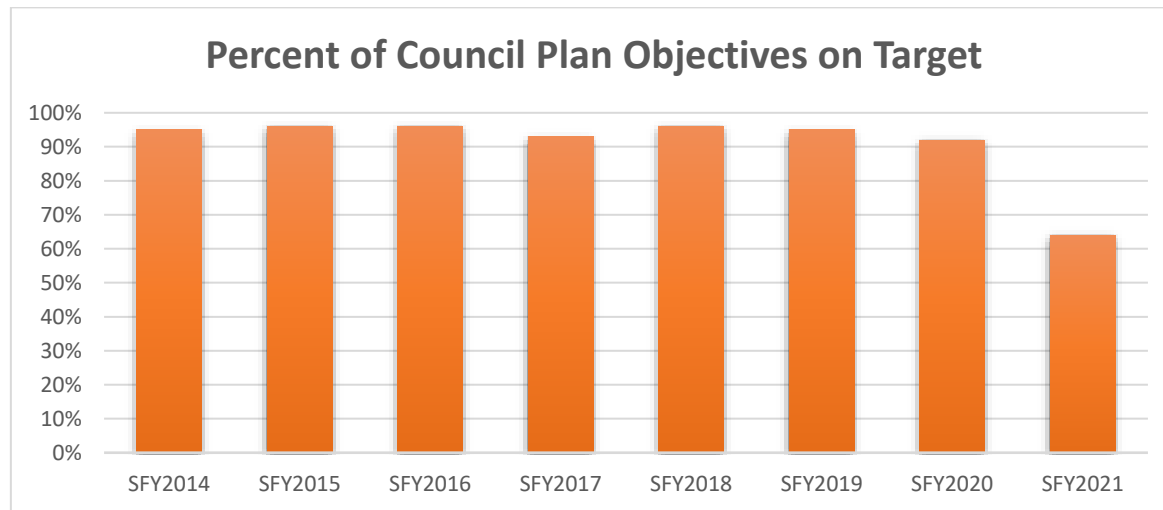
To obtain the Federal Developmental Disabilities Assistance and Bill of Rights Grant Allocation and ensure that Council plan objectives are met on an annual basis each year through June 30, 2028.

Strategies:

- 1.1 Prepare a comprehensive review and analysis of the extent to which services, supports and other assistance are available to individuals with developmental disabilities and their families, and the extent of unmet needs for services, supports, and other assistance for those individuals and their families in Louisiana.
- 1.2 Develop a State five-year plan to facilitate advocacy, capacity Building and systemic change for services/supports for individuals with disabilities and their families in Louisiana.
- 1.3 Expend funds on activities identified in the plan through contracts to various individuals, organizations or entities to facilitate advocacy, capacity building and systemic change for services/supports for individuals with disabilities and their Families in Louisiana.
- 1.4 Ensure that not less than 70% of funds paid to the State of Louisiana under the Act are expended on activities related to the goals identified in the State five-year plan.

Performance Indicator:

- Percent of Council plan objectives on target. *



Objective II:

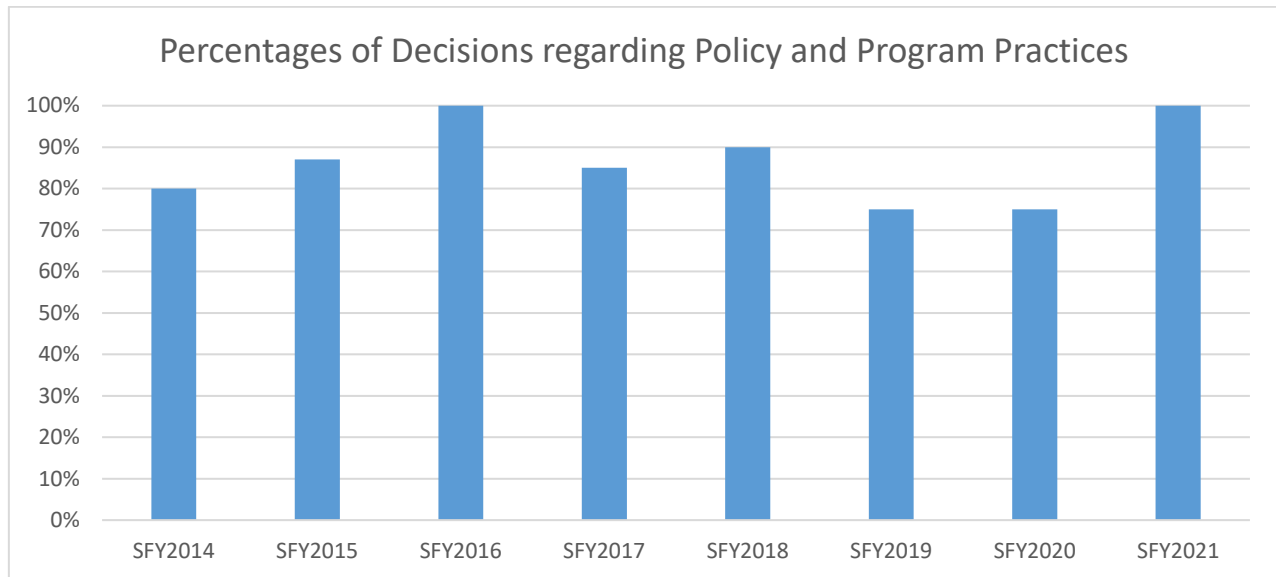
Undertake advocacy, capacity building, and systemic change activities that contribute to increased quantity and quality of community-based services for individuals with developmental disabilities each year through June 30, 2028.

Strategies:

- 2.1 Provide training for self-advocates and their family members to build their advocacy leadership skills, knowledge of the service delivery system and effective advocacy with policy makers.
- 2.2 Identify community needs and promote initiatives and activities that build the capacity of community members, service providers and family members.
- 2.3 Track progress of each agency or system charged with serving individuals with developmental disabilities and the policies that govern these agencies and services to promote movement toward practices that increase self-determination, independence, productivity, integration and inclusion of people with developmental disabilities in their communities.
- 2.4 Disseminate information to family organizations, listserv members, and other advocacy organizations to support grassroots advocacy efforts.

Performance Indicator:

- Percentage of decisions regarding policy and program practices influenced through Council involvement and education that promote self-determination, independence, productivity, integration and inclusion of people with developmental disabilities in their communities



Objective III:

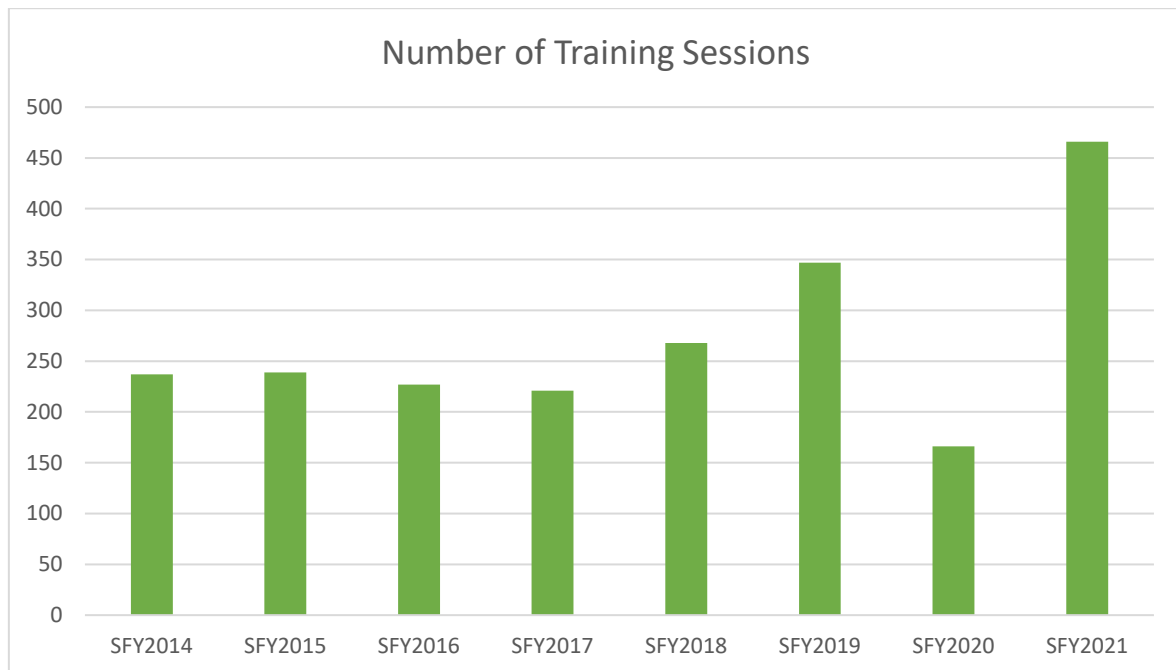
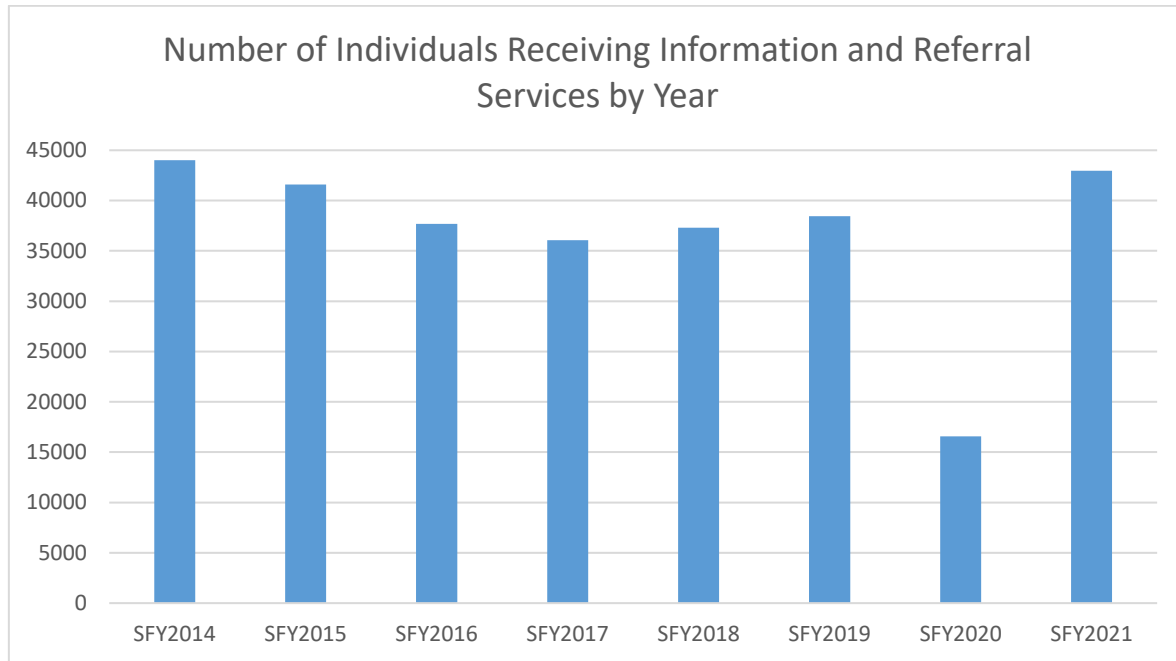
Support information and referral services, education and training for peer to peer support to individuals with developmental disabilities, parents/family members, and professionals each year through June 30, 2025.

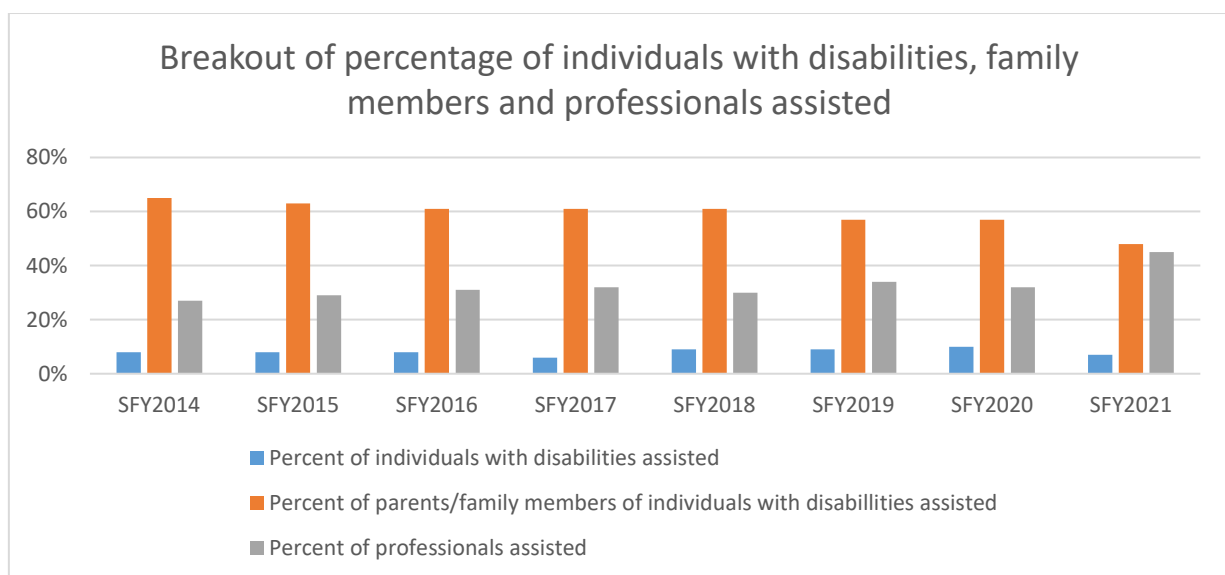
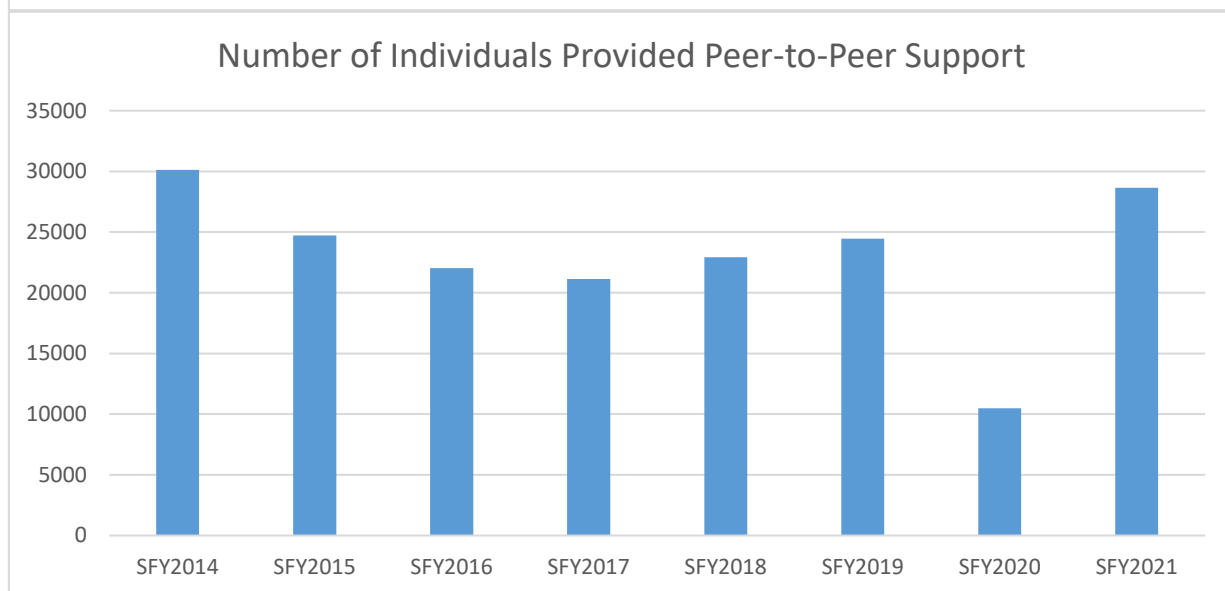
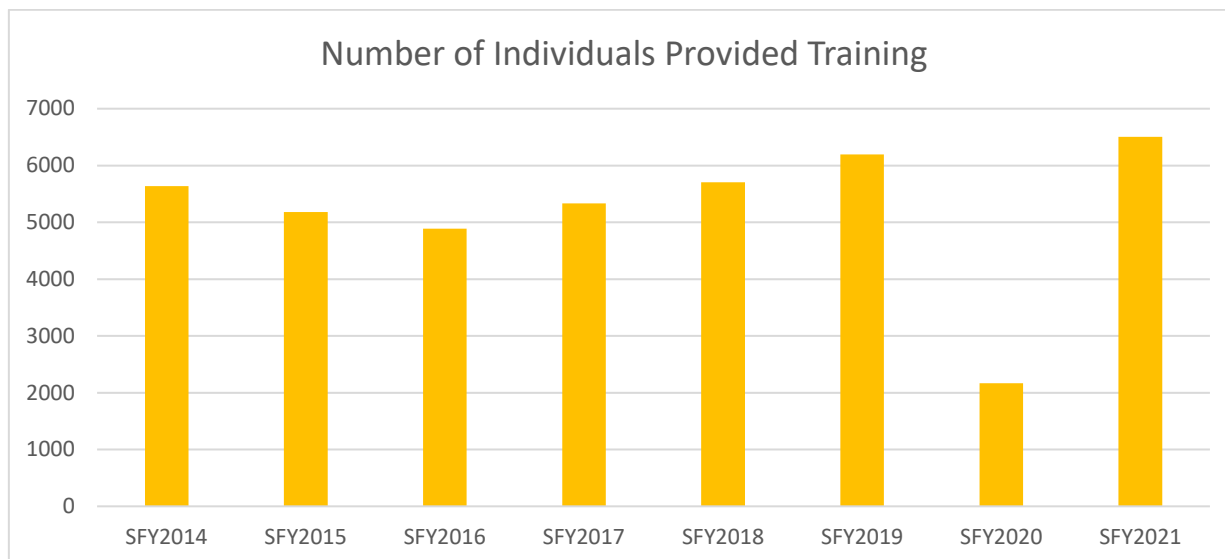
Strategies:

- 3.1 Provide support to Families Helping Families Regional Resource Centers to provide individuals with disabilities and their family members the information and referral to access existing services, education on disability issues and services, and peer to peer support.

Performance Indicators:

- Number of information and referral services provided
- Number of training sessions provided statewide
- Number of individuals provided training statewide
- Number of individuals provided peer-to-peer support opportunities statewide
- Percentage of individuals who report that they received the information or support that they needed *
- Percent of individuals with disabilities assisted
- Percent of parents/family members of individuals with disabilities assisted
- Percent of professionals assisted
- Percent of Families Helping Families Regional Resource Centers maintaining 100% compliance with DD Council contractual obligations and standards of operation.





Metropolitan Human Services District



Vision

Expanding Our Core, Enhancing Our Partnerships

To expand our core service capabilities and partnering collaborations for individuals with Addictive Disorders, Intellectual/Developmental Disabilities and Mental Illness in Orleans, Plaquemines and St. Bernard Parishes.

Mission

To ensure person-centered support and services are available and provided to eligible individuals with Addictive Disorders, Intellectual/Developmental Disabilities and Mental Illness living in Orleans, Plaquemines, and St. Bernard Parishes.

Philosophy/Values

We believe that it is the responsibility of MHSD to garner resources, identify innovative programs, and make available to individuals we serve, a comprehensive array of research-based services offered in an integrated system that promotes consumer choice.

Leadership: We are the center of excellence.

Quality: We commit to continuous quality improvement.

People: We treat people with respect & dignity, demonstrating inclusiveness and recognizing diversity.

Community: We enhance our community through our services and partnerships.

Service: We de-stigmatize services to persons with Addictive Disorders, Intellectual/Developmental Disabilities, and Mental Illness.

Fiscal Responsibility: We are good financial stewards.

Integrity: We do what we say, we say what we do.

Innovative: We promote cutting edge care.

Executive Summary

Metropolitan Human Services District (MHSD) is the local behavioral health authority and the largest comprehensive provider of behavioral health services for the tri-parish area. MHSD persists in engaging leadership and employment of highly trained professionals and professional supports, instrumental to ongoing successes and new strategies as outlined in the FY2024-2028 Strategic Plan. The Plan is the culmination of an inclusive process of partner consensus building around current relevant and measurable outcomes, aligned with the intent of our Vision and our person-centered Mission. As MHSD engages efforts to address the collective needs of our diverse population, it is our intent to be Values centered, fiscally responsible and pointedly transformative in our exercise of service to our community.

Agency Goals

The goals of MHSD represent our analysis of the needs and expectations of our organization. Leadership is the cornerstone of all successful completions. Foundational to successful leadership is commitment to high quality and to the drivers and indicators that promote continuous improvement to our services. Given the impact required to be successful in our goal of fostering healthier communities, we are keenly sensitive to the need for fiscal responsibility throughout this process of change.

Goal I: Leadership

To establish a dynamic Center of Excellence for Behavioral Health (Addiction and Mental Illness) and Intellectual/Developmental Disabilities.

Goal II: Quality

To establish a data driven environment, that includes but is not limited to system infrastructure, data management, and the service delivery monitoring, that supports continuous quality improvement across MHSD.

Goal III: Community

To build community capacity through designated partnerships and facilitate further community awareness of MHSD.

Goal IV: Services

To provide and facilitate a Behavioral Health and Intellectual/Developmental Disabilities continuum of care that is person centered, effective, and innovative for adults, children/adolescents, and their families.

Goal V: Fiscal Responsibility

To create, optimize, and maintain a balanced budget while responsibly managing resources and other assets equitably and sustainably.

Program A: Care Management/Administration

MHSD, serving as the planning body, implements a single point-of-entry care management system that bridges the current gap between inpatient and outpatient behavioral health and developmental disabilities services, assessing the consumer's broad needs, planning and linking the individual to resources to assure access to medical and behavioral health care, and partnering with other community-based providers to increase consumer choice around housing and other supportive services. This work will be supported by creating an administrative structure that is efficient, equitable, effective/evidence-based, patient-centered, safe, and timely.

MHSD Mission

To ensure person centered support and services for eligible individuals with Addictive Disorders, Intellectual/Developmental Disabilities and Mental Illness are available/provided to individuals living in Orleans, Plaquemines, and St. Bernard.

MHSD Goals

Care Management/Administration

- Goal 1 To establish a dynamic Center of Excellence for Behavioral Health (Addiction and Mental Illness) and Intellectual/Developmental Disabilities.
- Goal 2 Maintain data system infrastructure and data management policies and procedures.
- Goal 3 Continuously improve MHSD quality of care.
- Goal 4 Build community capacity through designated partnerships.
- Goal 5 Extend MHSD's training opportunities to various academic levels.
- Goal 6 Facilitate further community awareness of MHSD.
- Goal 7 Provide and facilitate continuum of care that is person-centered, effective, and innovative for adults, children/adolescents, and their families.
- Goal 8 To maximize funding to adequately address community partnerships.

Objective I:

MHSD will strive to provide staff with career development.

Strategy:

- 1.1.1 Supervision for accountability and performance monitoring.

Performance Indicator:

- Number of supervision training opportunity for supervisors. Quality Measure

Objective II:

MHSD will integrate meaningful research into its practices.

Strategies:

- 2.1 Utilize informed best practices in planning and decision making.
- 2.2 Monitor and, when warranted, adapt to the trends in Behavioral Health (Addiction and Mental Illness) and Intellectual/Developmental Disabilities.
- 2.3 Provide technical assistance to partnering agencies.

Performance Indicator:

- Across the agency, number of new programs/ operational changes that are based in research. Output Measure

Objective III:

MHSD will increase accessibility to services for those residing in Orleans, Plaquemines, and St. Bernard Parishes.

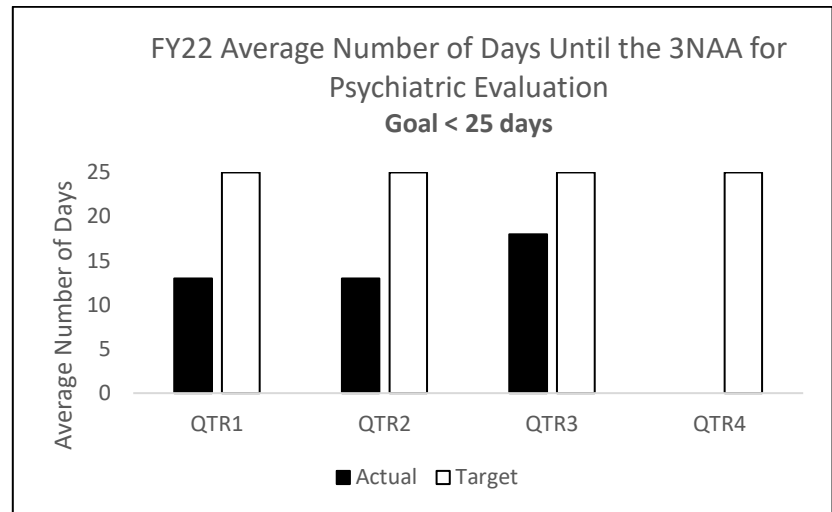
Strategies:

- 3.1 Develop and implement methods that impact accessibility across all MHSD clinics that align with the needs of the individuals whom we serve.

Performance Indicators:

- Percentage of MHSD clinics implementing at least three existing or newly implemented strategies that indicate accessibility to care (i.e., walk-ins, early morning, weekend, and evening hours). Quality Measure
- Average number of days until the third next available appointment for psychiatric evaluation. Efficiency Measure

Third next available appointment (3NAA) is an industry accepted quality indicator that reports the length of time in days between the dates a person served makes a request for an appointment with a provider and the third available appointment. To avoid misrepresentation of appointment availability, the "third next available" appointment is used rather than the "next available" appointment. The MHSD Division of Quality and Data Management (QDM) recognized the need to reliably measure access and benchmark performance. By ensuring timely appointment access, MHSD aims to avoid delays, which can be harmful to those seeking care. Our improvement efforts focus on developing highly efficient scheduling systems that can meet the needs of our persons served and their families.



Note: The bar graph above represents the FY2022 average number of days until the third next available appointment for psychiatric evaluations within MHSD clinics. The data is sourced from the MHSD electronic health record. For this indicator, MHSD seeks to lower the number of days to the 3NAA. When comparing the actual to the target, MHSD has exceeded performance expectations. MHSD attributes its performance to the implementation of flexible clinic scheduling via the establishment of walk-in scheduling.

Objective IV:

MHSD will disseminate District information to staff, providers, community partners, and state/federal agencies and continue to develop its data systems infrastructure.

Strategies:

- 4.1** Initiate and maintain a MHSD information dashboard.
- 4.2** Comply with essential reporting.
- 4.3** Utilize methods that lead to valid and reliable reporting.
- 4.4** Develop IT/systems, data management, and quality management policies and procedure.

Performance Indicator:

- Percentage of quarterly Board Ends reporting and bi-monthly state level data reporting submitted on by the due date. Output Measure

Objective V:

MHSD will identify and further develop the network of community providers and facilitate further community engagement.

Strategies:

- 5.1** Host a MHSD annual community health fair.
- 5.2** Staff/leadership will participate annually in community events.
- 5.3** Host annual meetings with MHSD community/contract partners.
- 5.4** Host annual multi-parish community meeting.
- 5.5** Integrate a new tagline: "Enhancing Our Core, Expanding Our Partnerships."

Performance Indicator:

- Number of non-MHSD staff that participate in MHSD community outreach/events. Outcome Measure

Objective VI:

MHSD will extend the current education and training program.

Strategies:

- 6.1** Identify education/training needs of staff and community partners.
- 6.2** Make available education/ training opportunities to various academic groups.
- 6.3** Increase child and youth addiction partners through MOUs.

Performance Indicator

- Number of collaborations with local academic partners regarding the development of an education/training program. Outcome Measure

Objective VII:

MHSD will identify and fill gaps in services while enhancing the quality of current contract provided services.

Strategies:

- 7.1** Increase the number of community collaborative partners.
- 7.2** Complete an annual gap analysis at the MHSD public forums that assess gaps in the existing service delivery system in Orleans, Plaquemines, and St. Bernard parishes.
- 7.3** Increase quality of contract monitoring to include performance-based budgeting.

Performance Indicator:

- Percentage of clinic service contracts monitored. Quality Measure

Objective VIII:

MHSD will provide an integrated system of care and service delivery.

Strategies:

- 8.1** Host interdisciplinary meetings and staffing.
- 8.2** Coordination of primary care services for persons seeking care.
- 8.3** Provide opportunity for staff to develop competency in services for persons with co-occurring disorders.

Performance Indicator:

- Percentage of MHSD clinical staff who have participated in training opportunities regarding co-occurring disorders. Outcome Measure

Objective IX:

MHSD will build shared resources with community partners.

Strategies:

- 9.1 Complete annual audits of providers' billing.
- 9.2 Conduct RFI's for all contracts over \$150,000.

Performance Indicator:

- Number of audits completed of provider billing. Quality Measure

Program B: Intellectual/Developmental Disabilities

This program focuses on providing cost effective, community-based services and supporting the continued de-institutionalization of individuals with developmental disabilities. Examples of these supports can include: identification of work and supports to maintain work, assisting with maintaining a household, such as paying bills, and assisting with learning hobbies.

Mission

To ensure person centered support and services for eligible individuals with Addictive Disorders, Intellectual/Developmental Disabilities and Mental Illness are available/provided to individuals living in Orleans, Plaquemines, and St. Bernard.

Program B Goals**Intellectual/Developmental Disabilities**

- Goal 1 To conduct aggressive and ongoing outreach.
- Goal 2 To provide timely access to appropriate, comprehensive community-based supports for individuals with disabilities, their families and/or support system such that they will be able to be maintained within their communities.
- Goal 3 To expand Intellectual/Developmental Disabilities services to include behavioral health services and supports to family members through MHSD integrated behavioral health system.
- Goal 4 To increase stakeholders' involvement in MHSD planning, education and decision making.
- Goal 5 To deliver quality services to individuals with intellectual/developmental disabilities and those with co-occurring disorders and their family members with behavioral health issues.

Objective I:

MHSD will conduct targeted collaboration with consumers, family members and community partners to identify individuals with disabilities who may be eligible for supports offered through MHSD.

Strategies:

- 1.1 Utilize school-based health clinics as a vehicle through which clients can be identified.

- 1.2 Community Education & Awareness events sponsored by MHSD to educate individuals, family member, community organizations, school systems and the medical community on how to access services.

Performance Indicator:

- Total number of individuals applying for developmental disabilities services. Output Measure

Objective II:

MHSD will ensure quality and timely assessment and initiation of services for each person with developmental disabilities seeking services through MHSD.

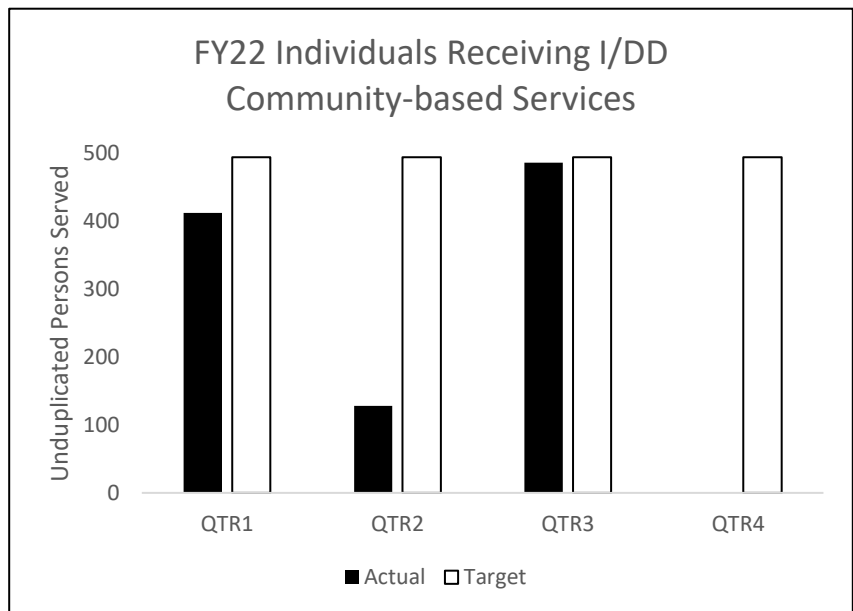
Strategies:

- 2.1 Identify staff to perform I/DD Continuous Quality Improvement function.
- 2.2 Re-Train staff on I/DD policies and procedures.
- 2.3 Include this objective expectation in staff PPR.

Performance Indicators:

- Total unduplicated count of people receiving state funded developmental disabilities community-based services. Outputs Measures
- Number of consumers receiving Flexible Family Funds. Outputs Measures
- Number of Individual Agreements with consumers. Outputs Measures

The bar graph represents the total unduplicated count of people receiving state-funded developmental disabilities community-based services. This measure is used to monitor the number of MHSD persons enrolled in I/DD services. The number of persons enrolled are correlate with state budgetary allowances. That is, when the budget is increased the number of persons served increases and when the budget is reduced the number of persons served reduces.



NOTE: Total unduplicated count of people receiving state funded developmental disabilities community-based services. The data source is the individual case record and is managed in the OCDD Individual Tracking System which tracks all persons receiving state-funded community-based intellectual/ developmental disabilities services.

Objective III:

MHSD will effectively manage the delivery of individualized community-based supports & services through support coordination that assists individuals and family supports in achieving their personally defined outcomes.

Strategies:

- 3.1 Work in partnership with individuals to identify his/her service desires.
- 3.2 Develop Individualized Service Plans that are periodically reviewed.
- 3.3 Partner with private support coordination agencies for continuity of care.
- 3.4 Train private support coordination agencies on person-centered service delivery.
- 3.5 Provide services in communities/neighborhoods.
- 3.6 Appropriately link individual and family into other MHSD behavioral health services.

Performance Indicator:

- Percentage of consumers who indicate satisfaction with services received from MHSD staff, as is reflected in consumer evaluations. Output Measure

Program C: Adult Behavioral Health

This program focuses on improving coordination of services across the outpatient continuum of care for adults with behavioral health problems. MHSD has redesigned its clinic-based structure so that mental health and addictive disorder services are integrated for the clients. MHSD will continue to focus its efforts on working with the hand-off between the inpatient and outpatient settings and ensuring that the necessary transitional services are available for these high-risk clients. And third, MHSD will expand services available to clients as it continues to build out a comprehensive continuum of care.

Mission

To ensure person-centered support and services are available and provided to eligible individuals with Addictive Disorders, Intellectual/Developmental Disabilities and Mental Illness living in Orleans, Plaquemines, and St. Bernard Parishes.

Program C Goals**Adult Behavioral Health**

- Goal 1 Provide and facilitate continuum of care that is person-centered, effective, and innovative for adults, children/adolescents, and their families.
- Goal 2 Continuously improve MHSD quality of care.

Objective I:

MHSD will broaden the array of evidenced-based services provided via outpatient individual, group, and family therapy.

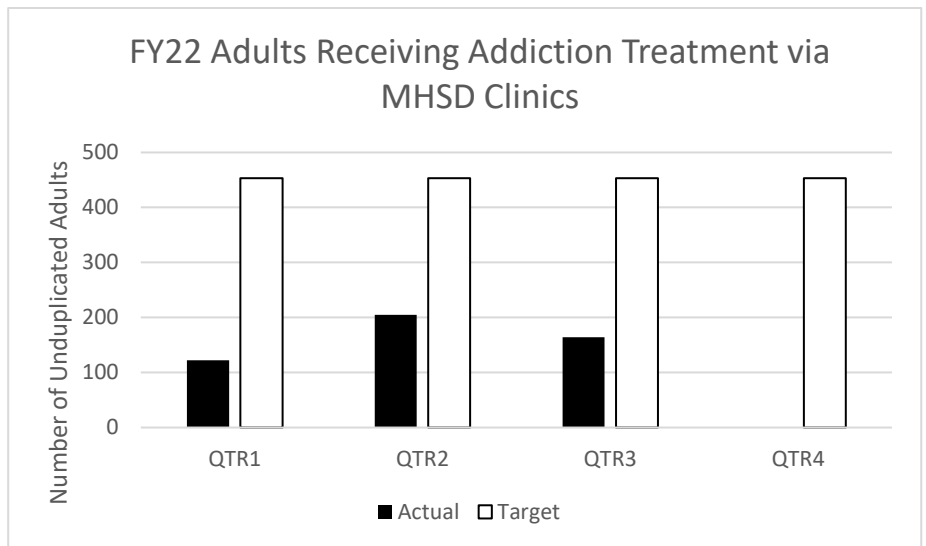
Strategies:

- 1.1 Increase the number of MHSD staff that provide outpatient individual, group and/or family therapy.
- 1.2 Increase the number and types of services provided via outpatient individual, group, and family therapy.

Performance Indicators:

- Unduplicated number of adults receiving mental health services in MHSD clinics. Output Measure
- Number of adults receiving Addiction treatment via MHSD clinics. Output Measure

The bar graph represents the unduplicated count of adults receiving addiction treatment in MHSD clinics. Historically, Addiction services were provided in the community by contractors/partners. This measure is used to monitor the growth of the recently established MHSD Addiction services provided in MHSD clinics.



NOTE: Number of adults receiving Addiction treatment via MHSD clinics. The data source is the MHSD Electronic Health Record.

Program D: Child and Adolescent Behavioral Health Services

This program focuses on improving the coordination of services across the outpatient continuum of care for children and youth with behavioral health problems. MHSD will continue its re-design of the clinic-based delivery system so that mental health and addictive disorder services are integrated for the clients. MHSD will continue to focus its efforts on working with the hand-off between the inpatient and outpatient settings and ensuring that the necessary transitional services are available for these high-risk clients. And third, MHSD will expand services available to clients as it continues to build out a comprehensive continuum of care.

Mission

To ensure person-centered support and services are available and provided to eligible individuals with Addictive Disorders, Intellectual/Developmental Disabilities and Mental Illness living in Orleans, Plaquemines, and St. Bernard Parishes.

Program D Goals

Children's Behavioral Health

- Goal 1 Provide and facilitate continuum of care that is person-centered, effective, and innovative for adults, children/adolescents, and their families.
- Goal 2 Continuously improve MHSD quality of care.

Objective I:

MHSD will broaden the array of evidenced-based services provided via outpatient individual, group, and family therapy.

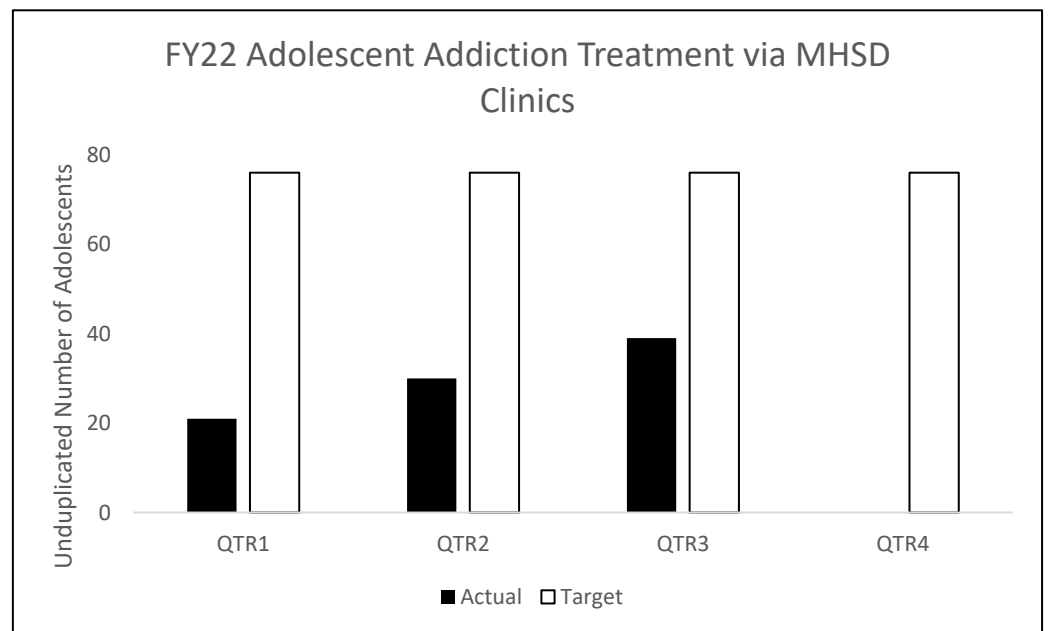
Strategies:

- 1.1** Increase the number of MHSD staff that provide outpatient individual, group and/or family therapy.
- 1.2** Increase the number and types of services provided via outpatient individual, group, and family therapy.

Performance Indicators:

- Unduplicated number of children and adolescents receiving mental health services in MHSD clinics. Output Measure
- Number of children and adolescents receiving Addiction treatment via MHSD clinics.

The bar graph represents the unduplicated count of adolescents receiving Addiction treatment in MHSD clinics. Historically, Addiction services were provided in the community by contractors/partners. This measure is used to monitor the growth of the recently established MHSD Addiction services provided in MHSD clinics.



NOTE: Number of adolescents receiving Addiction treatment via MHSD clinics. The data source is the MHSD Electronic Health Record. MHSD attributes the ascending trend to increased service array in the MHSD clinics.



09-305 Medical Vendor Administration

Vision

Medicaid envisions a future where every Louisianan has a fair and just opportunity to lead the healthiest life possible.

Mission

Our mission is to provide the right health care at the right time, reducing health disparities, and improving overall health outcomes in Louisiana.

Philosophy

Our philosophy is to operate the Medicaid program in a manner that achieves the Triple Aim of optimizing health system performance by improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

Executive Summary

The direction of health care nationally has been to improve care in ways that matter most to patients, families, and communities. It includes increased access to affordable, comprehensive, continuous health insurance coverage, which is essential to the ability to achieve and maintain good health. It emphasizes preventive and primary care to better identify problems, including non-medical drivers of health, and solutions further upstream and outside of acute care. With less complex and more coordinated care, the burden of illness is expected to decline and the per capita cost of care for populations to stabilize or decrease, lessening pressure on publicly funded health care budgets and providing communities with more flexibility to invest in activities, such as education, that increase vitality and economic wellbeing.

In keeping with the nation, Louisiana Medicaid strives to: maximize enrollment of eligible individuals and minimize gaps in coverage which can disrupt access to care and lead to poor health outcomes; promote health by balancing and integrating care through the use of managed care delivery models; increase access to community-based services as an alternative to institutional care; and, move away from a fee-for-service model of payments to health care providers tied to the volume of services that patients receive – amid growing evidence of inefficiencies and poor health outcomes stemming from this model – toward value-based payment models which link providers' reimbursements to the value of the services they provide to improve clinical quality and outcomes, while also containing or reducing health care costs.

Agency Goals

Goal I:

To make comprehensive, coordinated care and quality health services available to all who qualify

Goal II:

To increase access to community-based services as an alternative to institutional care

Goal III:

To reduce the per capita cost of care by balancing health care and prevention spending

Statement of agency strategies for development and implementation of human resource policies that are helpful and beneficial to women and families:

The Medical Vendor Administration is dedicated to the development and implementation of human resource policies that are helpful and beneficial to women and families and demonstrates its support through the following human resource policies: the Family Medical Leave Policy (8108-930), the Sexual Harassment Policy (8143-02) and the Equal Employment Opportunity Policy (8116-77). In addition, the allowance of flexibility in work schedules and the availability of Dependent Day Care Spending Accounts assist both women and their families.

Program A: Medical Vendor Administration

Program A: Mission

The mission of the Medical Vendor Administration Program is to administer an efficient and effective Medicaid program in compliance with state and federal requirements.

Program A: Goals

- I. Provide exceptional customer service
- II. Demonstrate good stewardship of public resources

Activity 1 – Medicaid Eligibility Determination and Enrollment

The Medicaid Eligibility Determination and Enrollment activity serves to identify, engage, enroll and retain eligible individuals in the Louisiana Medicaid program, applying modern technology and customer service functions. This activity advances the agency's Triple Aim philosophy, as access to quality health care is essential to everyone's ability to achieve and maintain good health and is not possible without comprehensive, continuous health insurance coverage.

The eligibility process begins with the completion of a Medicaid application. Either the prospective beneficiary or an authorized representative may apply online, by mail, at a local Medicaid office or at a Medicaid Application Center. Individuals who apply for Medicaid must meet the eligibility requirements of the program. Eligibility determination is a federally approved process operated in a uniform manner throughout the state. In Louisiana, caseworkers in each of the nine regions of the Department of Health determine an individual's eligibility for Medicaid in accordance with standardized policy. Processing times for applications vary depending on the coverage group and program under consideration, the amount of information the person is able to provide, and how quickly all needed information is made available to Medicaid staff. Eligible individuals and families enrolled in the Louisiana Medicaid Program are issued a Medicaid identification card.

In November 2018, LDH replaced its decades old Medicaid eligibility and enrollment system with modern technology. The new system improves customer service to applicants and enrollees. A "self-service" web portal provides applicants and enrollees with the convenience of updating their own information – addresses, employment, household characteristics – 24 hours a day, seven days a week.

Eligibility decisions are faster – within minutes for online applications and renewals when additional information or documentation is not required. In addition to real-time eligibility decisions, automated checks of 20 state and federal databases provide greater assurance that benefits go only to those who meet eligibility requirements, increasing program integrity. Likewise, the use of an automated business rules engine provides for consistent application of a complex and dynamic set of rules governing Medicaid eligibility and regulatory compliance.

With this new, highly automated system and technology-reliant customer service functions, Medicaid strives to strike the right balance between streamlining enrollment and continuing coverage of people who meet eligibility requirements and preventing enrollment or ending coverage of people who do not. Understanding that normal life events — such as getting married or divorced, having children or taking a second job — can change a person’s income and Medicaid eligibility, the agency seeks to implement policy and work processes that minimize “churn” – moving in and out of health insurance coverage, which can disrupt access to care, lead to poor health outcomes, and increase administrative burden for the Medicaid agency and the people it serves.

Objective I: Through the Medicaid Eligibility Determination activity, maximize the efficiency and accuracy of enrolling eligible individuals in Medicaid and CHIP by processing at least 98.5% of applications timely through continuous improvement that is technology driven, simplifies administrative processes and eliminates waste.

Strategies:

- 1.1 Maximize the use of data and technology to produce efficiencies that facilitate the (re)enrollment of eligible individuals, ensure program integrity, and improve customer service.
- 1.2 Increase enrollment and retention of eligible people by removing administrative barriers.
- 1.3 Simplify the application and renewal process.
- 1.4 Streamline enrollment and retention of eligible individuals based on enrollment in the Supplemental Nutrition Assistance Program (SNAP) through Express Lane Eligibility and SNAP Assisted Enrollment.
- 1.5 Streamline enrollment of justice involved population.

Performance Indicators:

- Percentage of Medicaid applications received online
- Percentage of Medicaid applications with real-time eligibility decisions
- Number of children enrolled through Express Lane Eligibility
- Number of certified Medicaid Application Centers
- Percentage of applications for pregnant women approved within 5 calendar days
- Percentage of applications for LaCHIP & Medicaid programs for children approved within 15 calendar days
- Number of individuals enrolled in Medicaid and LaCHIP programs
- Number of applications received annually
- Number of children enrolled as Title XXI Eligibles (LaCHIP)
- Number of children enrolled as Title XIX Eligibles (Medicaid)
- Total number of children enrolled
- Number of adults enrolled as New Adults (Medicaid Expansion)

- Total number of adults enrolled (in Medicaid)
- Percentage of renewals streamlined
- Percentage of renewals processed and not closed for procedural reasons
- Percentage of calls received through the Medicaid & LaCHIP hotlines who hold for a representative less than 5 minutes
- Number of children renewed through Express Lane Eligibility (ELE)
- Percentage of applications for the New Adult program approved within 15 calendar days
- Number of justice-involved adults enrolled pre-release from incarceration

Activity 2 – Medicaid Enterprise Systems (MES)

Louisiana's Medicaid providers deliver essential health care and long-term care supports and services to Medicaid recipients, and their continued participation is key to access to care and improved health outcomes. Medicaid Enterprise Systems (MES) handles most Medicaid provider relations functions, including the processing of provider claims and issuing payments for the fee for service (FFS) program, the processing of encounters (claims paid by managed care entities) for the managed care program, credentialing and enrolling providers in the Medicaid network, and combating fraud, waste and abuse in the Medicaid program.

Aligned with MVA goal of providing exceptional customer service, the provider enrollment and credentialing activity is intended to improve provider experience with the Medicaid program. In 2020, Louisiana Medicaid will fully implement a new, centralized provider management system and become responsible for credentialing and enrollment of all providers, including managed care and fee-for-service. Providers will no longer need to complete numerous, different applications to enroll, become re-credentialed, or updated information in FFS or with the managed care MCOs, leading to improved provider satisfaction. This new system will bring LDH in compliance with the Affordable Care Act's managed care screening requirements.

Provider management will also be the first MES function to comply with federal modularity requirements and be integrated into the statewide enterprise architecture. A primary focus of future MES Activity will be the development and execution of a multi-year strategy for the procurement, design, development and deployment of information technology services and software to further modernize the legacy MES, advancing state strategic objectives and in compliance with federal modularity requirements for MES functions.

Objective I: Through the MES Activity, operate an efficient and effective MES system.

Strategies:

- 1.1 Manage day-to-day activities of the legacy MES contractor responsible for a broad range of fiscal intermediary functions, including the payment of claims to providers, the payment of capitation rates to managed care entities, and timely and accurate reporting on Medicaid payments to state and federal stakeholders.
- 1.2 Develop and execute a multi-year strategy for the procurement, design, development and deployment of modern information technology services and software to replace the legacy MES, advancing state strategic objectives in compliance with federal modularity requirements for MES functions.

Performance Indicators:

- Percentage of total claims processed within 30 days of receipt
- Average claim processing time in days
- Total number of claims processed
- Total number of managed care encounters processed
- Total number of managed care capitation payments processed
- Number of competitive procurements issued for information technology services and software for modular MES functions
- Number of contracts executed for information technology services and software for modular MES functions
- Number of IT services and software designed, developed or deployed for modular MES functions

Objective II: Through the MES Activity, credential and enroll qualified providers in the Medicaid program.

Strategy:

- 1.1 Monitor provider enrollment and credentialing contractor performance to assure that provider enrollment is efficient and accurate.

Performance Indicators:

- Total number of providers credentialed and enrolled in the Medicaid program
- Average length of time to complete enrollment from date of receipt of a properly completed provider enrollment packet
- Average monthly receipts of enrollment requests

Activity 3 – Financial Management

The Louisiana Medicaid program is jointly funded by the federal government and the state. States must ensure they can fund their share of Medicaid expenditures for the care and services available under their state plan and are responsible for safeguarding Medicaid funds by making proper payments to providers, recovering misspent funds, and accurately reporting costs for federal reimbursement. Sufficient financial controls, monitoring and reporting functions are necessary to enable program transparency and demonstrate accountability of public resources to Louisiana taxpayers, lawmakers, and other constituents. Financial management supports the agency's broader goals of ensuring cost effectiveness in the delivery of health care services by using efficient management practices and implementing measures that will constrain the growth in Medicaid expenditures.

Medicaid rate setting and audit functions decrease avoidable public expenditures in the Medicaid program and ensure that limited resources are used for health care initiatives that have proven to be the most responsive to the needs of Medicaid members. These functions also ensure that funding allocated to institutional services, such as Nursing Homes and Intermediate Care Facilities (ICF), is properly spent and that the development of Medicaid cost reports and analysis and audit of hospital records, as required by federal regulations assure that hospitals are being reimbursed in accordance with the provisions of state and federal law, rules and regulations. Additionally, these functions include

monitoring of Local Education Authorities (LEAs) participating in Medicaid for school-based health services to ensure access to Early Periodic Screening Diagnostic and Treatment (EPSDT) and other Medicaid allowable services for children and that reimbursement for these services through certified public expenditures are tracked and audited.

The purpose of establishing and maintaining an effective collections/recovery and cost avoidance program is to reduce Medicaid expenditures and improve program integrity. Monitoring of third party liability (TPL) claims processing enables the Department to enforce that Medicaid is the payer of last resort. Maximizing recoveries will result in the most efficient use of Medicaid funds.

Collections:

- **TPL Collections** - Third parties are legally liable individuals, institutions, corporations (including insurers), and public or private agencies who are or may be responsible for paying medical claims of Medicaid enrollees. Medicaid pays only after a known third party has met its legal obligation to pay, with the exception of claims for prenatal, preventive pediatrics, and medical support enforcement, where Medicaid pays first and then pursues the third party payment, referred to as “pay and chase.” Liable third parties include other health insurers and parties liable for accidents and injuries to Medicaid enrollees.

Recovery:

- **Estate Recovery** - As required by federal regulations, the State must seek recovery of Medicaid payments for long-term care facility services, home and community-based services, and related hospital and prescription drug services from the estate of an individual who was age 55 or older when such services were received.
- **Recipient Recovery** - Payments made to Medicaid providers on behalf of a Medicaid enrollee are subject to recovery from the enrollee if it is subsequently determined that the Medicaid enrollee was ineligible for Medicaid on the date of service.

Cost Avoidance:

- **Cost Avoidance** - Cost Avoidance is the main goal of the TPL program. Once other insurance information is entered on the MES, the system will begin cost-avoiding claims by denying them back to the provider with a message that the beneficiary has other insurance on that date of service and claims should be filed there first. If the provider has already billed the other insurance, Medicaid will only consider making payment up to the Medicaid allowed amount.

Objective I: Through the Financial Management Activity, administer the Medicaid program and ensure that financial operations are in accordance with federal and state statutes, rules, and regulations.

Strategies:

- 1.1 Monitor total expenditures to ensure costs do not exceed available resources for administering the Medicaid Program.
- 1.2 Publish all State Plan Amendments and related documents and communication with Centers for Medicare and Medicaid Services (CMS) on Agency website.

- 1.3 Submit annual reports on managed care programs to the state Legislature.

Performance Indicators:

- Administrative cost as a percentage of total cost
- Percentage of State Plan amendments approved
- Number of State Plan amendments submitted

Objective II: Through the Financial Management Activity, reduce the incidence of inappropriate Medicaid expenditures and annually perform a minimum of 95% of the planned monitoring visits to Local Education Agencies (LEA) participating in the Medicaid School-Based Administrative Claiming Program or the Early Periodic Screening Diagnostic and Treatment (EPSDT) Direct Services Program.

Strategies:

- 2.1 Perform the monitoring of the LEA cost report submissions.
- 2.2 Monitor a minimum of 16 LEAs (school boards) annually, with all LEAs monitored once every three years.
- 2.3 Perform annual monitoring based on agreed upon procedures for nursing homes.
- 2.4 Perform annual monitoring based on agreed upon procedures for ICFs. Assure measurable and accurate performance reporting in accordance with standards established by the American Institute of Certified Public Accountants.
- 2.5 Conduct audits on one-third of cost reports submitted by nursing homes and ICFs to assure the integrity of our rate setting methodology.
- 2.6 Perform the monitoring of reviews of provider cost reports and submit recommendations for partial preliminary payments or contingent receivables.

Performance Indicators:

- Number of LEA quarterly claims targeted for monitoring
- Percentage of targeted LEA monitored
- Number of Nursing Home cost reports targeted for monitoring
- Percentage of Nursing Home cost reports monitored
- Number of ICF cost reports targeted for monitoring
- Percentage of ICF cost reports monitored
- Number of hospital cost reports reviewed and audited
- Number of LEA claims adjusted because of monitoring activities
- Amount identified as over claimed by LEAs because of monitoring
- Number of Nursing Home cost reports adjusted because of monitoring activities
- Number of ICF cost reports adjusted because of monitoring activities

Objective III: Through the Financial Management Activity, pursue collections from third party sources legally responsible for healthcare costs of Medicaid and CHIP enrollees.

Strategies:

- 3.1 Maintenance of the Resource File in order to assure that the most accurate, up-to-date

third party liability information for enrollees is reflected in the MES (payment) system that results in higher collection of funds due.

- 3.2 Monitor the logic of the Medicaid claims payment system and update as needed to be sure that TPL edits are applied correctly.
- 3.3 Streamline work processes for trauma recovery and further integrate technology and automation to increase productivity and, as a result, collections.

Performance Indicators:

- Number of TPL claims processed
- Number of claims available for TPL processing
- Percentage of TPL claims processed and cost-avoided
- Percentage of TPL claims processed through edits
- Funds recovered from third parties with a liability for services provided by Medicaid
- TPL trauma recovery amount
- Percentage change of TPL trauma recovery amount
- Number of requests generated for additional information relative to accidents or injuries

Objective IV: Through the Financial Management Activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from estates of individuals who were aged 55 or older when Medicaid paid long-term care facility services, home and community-based services, and related hospital and prescription drug services.

Strategies:

- 4.1 Pursue legislative updates to laws and regulations regarding estate recovery to reduce or remove the limitations on recoveries and, as a result, increase collections.
- 4.2 Determine the feasibility of contracting for estate recovery services to increase collections.

Performance Indicators:

- Estate recovery amount
- Annual number of cases on which estate recovery was initiated
- Annual number of estate recovery cases resulting in successful recovery
- Percentage increase in estate recovery cases with successful recovery
- Percentage of cases in which heirs claimed hardship exemption
- Louisiana's ranking among states for amount of Estate Recovery

Objective V: Through the Financial Management activity, increase collections through the Collections/Recovery and Cost Avoidance activity by 1% from individuals who were ineligible for Medicaid on the date(s) of service.

Strategy:

- 5.1 Determine the feasibility of a consulting contract for review, tracking, and/or collections related to Special Needs Trusts.

Performance Indicators:

- Recipient recovery amount
- Annual number of cases on which recipient recovery was initiated
- Annual number of recipient recovery cases resulting in successful recovery
- Percentage increase in recipient recovery cases with successful recovery

Activity 4 – Program Integrity

The Department is committed to combating fraud, waste, and abuse (FWA) in the Medicaid program in compliance with state and federal law and regulations. Louisiana Medicaid focuses resources on specific Medicaid activities, such as provider enrollment compliance, managed care compliance, Unified Program Integrity Contractor (UPIC), payment error rate measurement (PERM), surveillance and utilization review (SURS), and recipient fraud investigations.

- **Provider Enrollment Compliance:** Program Integrity checks against appropriate lists of excluded and terminated providers monthly. Program Integrity is responsible for processing provider exclusions, terminations and maintaining the LDH Adverse Actions web search database.
- **Managed Care Compliance:** Medicaid is responsible for ensuring the integrity of all Louisiana Medicaid managed care entities. Medicaid tracks contract compliance across a number of measures, including participating in quarterly program integrity/Medicaid Fraud Control Unit (MFCU) meetings, reporting all providers terminated for cause, compliance with mandatory exclusions, concurrent reporting of suspected or confirmed fraud to Medicaid, and contractually required MCO reporting. Medicaid ensures MCO adherence to contract requirements through issuance of notices of actions and assessment of monetary penalties for non-compliance.
- **Unified Program Integrity Contractor (UPIC):** UPIC vendors contracted with CMS identify and prevent overpayments in Medicaid and Medicare.
- **Payment Error Rate Measurement (PERM):** PERM measures state payment error rates on a 3-year cycle and determines the national error rate. Louisiana has ranked fifth, third, and eighth lowest in each of the past three PERM cycles, starting in 2008.
- **Surveillance and Utilization Review System (SURS):** SURS analyzes data from fee-for-service program and encounter data from Louisiana Medicaid MCOs to detect fraud and abuse by providers.
- **Medicaid Beneficiary Fraud unit:** The Medicaid Beneficiary Fraud (MBF) unit investigates Medicaid beneficiary eligibility. MBF receives tips and referrals of Medicaid beneficiaries and determines if there is an ineligible beneficiary receiving benefits.

Objective I: Through the Program Integrity Activity, process provider terminations and exclusions.

Strategy:

- 1.1 Identify providers for termination, mandatory, and permissive exclusion from the Medicaid program

Performance Indicator:

- Annual number of provider terminations and exclusions

Objective II: Through the Program Integrity Activity, rigorously oversee Medicaid MCOs ensure overall contract compliance in the managed care program.

Strategy:

- 2.1 Assess MCO compliance with contract requirements

Performance Indicators:

- Number of notices of action issued for contract non-compliance
- Amount of monetary penalties assessed for contract non-compliance

Objective III: Through the Program Integrity Activity, prevent and detect claims-based fraud and abuse through data analysis, coordination with MCOs and participation in external audit (UPIC and PERM) activities.

Strategies:

- 3.1 Increase use of predictive analytics in the SURS activity.
- 3.2 Coordinate fraud, waste, and abuse activities across MCOs through shared reporting for improved compliance.
- 3.3 Coordinate with the CMS Unified Program Integrity Contractor (UPIC) in identifying and recovering overpayments.
- 3.4 Participate in CMS Payment Error Rate Measurement (PERM) cycles and incorporate apply PERM findings to reduce improper payments.

Performance Indicators:

- Number of audits/reviews
- Amount of overpayments identified post and pre-pay
- Number of notices and referrals sent to the Attorney General
- State error rate identified through PERM

Objective IV: Through the Program Integrity Activity, identify and review beneficiary eligibility.

Strategies:

- 4.1 Conduct targeted reviews to identify suspected beneficiary fraud
- 4.2 Refer suspected beneficiary fraud cases to law enforcement

Performance Indicators:

- Number of reviews conducted
- Number of referrals to law enforcement



09-306 Medical Vendor Payments

Vision

Medicaid envisions a future where every Louisianan has a fair and just opportunity to lead the healthiest life possible.

Mission

Our mission is to provide the right health care at the right time, reducing health disparities, and improving overall health outcomes in Louisiana.

Philosophy

Our philosophy is to operate the Medicaid program in a manner that achieves the Triple Aim of optimizing health system performance by improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

Executive Summary

The direction of health care nationally has been to improve care in ways that matter most to patients, families, and communities. It includes increased access to affordable, comprehensive, continuous health insurance coverage, which is essential to the ability to achieve and maintain good health. It emphasizes preventive and primary care to better identify problems, including non-medical drivers of health, and solutions further upstream and outside of acute care. With less complex and more coordinated care, the burden of illness is expected to decline and the per capita cost of care for populations to stabilize or decrease, lessening pressure on publicly funded health care budgets and providing communities with more flexibility to invest in activities, such as education, that increase vitality and economic wellbeing.

In keeping with the nation, Louisiana Medicaid strives to:

- 1) Maximize enrollment of eligible individuals and minimize gaps in coverage which can disrupt access to care and lead to poor health outcomes.
- 2) Promote health by balancing and integrating care using managed care delivery models.
- 3) Increase access to community-based services as an alternative to institutional care.
- 4) Move away from a fee-for-service (FFS) model of payments to health care providers tied to the volume of services that patients receive. This is amid growing evidence of inefficiencies and poor health outcomes stemming from this model toward value-based payment models that link provider' reimbursements to the value of the services they provide to improve clinical quality and outcomes, while also containing or reducing health care costs.

Agency Goals

Goal I

To make comprehensive, coordinated care and quality health services available to all who qualify

Goal II

To increase access to community-based services as an alternative to institutional care

Goal III

To reduce the per capita cost of care by balancing health care and prevention spending

Program A: Payments to Private Providers

Program A: Description

The Payments to Private Providers Program (A) provides payments to private providers of health care services to Louisiana residents who are eligible for Title XIX (Medicaid), while ensuring that reimbursements to providers of medical services to Medicaid recipients are appropriate.

Program A: Mission

The mission of Payments to Private Providers is to administer a high-performing Medicaid program that maximizes high-value care and minimizes waste, paying for value over volume of services, and ensuring compliance with federal and state requirements regarding medically necessary services for eligible individuals.

Program A: Goals

- I. To reduce health care costs by providing comprehensive coordinated care that balances health care and prevention spending
- II. To increase access to community-based services as an alternative to institutional care

Activity 1 – Medicaid Managed Care

On February 1, 2012, the Louisiana Department of Health (LDH) transitioned nearly 900,000 Medicaid enrollees from the state's decades old FFS program to a Medicaid managed care model. Rollout occurred in phases based upon designated geographic service areas with the statewide rollout completed on June 1, 2012.

In transitioning from the FFS program to the Medicaid managed care model, Louisiana sought to:

- Improve access to care.
- Improve care coordination.
- Increase emphasis on disease prevention and the early diagnosis and management of chronic conditions.
- Improve health outcomes and quality of care.
- Provide for a more financially stable Medicaid program.

Louisiana's Medicaid managed care program is responsible for providing high-quality, innovative, and cost-effective health care to Medicaid enrollees. Guided by the Triple Aim, LDH partners with

enrollees, providers, and health plans to continue building a Medicaid managed care delivery system that improves the health of populations (better health), enhances the experience of care for individuals (better care), and effectively manages costs of care (lower costs).

More specifically, the Medicaid managed care objectives include:

- Advancing evidence-based practices, high-value care and service excellence
- Supporting innovation and a culture of continuous quality improvement (CQI) in Louisiana
- Ensuring enrollees ready access to care including through innovative means such as medical homes and telehealth
- Improving enrollee health
- Decreasing fragmentation and increasing integration across providers and care settings particularly for enrollees with behavioral health needs
- Using a population health approach, supported by health information technology, to advance health equity and address social determinants of health
- Reducing complexity and administrative burden for providers and enrollees
- Aligning financial incentives and building shared capacity to improve health care quality through data and collaboration
- Minimizing wasteful spending, unnecessary utilization, and fraud

Today, Louisiana Medicaid serves approximately 35 percent of the state's population. Five (5) statewide Managed Care Organizations (MCOs), one (1) Behavioral Health Prepaid Inpatient Health Plan (PIHP), and two (2) Dental Prepaid Ambulatory Health Plans (PAHPs) pay for health care services for more than 90 percent of the Louisiana Medicaid population including 727,501 new adults since Medicaid expansion took effect in July 2016 (<https://ldh.la.gov/HealthyLaDashboard/>). The Louisiana Medicaid Managed Care program is a full risk-bearing, MCO health care delivery system responsible for providing specified Medicaid core benefits and services included in the Louisiana Medicaid State Plan to Medicaid recipients. An MCO assumes full risk for the cost of core benefits and services under the Contract and incurs loss if the cost of furnishing these core benefits and services exceeds the payment received for providing these services. LDH establishes a Per Member per Month (PMPM) actuarially sound risk-adjusted rate for MCO payments. The rates are not subject to negotiation or dispute resolution. These managed care entities (MCEs) pay for Medicaid benefits and services included in the Louisiana Medicaid State Plan, state statutes and administrative rules, and Medicaid policy and procedure manuals. In addition, these MCEs also provide specified value-added Medicaid benefits and services.

In December 2015, LDH integrated specialized behavioral health services into the managed care program in an effort to improve care coordination for enrollees and facilitate provision of whole-person health care. Louisiana also continues to administer the Coordinated System of Care (CSoC), a single behavioral health PIHP to help children with behavioral health challenges that are at risk for out-of-home placement. Wraparound support and other services assist children with staying in or returning to their home.

The Dental Benefit Program (DPB) coordinates dental care for Medicaid recipients. The DBP provides children with preventive and diagnostic services such as regular exams and sealants as well as therapeutic services to treat dental medical problems. Adults receive denture services and comprehensive oral exams.

Objective I: Through the Medicaid Managed Care Activity, increase budget predictability while providing for a service delivery model of high quality, medically necessary health services, and avoiding unnecessary spending on duplication of services and low-value care.

Strategies:

- 1.1 Ensure greater budget predictability through the provision of health care services under managed care models that maintain PMPM full risk payment rates for the delivery of health care services.
- 1.2 Implement new and revised payment policies and models that discourage the inappropriate use of higher cost, procedures that are not medically necessary or evidence-based and further encourage quality of care through value-based payments.

Performance Indicators:

- Percentage of Medicaid enrollees enrolled in a managed care model
- Percentage of Medicaid enrollee expenditures under a managed care model
- Annual amount of premium taxes paid by Medicaid managed care plans

Objective II: Through the Medicaid Managed Care Activity, increase preventive and primary health care use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid members.

Strategies:

- 2.1 Encourage Medicaid recipients to obtain appropriate preventive and primary care in order to improve their overall health and quality of life, and to ensure that those who care for them provide the coordinated care through managed care programs.
- 2.2 Provide health services in the most integrated setting possible, and emphasize community and home based alternatives where appropriate.
- 2.3 Reimburse for a cohesive service delivery model of high quality medically necessary behavioral health services, avoiding the use of services that are not medically necessary or evidence-based and maximizing the use of federal funding.
- 2.4 Promote collaboration among dental providers and medical care providers that increases information sharing, understanding of eligibility requirements, and access to and utilization of oral health care benefits.

Performance Indicators:

- Percentage increase of children's access to behavioral health services
- Percentage of Medicaid enrollees, 2-21 years of age, who had at least one dental visit in a year
- Number of Medicaid enrollees, 6-9 years of age, enrolled for at least 90 consecutive days, who receive a dental sealant on a permanent molar tooth
- Percentage of child and adolescent well care visits
- Percentage of well care visits for children in the first 15 months of age
- Percentage of well care visits for children 15 to 30 months of age
- Percentage of adult access to preventive or ambulatory services

Activity 2 – Long-Term Services and Supports (LTSS)

In 1981, the Federal Government created Title XIX, Home and Community-Based Services (HCBS), in order to provide home and community-based services to the elderly and persons with physical disabilities, developmental disabilities, and/or mental illnesses. Since this act made an exception to the traditional Medicaid requirements, it required a waiver. Waivers give states flexibility to develop and test creative alternatives for operating their Medicaid programs that are cost neutral compared to what the federal government would have paid in absence of the waiver. These waiver programs allow Louisiana residents to receive Medicaid State Plan benefits while having greater flexibility to choose the services and supports that best suit their needs. They also allow individuals to preserve their independence by staying out of institutional settings and maintaining ties to families and friends.

Objective I: Through the Long-Term Services and Supports Activity, ensure the HCBS program remains in compliance with state and federal requirements so that Medicaid can continue to increase access for HCBS recipients.

Strategies:

- 1.1 Ensure compliance with CMS quality design and review processes for 1915(c) Waivers
- 1.2 Ensure provider compliance with Medicaid's Electronic Visit Verification (EVV) system for in-home personal care service providers.

Performance Indicators:

- Percentage of LTSS recipients receiving Home and Community Based Services
- Percentage of providers compliant with the State's EVV standard

Program B: Payments to Public Providers

Program B: Description

The Payments to Public Providers (B) provides payments to public providers of health care services to Louisiana residents who are eligible for Title XIX (Medicaid), while ensuring that reimbursements to providers of medical services to Medicaid recipients are appropriate.

Program B: Mission

The mission of Payments to Public Providers is to administer the Medicaid Program to ensure operations are in accordance with federal and state statutes regarding medically necessary services to eligible recipients.

Program B: Goals

- I. To facilitate contractual arrangements between safety net public providers and Medicaid managed care entities.
- II. To provide cost effective and medically appropriate Medicaid covered services through public providers.

Activity 1 – Payments to Public Providers

This activity provides access to care through state and local governmental providers of health care

services, including some services not readily available in the private sector, such as services provided to individuals with severe mental illness (Eastern Louisiana Mental Health System, Central Louisiana State Hospital) and developmental disabilities (Pinecrest Services and Supports Center).

With the privatization of the Louisiana State University hospitals and clinics through Public-Private Partnerships, payments to public providers previously made to those entities shifted to the Payments to Private Providers Activity. Remaining public providers include the Office of Public Health (OPH), which bills for services provided at local health units, and Local Education Authorities (LEAs) that provide health care services to children attending public schools.

School-based services can improve access to care for children who may have difficulty in receiving services in a physician's office or clinic. This will result in earlier identification of certain medical conditions leading to earlier intervention. The school nurse will make necessary referrals to a physician when appropriate and assist the child's family in making that appointment. School nurses must coordinate with the student's Medicaid managed care entity to assure continuity and coordination of care.

Objective I: Through the Payment to Public Providers Activity, track utilization of services provided by local school systems including nursing services, which allow important medical screenings to be provided by these school systems with Medicaid reimbursement.

Strategies:

- 1.1 Track utilization and growth of services that LEAs provide, including nursing services for screenings and referral to physicians for treatment.
- 1.2 Conduct outreach to LEAs.

Performance Indicators:

- Number of LEAs participating in school nursing services
- Number of unduplicated recipients receiving school nursing services from LEAs
- Number of school nurses in participating LEAs

Program C: Buy-Ins & Supplements

Program C: Description

The Buy-ins & Supplements Program (C) provides medical insurance for eligible Medicaid and CHIP enrollees through the payment of premiums to other entities. This avoids potential additional Medicaid costs for those eligible individuals who cannot afford to pay their own "out-of-pocket" Medicare costs.

Program C: Mission

The mission of the Buy-Ins & Supplements Program is to purchase health care services through the payment of premiums to other entities on behalf of certain Louisiana Medicaid and CHIP enrollees. This program has two major components:

1. **Medicare Buy-Ins and Supplements** is the federal program that allows states to purchase Medicare coverage for individuals with limited income and resources by paying their monthly Medicare Part A and/or B premiums. By doing so, the state provides medical insurance protection

to individuals with limited income and resources. For those individuals dually-eligible for Medicaid and Medicare, it has the effect of transferring some medical costs for this population from the Title XIX Medicaid program, which is partially state financed, to the Title XVIII Medicare program, which is fully financed by the federal government. Federal matching money is available through the Medicaid program to assist states with the premium payments for Medicare buy-in enrollees.

2. **Louisiana Health Insurance Premium Payment (LaHIPP)** is a program authorized under the authority of Section 1906 of the Social Security Act. It may reimburse all or a portion of an employer sponsored insurance (ESI) or individual market premium on behalf of a Medicaid recipient, if purchasing such insurance is determined to be more cost effective than having Medicaid as the primary payer of medical expenses. Medicaid may also pay the out of pocket expenses (co-pays and deductibles) for LaHIPP eligibles enrolled in ESI or individual market coverage.

Program C: Goals

- I. Medicaid cost avoidance through Buy-Ins (paying premiums) for Medicare and Medicaid dual eligibles.
- II. To reduce Medicaid expenditures for Medicaid enrollees through reimbursement of employee's share of paid premiums for employer-based or individual market health insurance when cost effective to do so.

Activity 1 – Medicare Savings Program for Low-Income Seniors & Persons with Disabilities

The ultimate aim of the Medicare Savings Program (MSP) is to improve the health of its beneficiaries. Reducing financial barriers to health care can lead to better health outcomes, and expanding access to health care improves health status and mortality for those with the lowest incomes. The MSP has been shown to improve access to medical care services. Utilization of all medical service types is greater for MSP enrollees than for eligible non-enrollees, even when accounting for differences in health status and other characteristics. Data has shown that MSP enrollment increases access to preventative and primary care through use of outpatient hospital services and a higher frequency of office visits.

As an added benefit, people who qualify for the MSP are automatically eligible for the low-income subsidy (LIS or Extra Help), which helps pay for the premium, deductible, and some copayments of a Medicare Part D drug plan, enabling them to maintain drug coverage. The state receives regular Medicaid federal match on Qualified Medicare Beneficiaries (income below 100% Federal Poverty Level [FPL]) and Specified Low Income Beneficiaries (income between 100-120% FPL), but expenditures for Qualified Individuals (between 120-135% FPL) are 100% federally funded.

Objective I: The Medicare Savings Program for Low-Income Seniors & Persons with Disabilities Activity will avoid more expensive costs that Medicaid would otherwise fund. It ensures that eligible low-income senior citizens do not forego health coverage due to increasing Medicare premiums that make maintaining coverage increasingly difficult.

Strategies:

- 1.1 Resolve buy-in problems quickly, so that MSP coverage continues.
- 1.2 Continue outreach to promote the program to the public.

- 1.3 Simplification of renewal process so that it is not burdensome to the recipients.

Performance Indicators:

- Total number of recipients (Part A)
- Total number of recipients (Part B)
- Total number of Buy-In eligibles (Part A and B)
- Buy-In Expenditures (Part A)
- Buy-In Expenditures (Part B)
- Total savings (cost of care less premium cost) for Medicare benefits

Activity 2 – Louisiana Health Insurance Premium Payment (LaHIPP) Program

The Louisiana Health Insurance Premium Payment (LaHIPP) Program Activity focuses on ensuring access to affordable and appropriate care to Medicaid & LaCHIP eligibles and their families who have access to Employer Sponsored Insurance (ESI) or individual market coverage. LDH reinstituted the LaHIPP program in April 2017 after it was retired in 2015. LaHIPP reimburses eligible Medicaid recipients for some costs related to ESI or individual market coverage, including premiums, copays, and deductibles when the provider bills Medicaid secondary. The program aims to reduce Medicaid costs by making it more affordable for eligible individuals to maintain private insurance coverage.

Through coordination of services with private health insurance, the state Medicaid agency can leverage other resources that would otherwise have to be assumed for this population in the Medicaid program. LaHIPP reduces the number of uninsured Louisiana residents and establishes a third party resource as the primary payer of medical expenses to reduce Medicaid costs, assuring that Medicaid pays only after the responsible third party has met its legal obligation to pay.

According to the National Academy for State Health Policy, there are a number of benefits that states experience from building and growing premium assistance programs like LaHIPP, including: 1) strengthening of the private insurance market and preventing the substitution of public coverage for available private coverage; 2) allowing Medicaid agencies to benefit from employer contributions towards the care of Medicaid eligibles; 3) easing the transition from public coverage to private coverage; and 4) allowing children to enroll in a single health plan with their parents, which often ensures greater access to services.

Objective I: Each year, the LaHIPP program will assist eligible Medicaid enrollees and their families in purchasing private health insurance through an employer or the individual market while maintaining Medicaid/LaCHIP coverage as a secondary payer of medical expenses for Medicaid enrollees, resulting in reduced cost to the state.

Strategies:

- 1.1 Maximize the number of LaHIPP cases where it is determined to be cost effective to pay for employer sponsored health insurance or individual market coverage which becomes the primary payer of medical expenses for Medicaid enrollees.
- 1.2 Reduce the number of uninsured Louisiana residents and reduce total Medicaid costs by reimbursing the most cost effective ESI or individual market premium, which may provide health insurance coverage for non-Medicaid eligible family members.

Performance Indicators:

- Number of cases added in LaHIPP

- LaHIPP Total Savings in Millions
- Number of Medicaid enrollees with private coverage paid by LaHIPP
- Number of non-Medicaid family members with private coverage paid by LaHIPP

Program D: Uncompensated Care Costs

Program D: Description

The Uncompensated Care Costs (UCC) Program (D) pays inpatient and outpatient medical care providers serving a disproportionately large number of uninsured and low-income individuals. Hospitals receive reimbursements for their uncompensated care costs associated with the free care that they provide.

Program D: Mission

The mission of the Uncompensated Care Costs (UCC) Program is to encourage hospitals and providers to serve uninsured and indigent clients. Because of UCC, the client's quality and access to medical care is improved. Louisiana's disproportionate share hospital (DSH) cap allotment provides federal funding to cover a portion of qualifying hospitals' costs of treating uninsured and Medicaid patients.

Program D: Goal

- I. To encourage qualifying providers (LSU facilities/public providers, LDH Office of Behavioral Health, and qualifying private hospitals) to provide access to medical care for the uninsured and those eligible for Medicaid with Medicaid reimbursement lower than the cost of service.

Activity 1 – Uncompensated Care Costs (UCC) Program

Without access to care, the uninsured population is likely to experience poorer health outcomes because they may not receive recommended screenings and follow-up care for urgent medical conditions. Delaying or forgoing needed medical care increases overall health care costs incurred because uninsured patients are more likely to receive treatment in either an emergency room or hospitalized for avoidable medical conditions. High bills that uninsured patients incur can permanently jeopardize their family's financial security.

The UCC Program also funds a significant portion of the cost of training physicians in Louisiana hospitals, which results in long-term increased access to primary, preventive and specialty care for all citizens.

Objective I: Through the Uncompensated Care Costs activity, to encourage hospitals and other providers to provide access to medical care for the uninsured through the Uncompensated Care Costs activity.

Strategy:

- 1.1 To facilitate Disproportionate Share (DSH) payments to compensate for the cost of care provided to uninsured residents of the state.

Performance Indicators:

- Total DSH funds collected in millions
- Total federal funds collected in millions
- Total state match in millions



09-307 Office of the Secretary

Vision

The vision of the Office of the Secretary, through leadership and support, will provide the people of Louisiana with the opportunity to grow, in a nurturing environment that is supportive, safe, and that promotes the physical, mental and social health of individuals, families, and communities.

Mission

The mission of the Office of the Secretary is to provide leadership and technical support services while maximizing resources to fulfill the Department's mission.

Philosophy

The Office of the Secretary is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner.

LDH Priorities:

There are four major categories in which we are committed to making measurable improvements:

- Improve the Health and Well-being of Louisianans with an Emphasis on Prevention
- Reshape #TeamLDH Culture
- Enhance Customer Service, Partnerships, and Community Relations
- Promote Transparency, Accountability, and Compliance
- Promote Health Equity

Agency Goal

The goal of the Office of the Secretary is to provide primary leadership and direction for the Department and to coordinate statewide programs, services, and operations.

Program A: Office of Management and Finance

Program Description: The Office of Management and Finance consist of the following activities: Executive Management, Governmental Relations & Community Partnerships, Bureau of Media and Communications, Human Resources, Training and Staff Development; Governor's Council on Physical Fitness and Sports, Fiscal Management, Emergency Preparedness, Policy, Planning and Budget, Bureau of Legal Services, Fiscal Services, Health Standards Section, and Internal Audit.

Mission

The mission of the Management and Finance program is to provide overall direction and administrative support to agencies and activities within the Department.

Goal

The goal of the Management and Finance program is to provide leadership and technical support services while maximizing resources to fulfill the Department's mission.

Activity: Executive Administration and Program Support

Activity Description: The Executive Management and Program Support program provides leadership, technical support, strategic and policy direction to various functions throughout the department and ensures that policies and procedures put in place are relevant to the structure of agency operations and adhere to strictest government performance and accountability standards.

Objective I: Through the Executive Administration and Program Support activity, to provide leadership, strategic and policy direction while maximizing resources and maintaining the highest level of government performance and accountability standards each year through June 30, 2028.

Strategies:

- 1.1 Provide oversight and supervision to the Divisions and Bureaus responsible for auditing, budget preparation, financial services, human resources, accounting, and the development of strategic and operational plans.
- 1.2 Participate in bi-monthly meetings with Assistant Secretaries and executive management team members to review/discuss departmental issues.
- 1.3 Develop clear understandable human resource (HR) policies that balance the interest of both management and employees; ensure that HR policies and procedures are maintained, documented, and communicated in a timely and comprehensible manner.

Performance Indicators:

- Percentage of indicators in the Office of the Secretary meeting or exceeding targeted standards
- Percentage of the department's employees receiving Performance Evaluation System (PES) evaluations by the due date

Activity: Office of Community Partnerships & Health Equity

Activity Description: The Office of Community Partnerships & Health Equity (OCPHE) works to support Louisiana Department of Health's (LDH) public health professionalism by supporting the operationalizing and monitoring of community engagement and health equity best practices and protocols.

In 2019, OCPHE leadership led the development of LDH's first agency-wide health equity plan – LDH Phase-I Health Equity Plan. It is the first agency-wide plan of its kind in a southern state. The Phase-I plan operationalizes health equity practices and protocols throughout LDH. The health equity plan is centered on:

- Public Health Professionalism: Informing individual behaviors and organization actions
- Organizational Culture: Sharing, encouraging and supporting communicative strategies and professional development opportunities
- Organizational Systems: Creating processes that operationalize and monitor health equity practices and protocols in LDH

The plan includes a Community Engagement Framework that supports the institutionalization of community engagement best practices agency-wide in LDH.

The plan's internal strategies and action-steps, with its future results, support and expand a culture of health equity throughout LDH. The goal of the plan is to improve LDH professionalism, resulting in improved services and health outcomes of the people, populations, and communities LDH serves.

The Office of Community Partnerships and Health Equity (OCPHE) is working to promote health equity by building individual and community capacity through the development of its LDH Health Promotion Ambassadors initiative. LDH Health Promotion Ambassadors serve as points of contact who aid LDH in distributing vital information to people, populations, and communities, especially those that are most vulnerable. This initiative:

- Identifies community gatekeepers and stakeholders to become Ambassadors – individuals who have expressed an interest (to OCPHE) in providing health promotion education/resources in their community.
- Build Ambassador's competencies to a) share information and b) support the learning of new skills.
- Ambassador's health promotion competencies are built via OCPHE's Ambassador Tele-orientation, other Tele-trainings, and resources.

Goal: To operationalize community engagement and health equity best practices and standards agency wide.

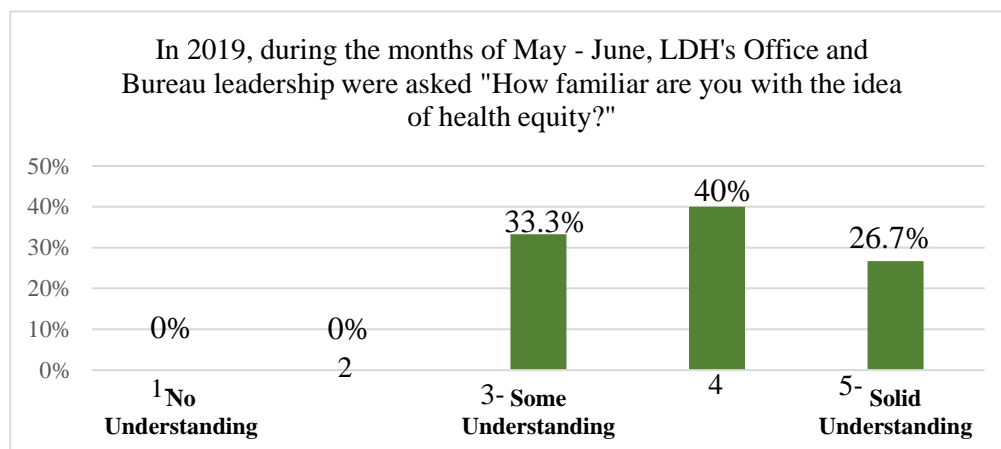
Objective II: To improve public health professionalism, thereby resulting in improved services and health/health outcomes.

Strategies:

- 2.1 Community Partnerships, with support from LDH HEAT and the Bureau of Media and Communications, will continue to expand and develop key tools of LDH Health Equity Plan: 1) The LDH Health Equity Communications Plan and 2) The LDH Health Equity Community Engagement Framework.
- 2.2 Provide ongoing guidance to the Bureau of Minority Health Access and Promotion (BMHAP) and support of LDH's Public Health Accreditation Board (PHAB).
- 2.3 To develop and update performance indicators that reflect the evaluative metrics in LDH's health equity.

Performance Indicator:

- At least 50% of previously surveyed LDH Offices, and Bureau leadership will indicate they have a solid understanding of health equity



[Graph Note: this question presented five (5) options for selection: **option 1** - no knowledge; **option 2** – between 1 and 3; **option 3** - some knowledge; **option 4** – between 3 and 5; and **option 5** - solid understanding]

Activity: Governor's Council on Physical Fitness and Sports

Activity Description: The Governor's Council on Physical Fitness and Sports (Governor's Games) promotes physical fitness and health through participating in competitive sports, workshops and conferences. Its main purpose is to motivate all Louisiana residents to become and stay physically active by promoting the benefits of physical activity through sports and fitness programs. The Governor's Games offer Olympic style sporting events across the state that provide an opportunity for competition, physical activities for all ages, skill level, and economic demographics. Some of the sporting events include: basketball, baseball, boxing, golf, karate, gymnastics, swimming, volleyball, weightlifting and track & field. The Governor's Council on Physical Fitness and Sports also hosts "Own Your Own Health," a program that allows Louisiana residents to track their fitness and nutrition levels online by forming teams of 2-10 people for adults and 10-30 for youth. These programs foster and encourage ways for residents of the state of Louisiana to become physically fit by getting them involved in competitive activities that require physical fitness.

Objective III: Through the Governor's Council on Physical Fitness & Sports, to offer competitive sporting events, workshops and conferences that will educate elementary age school children about the importance of physical fitness and work with non-profit health oriented organizations to educate all age groups in Louisiana about the value of staying physically active.

Strategies:

- 3.1 Work with local school boards and physical education teachers to expand the parish and statewide Elementary Fitness Meets to include every parish in Louisiana;
- 3.2 Sponsor physical fitness and sports workshops, clinics, conferences and other similar activities. An example would be the Athlete Leadership Summit, which is designed to give youth in Louisiana an opportunity to listen to former and current professional athletes talk about the important of education, values, leadership, team work and other items;
- 3.3 Produce high quality sporting events in an Olympic-style atmosphere that will make sporting events and recreational activities attractive to potential competitors;
- 3.4 Solicit corporate sponsors who will invest in the Governor's Games competitions, which will help finance the expansion of the event and promote commerce in Louisiana;
- 3.5 Collect and disseminate physical fitness and sports information and initiate advertising campaigns promoting physical fitness and sports;
- 3.6 Assist the Department of Education in helping schools in developing health and health and physical fitness programs for students;
- 3.7 Encourage local governments and communities to develop local physical fitness programs and amateur athletic competitions.

Performance Indicator:

- Number of participants in the Governor's Games

Activity: Financial Services

Activity Description: Fiscal Management performs accounting functions which includes depositing revenue into the State's Treasury, processing expenditures, preparing and issuing financial reports and maintenance of LDH's general ledger on the State's financial system; Planning & Budget administers and facilitates the operation of the budget process and performance accountability activities; provides technical assistance, analyzes budget requests, monitors the legislative process, conducts expenditure analyses; manages and monitors the department's performance accountability and strategic planning information by assisting agencies in integrating agency plans with budget requests, developing goals, objectives, performance measures, and reviewing quarterly performance progress reports.

Objective IV: To promote efficient use of agency resources and provide support to all activities within the Office of the Secretary by ensuring fiscal responsibility and accountability, excellence in customer service, and promoting innovation in the use of technology each year through June 30, 2028.

Strategies:

- 4.1 Provide guidance and assistance to agencies on strategic planning, financial planning, organizational structure, and other legislative or executive information requirements.
- 4.2 Participate in agency related meetings, including regular contact with state agency directors and other personnel to facilitate communication of financial and management practice information.
- 4.3 Coordinate with agencies, the Division of Administration, and Legislative Offices regarding the review of financial and budget information in accordance with year-end closing guidelines and responsibilities.
- 4.4 Analyze, compile, and present monthly revenue fiscal statements and expenditure analysis reports to determine the status of departmental agencies revenues and expenditures.
- 4.5 Participate in the National Association of State Human Services Finance Officers activities to ensure information compatibility with other states and to seek innovative concepts and other features that may be applied to the Department for improved operations.
- 4.6 Produce the Annual Departmental Budget Request in accordance with guidelines from the Division of Administration

- 4.7 Establish regular communications and ensure that transactions are executed according to management's authority and recorded properly

Performance Indicators:

- Percentage of invoices paid within 90 days of receipt
- Percentage of budget related documents submitted in accordance with DOA and Legislative timelines

Activity: Legal Services

Activity Description: The Bureau of Legal Services provides a wide array of legal services. Some of these services include legal advice and counsel, litigation in administrative hearings in state and federal court, policy and contract review, recoupment activities, legislation, and guidance on personnel and Civil Service issues. Legal Services also assists the agency in statewide departmental operations by observing and participating in management discussions, day-to-day operations, conducting legal risk analysis, and providing representation to the various offices of the department.

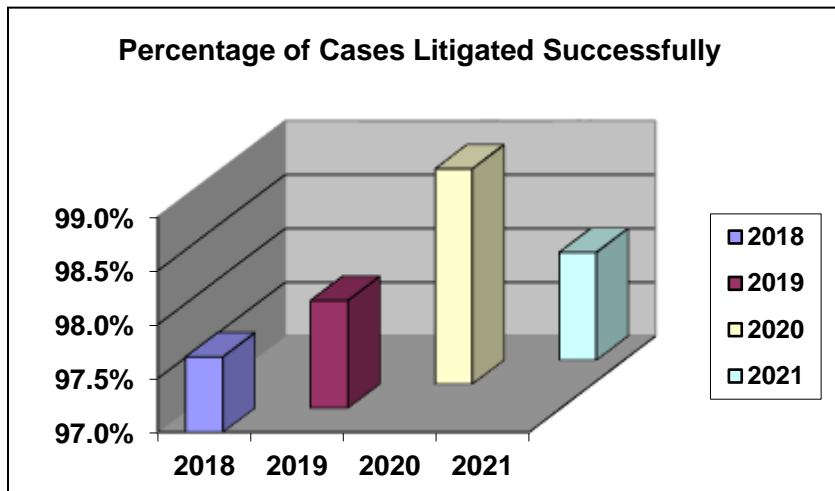
Objective V: To provide legal services to the various LDH agencies and programs through fair, timely, efficient and legally correct adjudication of disputes and protests each year through June 30, 2028.

Strategies:

- 5.1 Litigate cases and provide advice, counsel and legal representation to LDH agencies
- 5.2 Conduct administrative hearings and provide policy and contract review
- 5.3 Recoup monies owed to the Department
- 5.4 Provide guidance on Civil Service and personnel actions
- 5.5 Handle all assignments in an efficient, effective and timely manner

Performance Indicators:

- Percentage of cases litigated successfully
- Number of cases litigated
- Amount recovered



From 2018 thru 2021, the Bureau of Legal Services has litigated an average of 98% of cases successfully. Data obtained from the Louisiana Performance Accountability System (LaPAS).

The Bureau of Legal Services provides professional and competent representation for the department and all of its offices and/or facilities before state and federal courts, administrative tribunals, and the Civil Service Commission and/or its referees in the defense/prosecution of litigation or matters filed by or against the Department (this includes new areas of regulatory enforcement, Medicaid appeals and mental health proceedings, interdictions and adult protective services matters).

Activity: Internal Audit

Activity Description: Internal Audit is a unit of management that independently appraises activities, examines and evaluates the adequacy and effectiveness of controls within LDH and provides management with a level of assurance regarding risks to the organization and whether or not appropriate internal controls are in place and are functioning as intended.

Objective VI: Through the Internal Audit activity, programs and agencies of LDH are independently appraised. In an effort to safeguard the department against fraud, waste & abuse, Internal Audit completes at least 6 audits and 6 operational reviews each year through June 30, 2028.

Strategies:

- 5.1 Build and maintain a quality audit team that provides opportunities for development and advancement of personnel
- 5.2 Use technology to more effectively and efficiently perform our work

- 5.3 Respond to and prioritize requests from executive management for audit services (as resources permit) and emphasize adherence to auditing standards during the planning, field work, and report writing phases of every audit.
- 5.4 Document and test internal controls
- 5.5 Handle all assignments in an efficient, effective and timely manner

Performance Indicators:

- Number of audit assessments
- Number of audit reviews

<p>Activity: Healthcare Licensure and Certification Survey Process (Health Standards Section)</p>
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Activity Description: The Health Standards Section conducts periodic onsite surveys and complaint surveys in response to consumer complaints against health care facilities. Health Standards advances the state's goal of improved healthcare for citizens by bringing to the attention of health care facilities those system failures that have the potential for or that have resulted in harm to patients/residents or clients. This allows the facility/provider to review and revise their policies and practices to bring them into alignment with federal and state regulations for the provision of care.

Goal: To license and survey health care facilities providing services to Louisiana citizens. To provide leadership and technical support services while maximizing resources to fulfill the Department's mission.

Objective VII: Through the Health Standards activity, to perform required state licensing surveys and complaint surveys of healthcare facilities and federally mandated certification of healthcare providers participating in Medicare and/or Medicaid each year through June 30, 2028.

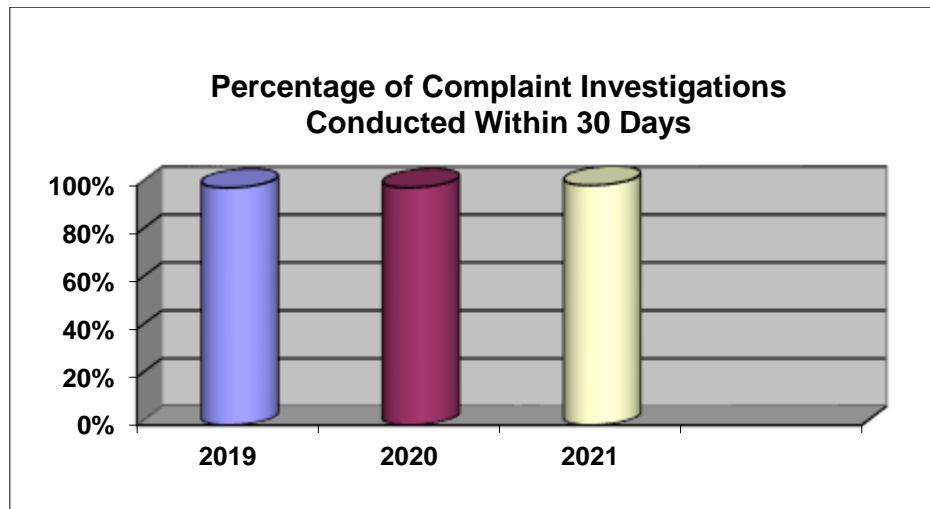
Strategies:

- 1.1 Maximize use of technology to comply with survey and license requirements
- 1.2 Review and revise staffing scheduling processes for licensing workload

Performance Indicators:

- Percentage of complaint investigations conducted within 30 days after receipt by the Health Standards section
- Percentage of abuse complaint investigations conducted within two days after receipt by the Health Standards section

- Percentage of annual licensing surveys conducted
- Total number of facilities (unduplicated)
- Number licensing surveys conducted
- Number of certified facilities
- Number of licensed facilities
- Number of provider exclusions
- Number of facilities terminated
- Percentage of facilities out of compliance
- Number of facilities sanctioned



Health Standards Section enforces state licensing standards and federal certification regulations through licensing and certification surveys of health care providers and reviews and investigates complaints made in connection with health care facilities.

Data obtained from the Louisiana Performance Accountability System (LaPAS).

South Central Louisiana Human Services Authority**Vision**

To become the Center for Behavioral Health and Community Based Services in South Central Louisiana by removing barriers to treatment while focusing on unity and equality of individuals by implementing collaboration of public and private services, creative resource allocation and advocating for the provision of efficient, effective quality care to the people we serve.

Mission

The Mission of the South Central Louisiana Human Services Authority (SCLHSA) is to increase public awareness of and to provide access for individuals to integrated behavioral health and community based services while promoting wellness, recovery and independence through education and the choice of a broad range of programmatic and community resources.

Philosophy/Values

The SCLHSA shall operate as an organized professional entity of the health care system functioning as an integral part of the interdisciplinary health care team dedicated to total patient care in the community.

Our prescribed purpose is to be helpful and innovative in the pursuit of quality behavioral health care for our clients. We serve as an advocate on behalf of our clients and assist in planning a course of care while in treatment and at home. Our goal is to always maintain a high level of professional practice, cooperation and courtesy in contact with our clients, families, community and other health care personnel.

The SCLHSA endeavors to enable individuals to utilize the health care system to achieve their optimal level of physical, emotional and social well-being. We help individuals and their families deal with problems related to illness, treatment and recovery. The relationship between psychosocial factors and illness is addressed with clients and their families and its application serves as the basis for our therapeutic technique. By assisting our clients in utilizing the health care system, community agencies and his/her own resources; we hope to provide them with continuity of care while pursuing the goal of wellness.

Executive Summary

The Louisiana State Legislature established the South Central Louisiana Human Services Authority (SCLHSA) in 2006 to provide administration, management and operation of mental health, addictive disorders, and developmental disabilities services to the residents of Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, and Terrebonne parishes. Direct oversight of these services was

previously provided through the Louisiana Department of Health (LDH).

Governance of SCLHSA is conducted by a nine (9) member Board of Directors representing the seven parish catchment area. The Board is comprised of two residents from the parishes of Lafourche and Terrebonne and one resident from the parishes of Assumption, St. Charles, St. James, St. John the Baptist and St. Mary. Each board member is appointed by the governing authority of his/her parish and must possess experience in the areas of mental health, addictive disorders, or developmental disabilities and represent parents, consumers, advocacy groups, or serve as a professional in one of the areas. All members serve without compensation.

The Administration of the SCLHSA is headed by an Executive Director, who is selected by the Board of Directors. The Deputy Director, Chief Financial Officer and Directors of Behavioral Health, Developmental Disabilities, Human Resources, Information Technology, Risk Management and Special Projects support the Executive Director in management and day-to-day operations.

The SCLHSA utilizes community stakeholders and volunteers to assist in fulfilling the Mission, Vision, Intent and Philosophy adopted by the Board. The SCLHSA has also partnered with community agencies and other health care entities to foster cooperative endeavors that benefit the behavioral health population in SCLHSA community.

Geography

The SCLHSA serves a large diverse population in its seven parishes including Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne. The geographical area covers over 31,297 square miles and contains a population of approximately 410,000 individuals. Of this population, the SCLHSA has an inherent responsibility to the medically indigent (e.g. – the uninsured and under-insured and those with Medicaid) as all individuals who present at our program sites in crisis or in need of other services.

Demographics

SCLHSA Staff demographics consist of 145 Civil Service Employees and approximately 50 contract employees ranging from 25 to 74 years of age. Staff includes psychiatrists, psychologists, primary care and psychiatric nurse practitioners, counselors, social workers, case managers, nurses, clerical, billing, fiscal, human resources, information technology, quality, marketing and administrative personnel. The SCLHSA patient population consists of children (ages 6-12), adolescents (ages 13-17), adults and geriatrics. The patient population is approximately one-third Caucasian, one-third African American and one-third Native American with a growing number of patients of Southwest Asian descent. The SCLHSA works closely with the United Houma Nation, Inc., the NAACP and other affiliations to enhance our ability to meet the needs of the individuals we serve.

Core Values:

Respect – A high regard for the worth and dignity of each individual

Clarity – Openness, honesty and accountability in all services, supports and information

Quality – Excellence in services without regard to race, creed, color, religion, background, sexual orientation, gender, national origin or ability to pay

Advocacy – Supporting the cause of those whom lack resources for a reasonable quality of life

Creativity – Inventiveness, flexibility and innovation in order to provide methods for continuous development and improvement of services to meet the behavioral health needs of the community

Knowledge – Development through learning and teaching to offer a continuum of services ranging from recovery to independence while serving the behavioral health needs of the community

Choice – Giving individuals the opportunity to learn about options for their care and use this information to make informed decisions, and

Partnership – Work cooperatively with other healthcare providers and educational institutions.

Stewardship - Effectively managing the resources bestowed upon our organization in an ethical and sustainable manner.

Intent

1. To provide comprehensive 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.
2. To provide community-based services, residential services, and continuity of care for the prevention, detection, treatment, rehabilitation, and follow-up care of mental/emotional illness and addictive disorders to include alcohol, drug abuse and gambling and to be responsible for community-based programs and functions relating to care, diagnosis, training, treatment, case management, and education of the developmentally disabled.
3. To improve personal outcomes through effective implementation of best practices and data-driven decision-making.
4. To promote healthy and 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.
5. To retain an adequate workforce to fulfill the mission and priorities of South Central Louisiana Human Services Authority.
6. To advocate on behalf of the clients we serve at all times and ensure that our care plan activities are in their best interest.

Resource Allocation:

The SCLHSA allocates its resources according to the following priorities:

First Priority – Persons and families in crisis related to mental illness, addictive disorders or developmental disabilities shall have their crisis resolved and a safe environment restored.

Second Priority – Persons with serious and disabling mental illness, addictive disorders or developmental disabilities shall make use of natural supports and community resourced and shall participate in the community.

Third Priority – Persons with mild to moderate needs related to mental illness, addictive disorders or developmental disabilities shall make use of natural supports and community resources and shall participate in the community.

Fourth Priority – Persons not yet identified with specific serious or moderate mental illness, addictive disorders, or developmental disabilities, but who are at significant risk of such disorders due to the presence of empirically established risk factors or the absence of the empirically protective factors do not develop the problems for they are at risk.

Performance Improvement Process

The authority's performance improvement program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided, and safety practices conducted, throughout the organization. The program consists of the following components: performance improvement (PI), safety, and quality assurance (QA), satisfaction, and utilization management (UM) activities.

Collaborative and specific indicators of both key processes and outcomes of care are designed, measured and assessed by all appropriate services and disciplines of each program in an effort to improve safety and performance. Indicators are objective, measurable, based on current knowledge and experience and are structured to produce statistically valid performance measures of care provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time. Measures are related to the accessibility, efficiency and effectiveness and availability of services, and the satisfaction of clients served. Indicators reflect the quality of community-based human services and support provided by SCLHSA to persons with Addictive Disorders, Developmental Disabilities and Mental Illness.

Additional indicators shall be those required for monitoring federally funded block grants or other federal grants received by any program. Approved outcome measurements developed by the Louisiana Department of Health (LDH), Human Services Interagency Council (HSIC), and the Offices of Behavioral Health and Citizens with Developmental Disabilities will also be collected and submitted as requested as stated in the contract established with LDH.

Records Retention

SCLHSA follows prescribed guidelines to create, maintain, and store records to comply with all state, federal, funding source, auditing, and accrediting body requirements to ensure the safety, security, and accessibility of all types of records in the necessary formats and storage in the required locations.

The permanent copies of all clinical records belong to the office of origin except medical records that are the property of the SCLHSA. Modifications to the SCLHSA Records Retention Schedule must be made in writing and submitted to the SCLHSA Director of Information Technology and IM Committee for review. Final approval must be given by the SCLHSA Executive Director. Paper records may be converted to any secure electronic medium for archival purposes. Records in electronic format shall be maintained, secured, and accessible according to the same rules as the original paper record.

Strategic Links

Substance Abuse Mental Health Services Administration's (SAMHSA) vision is to provide leadership and resources – programs, policies, information and data, funding, and personnel – advance mental and substance use disorder prevention, treatment, and recovery services in order to improve individual, community, and public health.

SCLHSA participates in programs funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) to further its mission to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA has identified its top priorities in achieving their overarching Strategic Plan. SCLHSA supports and utilizes the resources made available for three priorities.

Priority 1: Combating the Opioid Crisis through the Expansion of Prevention, Treatment, and Recovery Support Services

Priority 2: Addressing Serious Mental Illness and Serious Emotional Disturbances

Priority 3: Advancing Prevention, Treatment, and Recovery Support Services for Substance Use

* Prevention services as described by the Substance Abuse Prevention and Treatment (SAPT) is an anticipatory process that prepares and supports individuals and systems in the creation and reinforcement of healthy behaviors and lifestyles. In addition, prevention is a process that utilizes multiple strategies designed to preclude the onset of the use of alcohol, tobacco and other drugs by youth. Prevention principles and strategies foster the development of social and physical environments that facilitate healthy, drug-free lifestyles. Prevention strategies target universal, selective, or indicated populations.

The American Association of Intellectual and Developmental Disabilities (AAIDD)

The mission statement for AAIDD is to promote progressive policies, sound research, effective practices, and universal human rights for people with intellectual and developmental disabilities.

AAIDD Goals indirectly linked to the service oversight provided by SCLHSA include:

Goal 1: Enhance the capacity of professions who work with individuals with intellectual and developmental disabilities

Goal 2: Promote the development of a society that fully includes individuals with intellectual and developmental disabilities.

Substance Abuse Mental Health Services Administration's Center for Substance Abuse Prevention (SAMHSA) provides leadership and devotes its resources - programs, policies, information and data, contracts and grants- toward helping the Nation act on the knowledge that:

- Behavioral Health is essential for health;
- Prevention works; (CSAP)
- Treatment is effective; and (CSAT)
- People recover from mental and substance use disorders

SCLHSA participates in SAMHSA funded programs to further the Substance Abuse and Mental Health Services Administration's (SAMHSA) mission to reduce the impact of substance abuse and mental illness on America's communities. Prevention is an anticipatory process that prepares and supports individuals and systems in the creation and reinforcement of healthy behaviors and lifestyles. In addition, prevention is a process that utilizes multiple strategies designed to preclude the onset of the use of alcohol, tobacco and other drugs by youth. Prevention principles and strategies foster the development of social and physical environments that facilitate healthy, drug-free lifestyles. Prevention strategies target universal, selective, or indicated populations.

World Health Organization's (WHO) Comprehensive Mental Health Action Plan's goal is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. SCLHSA has utilized one or more of these strategies listed in the plan to assist with service delivery implementation.

The four major objectives of the action plan are to:

1. Strengthen effective leadership and governance for mental health;
2. Provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
3. Implement strategies for promotion and prevention in mental health and
4. Strengthen information systems, evidence and research for mental health

Agency Goals

Goal I

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

Goal II

Increase staff accountability and fiscal integrity of the agency.

Goal III

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

Goal IV

Maintain CARF Accreditation by committing to quality improvement, focusing on the unique needs of each person we serve, and monitoring the results of services we provide.

Program A: South Central Louisiana Human Services Authority Administration

SCLHSA Administration provides management and oversight of agency services to include fiscal, human resources, clinical, contract monitoring, information technology, community relations, compliance/risk services, medical staff/credentialing, quality improvement and special projects for the seven Parishes of Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne. SCLHSA operates five (5) Outpatient Behavioral Health settings which provide treatment

and assessment services with a focus on increased access to our clients through a statewide managed care system. SCLHSA has narrowed its focus on the fiscal integrity of the agency, service provision and billing processes with the expansion of billable services for behavioral health. Developmental Disabilities oversee waiver and non-waiver services and have increased efforts for client outreach and employment opportunities for individuals in the community. The Health Home Program offers integrated primary care and behavioral health services to active clients that have been stabilized on medication. The Health Home approach is holistic in nature coordinating all of the patient's health care needs and focusing on disease management, nutritional intervention and other medical specialty programs to assist in the quest for optimal health and wellness. SCLHSA's Behavioral Health Centers, Developmental Disability and Health Home Services have all been accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). SCLHSA's goal is to focus on person centered treatment that reflects the total mind and body needs by implementing a collaboration of public and private services, creative resource allocation and advocating for the provision of efficient, effective quality care to the people we serve.

Program A Mission

To integrate service provision among Addictive Disorders, Mental Health and Developmental Disabilities agencies under local governing entity administration.

Goal:

To provide management and oversight of services to include fiscal, human resource, clinical, contract monitoring, information technology, community relations, compliance/risk services, medical staff/credentialing, quality improvement and special projects in Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne parishes.

Objective I:

To provide programmatic leadership and direction to the programs of Addictive Disorders (AD), Developmental Disabilities (DD) and Mental Health (MH) under SCLHSA; to continue the operational activity of the SCLHSA Central Office in relation to regulatory/licensure processes each year through June 30, 2028

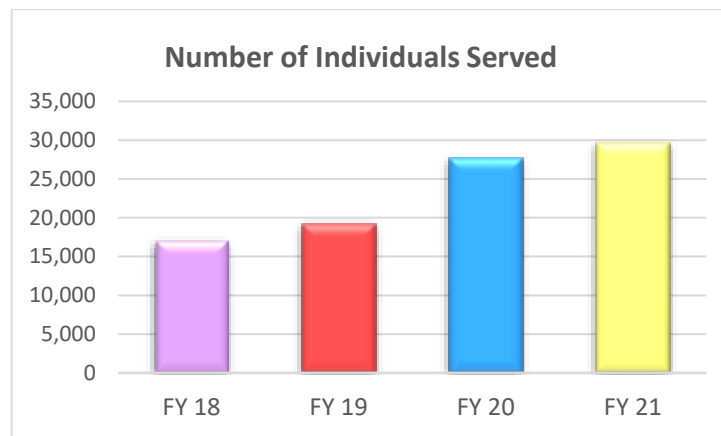
Strategies:

- 1.1 Develop, implement and monitor guidelines for assessment and treatment services for individuals with addictive disorders, developmental disabilities and mental health with a focus on building community partnerships and early intervention services.
- 1.2 Develop and implement a variety of innovative restructuring activities which focus existing funding toward achievement of quality outcomes targeted to individual needs.
- 1.3 Manage compliance with federal and state regulations and AD, DD, and MH policies governing statewide programs.
- 1.4 Provide effective management of AD, DD, and MH community service programs with LDH input of program delivery of services in order to optimize the use of community-based services while decreasing reliance on institutional services.
- 1.5 Continue Executive Management Meetings with SCLHSA Administration and Clinic Managers to engage in policy and goal setting and receive feedback on administrative actions.

- 1.6 Provide advocacy, one-on-one assistance, and collaboration with other agencies to overcome barriers for persons to obtain accessible and affordable services.
- 1.7 Continue ongoing development and training for all staff to enhance skill sets and service provision.
- 1.8 Educate all staff on services provided by AD, DD, and MH programs to assist with cross training of staff for use with future staffing strategies.

Performance Indicators:

- Total number of individuals served in the SCLHSA. (Output)
- Percentage of SCLHSA clients who state they would continue to receive services at our clinics if given the choice to go elsewhere. (Quality)



Objective II:

To provide administrative and support functions to SCLHSA programs in a manner that is responsive to individual needs and results in effective/efficient service delivery each year through June 30, 2028

Strategies:

- 2.1 Produce an accurate and timely monthly expenditure report beginning September of each fiscal year through June reflecting the current budgetary position and proposing any necessary actions to the SCLHSA Board and LDH remaining within the appropriations for the fiscal year.
- 2.2 Conduct quarterly satisfaction surveys reviewing data obtained and developing quality improvement strategies for prioritized areas of concern.
- 2.3 Continue implementation of the operational data for reporting Human Services Accountability and Implementation Plan (AIP) performance indicators and validating.
- 2.4 Produce monthly contract reports to include the current status and expenditures for each program for the current fiscal year.
- 2.5 Develop or purchase information system from a variety of sources including but not limited to computerized systems for knowledge, information, communications, planning, and policy to support SCLHSA goals and strategies.

Performance Indicators:

- Percentages of appointments kept for assessments and ongoing client appointments. (Outcome)
- Percentage of SCLHSA clients who state they would recommend the clinics to family and friends. (Quality)

Program B: Behavioral Health

Through the Behavioral Health Services activity, SCLHSA provides both Screening/Assessment, plan of care and level of need determination for children, adolescent, adult and senior populations as well as Treatment Services, including individual/group sessions, family/couple sessions, psychiatric evaluations, psychological testing, medication administration, medication management, crisis stabilization, gambling counseling, breath tests, urine screens and referrals to children, adolescents, adults and senior populations. SCLHSA shall make every effort to ensure that our client care and services treat each person as an individual, that we are responsive to our client's needs and wishes and that our services are of the highest possible quality within the resources available. Our intent is to remove barriers to treatment and service coordination by collaborating with public and private services, devising creative resource allocation and advocating for the provision of efficient, effective quality care to the people we serve.

Program B Mission

To provide a person centered approach when screening for individual need, appropriate service structure and crisis stabilization in determining referral options for behavioral health treatment and to develop a Person Centered Plan of Care which enables clients to manage their behavior in order to maintain gains made in treatment and make positive changes to achieve their highest quality of life.

Program B Goals

To serve as the point of entry for all SCLHSA behavioral health services and to guide clients in understanding the potential to heal themselves through treatment, collaboration, and follow-up services.

Objective I:

To provide screening, assessment, plan of care and level of need determination for children, adolescent, adult and senior populations each year.

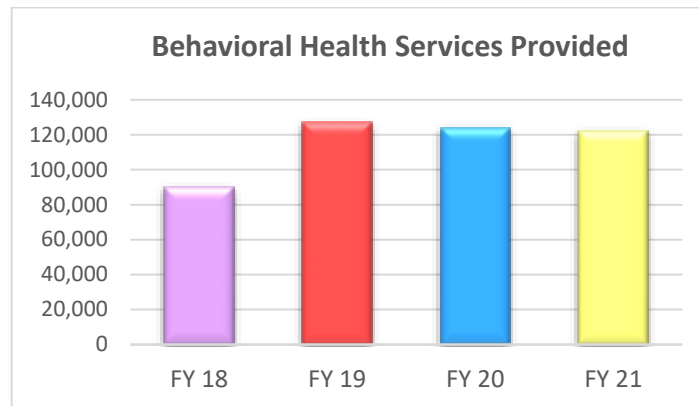
Strategies:

- 1.1 Standardize screening, registration, intake procedures and related documentation.
- 1.2 Ensure that referrals from the outpatient single point of entry are clients in need of inpatient level of care.
- 1.3 Decrease the no-show/cancellation rate for scheduled appointments by sending confirmation/reminder letters and/or calling clients one business day prior to scheduled appointments.

Performance Indicators:

- Total number of individuals served by outpatient mental health in SCLHSA. (Output)

- Number of referrals received by SCLHSA outpatient centers from local stakeholders/community behavior health services. (Outcome)



Objective II:

Establish a recovery and consumer focused system of person centered care utilizing evidenced based practices supported by service outcomes and accountability each year through June 30, 2028

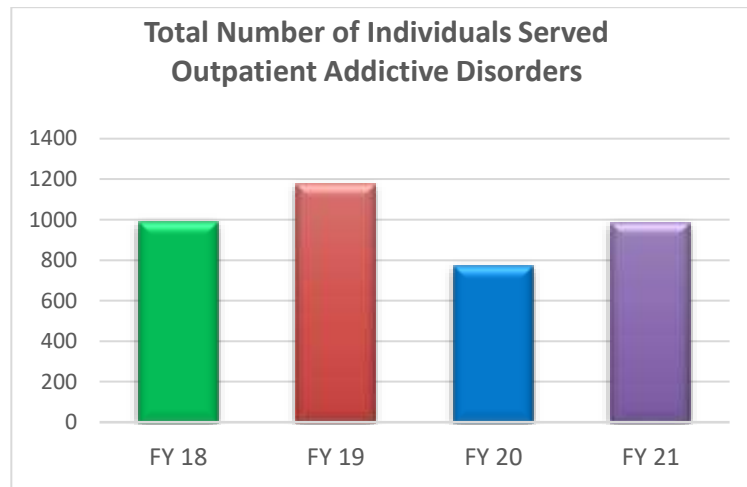
Strategies:

- 2.1 Assess current access procedures (adult and youth) to determine best practices based on procedures, staffing, and technical support.
- 2.2 Standardize screening, registration, and intake procedures and related documentation.
- 2.3 Establish standardized admission criteria.
- 2.4 Re-organize resources and procedures to ensure that clients receive psychosocial evaluation and other indicated services within intensity of need times frames: routine – no more than 7 days; urgent - no more than 48 hours; emergent – a.s.a.p. / same day.
- 2.5 Provide evidence based treatment to clients and contact those clients who have dropped out of treatment for inclusion in individual and/or group services.
- 2.6 Decrease the no-show/cancellation rate for scheduled appointments by sending confirmation/reminder letters and/or calling clients one business day prior to scheduled appointments.

Performance Indicators:

- Percentage of child/adolescents with a diagnosis of major depressive disorders who received psychotherapy. (Outcome)
- Appropriate level of care, frequency of service and reasonable duration is consistent with LOCUS and Clinical Justification. (Quality)
- Percentage of adults and adolescents with an addictive disorder who successfully complete outpatient treatment. (Outcome)
- Percentage of adults and adolescents with an addictive disorder who report improvement at discharge. (Quality)

- Total number of individuals served by inpatient Addictive Disorders in SCLHSA. (Output)
- Total numbers of individuals served outpatient by Addictive Disorders in SCLHSA. (Output)
- Total number of enrollees in prevention programs. (Output)



Objective III:

Develop Community Crisis Continuum Mobile Teams that provide pre-screening assessments, act as gatekeepers for inpatient hospitalization, and manage and control access to crisis diversionary services.

Strategies:

- 3.1 Create a main repository of information regarding provider services, capabilities, and specialties;
- 3.2 Provide uniformity in assessing, triaging, and tracking service requests;
- 3.3 Facilitate prompt access to services;
- 3.4 Serve as a resource to guide consumers to appropriate non-behavioral health services (e.g., child and family services, aging services, alcohol and drug services, etc.);
- 3.5 Reduce client frustration in attempting to negotiate the maze of available behavioral health services and providers.

Performance Indicators:

- Number of crisis visits in all SCLHSA Behavioral Health Clinics. (Output)

Program C: Developmental Disabilities

SCLHSA Developmental Disabilities core services consist of serving as the Single Point of Entry (SPOE) into the Developmental Disabilities (DD) Services System and providing support coordination services to individuals and their families through DD and other available community resources. SCLHSA staff members assess the needs for supports and services, develop individual plans of support, make applicable referrals, and provide ongoing coordination for the client's support plans. Targeted services are centered on Home and Community-Based Services Waiver programs

and federal criteria which allow services to be provided in a home or community-based setting for the recipient who would otherwise require institutional care. The Family Support Program is designed to assist individuals whose needs exceed those normally used resources in the community, and other natural resources available. Individual and Family Supports include but are not limited to: respite care, personal assistance services, specialized clothing, such as adult briefs, dental and medical services not covered by other sources, equipment and supplies, communication services, crisis intervention, specialized utility costs, specialized nutrition, and family education. The Cash Subsidy Program is intended to assist families with children with severe or profound disabilities to offset the extraordinary costs of maintaining their child in their own home. The program provides a monthly stipend to families of children who have qualifying exceptionalities identified through their local educational authority.

Program C Mission

To provide quality services, supports information and opportunities for choice to individuals with developmental disabilities and their families.

Program C Goals

To serve as the Single Point of Entry (SPOE) into the Developmental Disabilities (DD) Services System providing support coordination services to individuals and their families through OCDD and other available community resources.

Objective I:

To foster and facilitate independence for citizens with disabilities through the availability of home and community based services each year through June 30, 2028

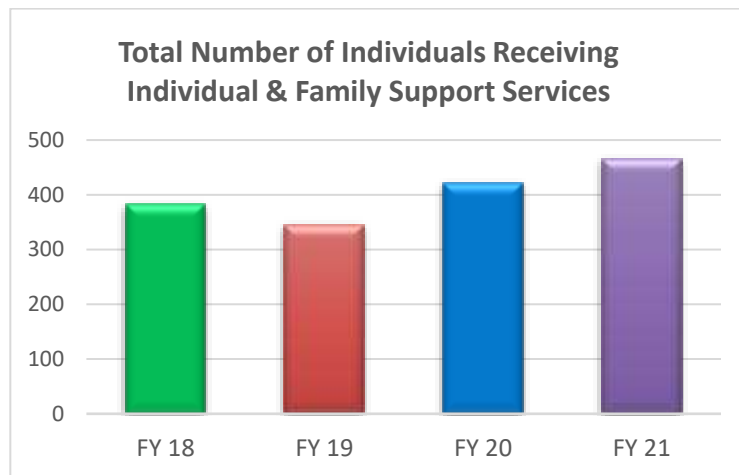
Strategies:

- 1.1 Provide training and support to encourage providers, individuals with disabilities, and their families to utilize Residential Options Waiver conversion and Money Follows the Person.
- 1.2 Review all New Opportunities Waiver plans before submission to assure consistency with the Guidelines for Support Planning.
- 1.3 Identify state agencies and community organization resources in order to better support people with developmental disabilities to live full community lives and support partnerships with and referrals to these agencies and organizations.
- 1.4 Monitor program utilization, effectiveness, and collect performance indicator data.
- 1.5 Implement policies and procedures for adult waiver participants to have pathways to community employment.

Performance Indicators:

- Percentage of home and community based waiver assessments completed timely. (Efficiency)
- Percentage of eligibility determinations determined valid according to the Flexible Family Fund criteria. (Quality)
- Number of people receiving (flexible family funds) support. (Output)

- Total number of individuals receiving individual and family support services in SCLHSA. (Output)



Program D: Integrated Care

The integration of Primary Care in a Behavioral Health Care setting refers to the intentional, ongoing, and committed coordination and collaboration between all providers treating the individual. SCLHSA recognizes the need for patients to take care of both their physical and behavioral health needs in an outpatient setting and is devoted to making these services available in a "one-stop shop" process. The Health Home (Integrated Care) Program emphasis is designed to deliver healthcare that focuses on the whole person and integrates primary care, behavioral health and developmental disability needs along with comprehensive care management, care coordination, wellness promotion, comprehensive transitional care, individual and family support services, referral and linkage to community and social services. This holistic approach helps guide patients in the quest for optimal health and wellness.

Program D Mission

To provide for the integration of Primary Care in a Behavioral Health Care setting by coordinating and collaborating between all providers treating an individual in order to positively impact healthcare outcomes and promote the overall health of our clients.

Program D Goals

To provide a delivery model for individuals that encompasses medical and behavioral health care by meeting all of the individuals needs in one location.

Objective I:

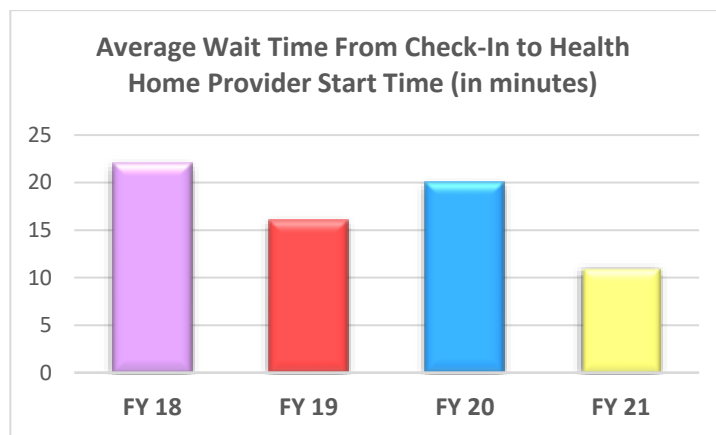
Integrated Care/Health Home program expanded to include all patients with behavioral health and medical diagnoses.

Strategies:

- 1.1 Promote Integrated Care/Health Home concept to the patient population.
- 1.2 Incorporate nutritional services and wellness into individual treatment plans.
- 1.3 Develop comprehensive disease management program to include hypertension and diabetes monitoring and education.

Performance Indicators:

- Total number of patients seen per day by the Primary Care Team. (Output)
- Average wait time from check-in to provider start time (in minutes). (Quality/Efficiency)
- Percentage of patients who maintain blood pressures within normal limits (<140/90) in the Quarter. (Outcome/Effectiveness)



Information Management

The SCLHSA shall ensure that all information regarding the individuals served, the care provided, the outcomes of care, the performance of the organization, and all activities conducted are coordinated and integrated throughout all departments in a timely manner and that this information shall serve as an important resource to be used effectively and be efficiently managed as mandated by specific agency, state, federal and regulatory mandates.

A comprehensive assessment and continued reassessment of agency information management needs is by Information Technology Staff. This needs assessment is based on review and analysis of SCLHSA's mission, vision, goals, services, staff, mode of service delivery, resources and access to affordable technology. Those areas where it has been determined to have the greatest impact on individual care and outcome of the delivery system will receive the highest priority for process revision and/or enhancement. The data obtained from this assessment is used for decision making in all areas of the organization.

The need for coordination across the organization of all elements of the information management function is considered a primary focus for staff, agency and community resource development. The Information Technology Department strives to; encourage individual inquiry and problem solving through expanded

self-service access and self-help information resources; provide increasingly seamless access through the

thoughtful integration of varying systems and access control components; and maintain the availability, integrity and confidentiality of SCLHSA's information technology resources by instituting appropriate security controls and awareness efforts.

Additionally, SCLHSA will ensure that it has the proper security in place (both cyber and physical) in the form of technologies, processes and practices to protect our networks, computers, programs and data from attack, damage or unauthorized access. Our goal is to defend the organization's assets against all threat actors throughout the entire life cycle of a cyber-attack.

Northeast Delta Human Services Authority



Vision

The vision of the Northeast Delta Human Services Authority is to build a unified Northeast Louisiana where individuals are thriving and reaching their full human potential.

Mission

The mission of the Northeast Delta Human Services Authority is to serve as a catalyst for individuals with mental health, developmental disabilities, and addictive disorders to help realize their full human potential by offering quality, excellent care with greater accessibility.

Philosophy/Values

- Demonstrate that we understand citizens' concerns and provide hope and integrity to the mental health, addictive disorder and developmental disabilities arenas.
- Connect with citizens we serve and help them reach their best potential.
- Focus on commonalities among us rather than differences. Unify around opportunities.
- Accountable for our actions.
- Opportunity for success equal for all citizens regardless of demographics.
- Acknowledge any previous shortcomings and demonstrate how we are improving. Build trust through accountability.
- We are a catalyst and co-advocate with citizens as we engage in personal, family, governmental systems and community transformation.

3 Tenets

- Greater access to services
- Excellent customer service
- Quality competent care

Executive Summary

Northeast Delta Human Services Authority (NE Delta HSA) serves the parishes of Jackson, Lincoln, Union, Morehouse, West Carroll, East Carroll, Ouachita, Richland, Madison, Caldwell, Franklin, and Tensas. (NE Delta HSA has been in operation since 2014. A governing board comprised of members of the local communities served by the LGE oversees the executive director's administration of programs and financial resources for the authority. Northeast Delta HSA has an ongoing performance improvement process within its operational structure. That system supports the use and development of data and information to make informed decisions about the needs of the citizens we serve and other stakeholders as well as the administration of these services.

NE Delta HSA is dedicated to transforming how we provide vital services to our citizens. We bring

innovative programs to our citizens, which include integration of behavioral health with primary care services; services for children and adolescents with behavioral disorders that are at risk for experiencing a psychiatric or behavioral emergency; and collaborations with law enforcement agencies that help first responders know how to recognize a mental health issue. We also work to break down barriers that may keep citizens from obtaining treatment, like providing transportation to health clinics in rural areas; and ensuring that we keep the specific needs of the people in our communities at the forefront of our efforts.

Northeast Delta HSA's annual operating budget includes state general funds, self-generated revenue and interagency transfers for programs and services along with federal funding through grant awards. Northeast Delta HSA has maximized the use of self-generated revenue to implement innovative programs and services within the service area.

Agency Goals Goal I

Improve the outcomes of citizens by expanding access to a network of appropriate, quality prevention and wellness, integrated care and developmental disability services.

Goal II

Provide integrated services that promote holistic care through best practices and strategies; ensure a person centered approach through prevention, treatment, support, education, and advocacy.

Goal III

Evaluate and analyze outcomes to strengthen internal operations to accommodate trending healthcare environments, payments, and electronic health records systems to produce data-driven decisions that best maximize efficiency and effectiveness.

Goal IV

Proactively address risks that impact the behavioral health of our citizens by using collaboration and sound communication practices both internally and with key partners and providers.

Activity A: Integrated Care

Northeast Delta HSA provides integrated mental health, substance abuse, and primary care services through the systematic coordination of general and behavioral healthcare, which includes integration of behavioral health with primary care services from children/adolescents across the lifespan for the parishes of Jackson, Lincoln, Union, Morehouse, West Carroll, East Carroll, Ouachita, Richland, Madison, Caldwell, Franklin, and Tensas.

Mission

To produce the best outcomes and provide the most effective approaches to caring for people with multiple healthcare needs.

Goals

- Improve access to primary care services
- Increase availability of integrated, holistic care for physical and behavioral health disorders
- Improve overall health status of clients

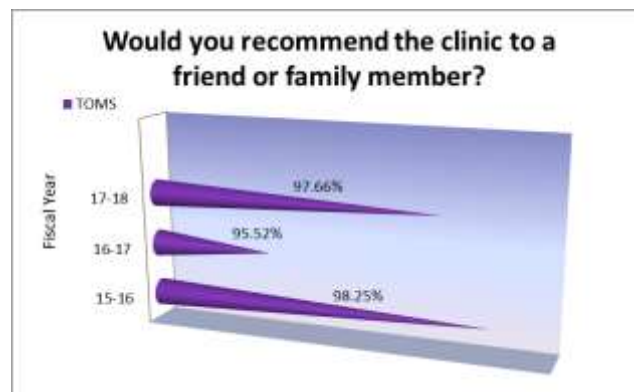
Objective I: Northeast Delta HSA Integrated healthcare services will provide access to integrated care services for adults and adolescents with behavioral health diagnoses.

Strategies:

- 1.1 Increase capacity for identifying, screening, and integrating primary care and behavioral healthcare needs.
- 1.2 Seek partnerships and billing/reimbursement opportunities to provide integrated services.
- 1.3 Maintain existing relationships with providers and develop new relationships to identify and address geographic gaps of unserved populations.

Performance Indicators:

- Output: Number of adults served through Integrated Healthcare Services
- Output: Number of children/adolescents served through Integrated Healthcare Services
- Quality: Percentage of persons served who indicate they would recommend the clinic to a friend or family member



Objective II: Northeast Delta HSA will provide a continuum of quality, competent behavioral health and integrated services that meet the needs of persons served.

Strategies:

- 2.1 Provide customized trainings to ensure quality, culturally competent care and proper identification of co-morbidities for holistic care
- 2.2 Coordinate care throughout the region to improve consumer outcomes
- 2.3 Utilize consumer feedback data to make informed decisions about effectiveness of programs and processes

Performance Indicators:

- Output/Efficiency/Quality: Number of referrals made to partner agencies in the Northeast Delta HSA Integrated Care Network
- Outcome: Percentage of persons served who indicate that staff was sensitive to his/her cultural background (race, religion, language, etc.)
- Outcome: Percentage of successful completions (residential addiction treatment programs, level 3.1 and 3.3)
- Outcome: Percentage of successful completions (inpatient addiction treatment programs, level 3.5)
- Output: Percentage of Consumer Care Resource funds expended

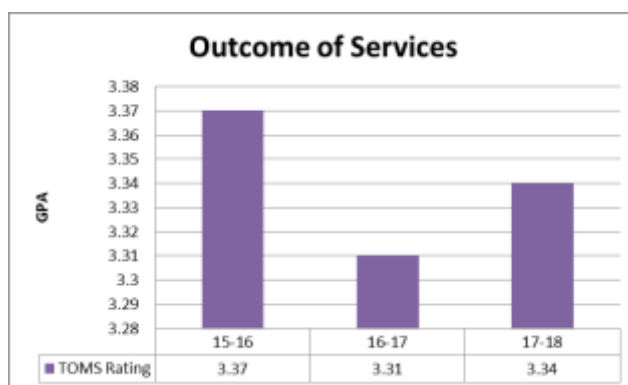
Objective III: Support critical needs of consumers by leveraging community based services that will encourage recovery and stabilization.

Strategies:

- 3.1 Incorporate peer support and care management services as an integral part of the integrated care network
- 3.2 Assist consumers with Medicaid application process
- 3.3 Advocate for consumer primary and behavioral healthcare services based on consumer needs

Performance Indicators:

- Output: Number of persons served in an evidence-based community-based program
- Outcome: Number of persons assisted with Medicaid application
- Outcome/Quality: GPA rating of Outcomes of Services



Activity B: Prevention and Wellness

NE Delta HSA Prevention & Wellness department uses research-based curriculums, environmental strategies, coalition building and other proactive and data-driven strategies to help prevent and reduce risk-taking behaviors among regional youth, adolescents, and the general population. NE Delta HSA manages and administers these evidence-based prevention programs through its trusted regional and local community partners. Northeast Delta HSA provides prevention & wellness services to 8 of the 12 parishes served.

Through our continuous efforts and great partnerships with local school districts, Northeast Delta HSA has been able to provide evidence-based prevention programs from Pre-K to 10 grades. School districts participate in Red Ribbon Week, Orange Ribbon Week, Prevention Week, and Anti-Bullying Awareness Day; these efforts are achieved with school systems implementing research-based prevention programs and policies.

Mission

To develop a comprehensive framework system that will utilize partnerships across state government agencies, private sector agencies, and local communities to implement programs, practices, and policies identified as evidence-based strategies to make impactful change.

Goals

- Northeast Delta HSA Prevention and Wellness will serve as a functioning and well-organized health data infrastructure supported by the internal Health Data Informatics department.
- The Northeast Delta HSA Prevention and Wellness unit will be a culturally competent prevention system that elicits, motivates, and coordinates the best efforts, ideas, and resources of all participating stakeholders and partners through coalition work and advocacy.
- Reduce misuse and abuse of alcohol, tobacco, illicit drugs, and prescription drugs, including misuse and abuse of opioids, and negative health behaviors that contribute to addiction across the lifespan.

Objective I: Formalize processes for sustainability of integrated health data infrastructure and ensure behavioral health data is available to state, regional, and community partners.

Strategies:

- 1.1 Develop an internal sub-committee for data and analytics.
- 1.2 Formalize a data communication and dissemination plan.
- 1.3 Create local and state-wide partnerships for data sharing opportunities.

Performance Indicators:

- Output & Quality: Number of schools participating in Communities that Care Youth Survey (CCYS)
- Output: Number of participants at annual data sharing stakeholder meeting
- Quality: Number of prevention related presentations with community-level data

Objective II: Utilize coalitions to mobilize communities based on culturally competent programs and interventions.

Strategies:

- 2.1 Ensure sustainable and functioning coalitions.
- 2.2 Develop and update an annual resource guide through our Strategic Prevention Framework-State Incentive Grant (SPF-SIG) model.
- 2.3 Develop a Prevention and Wellness communications plan that promotes positive health outcomes through evidence-based practices and empirically researched model of behavioral changing techniques.

Performance Indicators:

- Output/Quality: Number of participants that attend monthly Northeast Delta HSA sponsored coalition meetings throughout the Northeast Delta HSA region
- Output: Number of people reached through prevention campaigns

Objective III: Northeast Delta HSA will expand the utilization of the Strategic Prevention Framework process in order to reduce misuse and abuse as well as address associated shared risk and protective factors across the lifespan.

Strategies:

- 3.1 Teach the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) models in communities.
- 3.2 Create training opportunities to facilitate social norming techniques.
- 3.3 Enlist and sustain current partnerships for providing prevention services and prioritizing rural communities.

Performance Indicators:

- Output: Number of social norming campaigns facilitated
- Output/Quality: Percent decrease in misperceptions of the effects of alcohol, tobacco, and other drugs (ATODs)

Activity C: Developmental Disability Services

Program Description: The Northeast Delta HSA Developmental Disability Services unit has two core specializations:

Waiver Services - Medicaid Home and Community-Based Waiver programs allow people greater flexibility to choose where they want to live and to use services and supports that best suit their needs. Services are provided in the home or in the community.

Home and Community Based Services - Individual and family support services provide assistance not available from any other resource that will allow people with intellectual and developmental disabilities to live in their own home or with their families in their own community. These services include respite care, personal assistance services, specialized clothing, dental and medical services, equipment and supplies, communication services, crisis intervention, utility costs, specialized nutrition, and family education. These services are also inclusive of Flexible Family Funds that provide a monthly stipend to families of eligible children with severe or profound developmental disabilities from birth through age 18 to help families meet extraordinary costs. Services are provided through contractual agreements by private provider agencies or through individualized agreements with individuals and families who obtain their own service providers.

Mission

To provide person-centered supports and services to people with developmental disabilities that are flexible, meet their needs and allow for maximum independence in the home and community of their choice.

Goals

- Serve as the single point of entry for developmental disabilities services in the northeast region of the state of Louisiana.
- Advocate for people with developmental disabilities to be included and participating in their communities.
- Promote positive health outcomes for people with developmental disabilities.
- Support the need for people with developmental disabilities to have access to competent, quality care and services to meet their individual goals.

Objective I: Facilitate improved outcomes for citizens with intellectual and developmental disabilities.

Strategies:

- 1.1 Provide annual budgeted funding to purchase goods and services for identified needs through support planning with individuals and families.
- 1.2 Ensure the development of person centered plans of care that are inclusive of personal goals that meet the needs of the participants.
- 1.3 Ensure the development of person centered plans of care that are inclusive of both natural and community resources.
- 1.4 Monitor program utilization and effectiveness following policy and standards for use of funding and person centered practices.

Performance Indicators:

- Efficiency & Outcome: Percentage of Individual and Family Support Funds expended for individuals and families
- Quality: Percentage of Individual and Family Support Plans that meet the participants' goals
- Quality & Outcome: Percentage of Waiver participants whose Plan of Care meets their needs
- Quality & Outcome: Percentage of Waiver participants whose Plan of Care includes natural and community resources

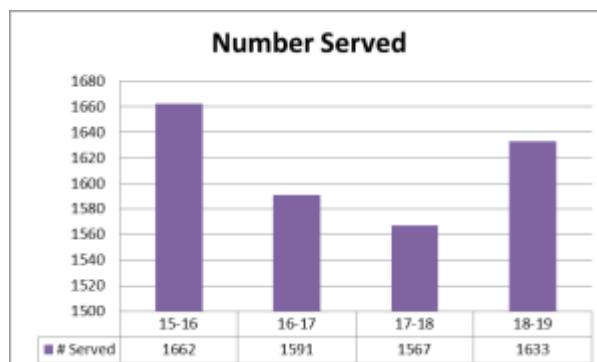
Objective II: Promote the delivery of quality supports to increase community capacity allowing people to live in the setting of their choice.

Strategies:

- 2.1 Ensure the development of person centered plans of care that are inclusive of personal goal.
- 2.2 Ensure that Family Support funds are as flexible as policy allows to support individualized needs to remain in the home and community.
- 2.3 Ensure that DD staff attend community events to promote services and provide eligibility and referral information with families, organizations, and other agencies throughout the region.
- 2.4 Ensure that person centered planning is utilized in service planning for recipients of service for quality outcomes.

Performance Indicators:

- Output: Number of people receiving DD services per year
- Outcome, Efficiency & Quality: Percentage of Individual & Family Support (FS) plans for which fund guidelines were followed
- Efficiency & Outcome: Percentage of valid Flexible Family Fund (FFF) eligibility determinations (in accordance with FFF promulgation)
- Efficiency & Output: Percentage of new systems entry applications received and completed per policy
- Efficiency & Quality: Percentage of referrals for children receiving Early Steps who request developmental disability services that are processed by age 3



Activity D: Administrative Functions

Program Description: Provides executive oversight and support functions to various programs, including accounting and fiscal management, budget development, purchasing & accounts payable, contract development, implementation & management, property control, fleet management, telecommunications management, travel, and information technology.

Mission

The mission of Northeast Delta HSA administrative functions is to coordinate and organize people, resources and systems to effectively and efficiently support the overall mission, vision and tenets of the agency.

Goal

The agency's analytics, business and fiscal operations, compliance, communications and external affairs and human resources operations provide ongoing support for core opportunities, resources and services offered to the residents of the 12 parishes across northeastern Louisiana.

Objective I: Provide administrative support to programmatic services to ensure efficient, effective, and quality services.

Strategies:

- 1.1 Perform the functions of accounting and fiscal management, budget development, purchasing & accounts payable, contract development, implementation & management, property control, fleet management, telecommunications management, travel, information technology, and executive oversight that supports Northeast Delta HSA's employees, providers, and consumers.
- 1.2 Incorporate media relations and public relations approaches to engage media outlets as a part of bringing more awareness to the agency generally and to specific agency activities, events, initiatives and programs.
- 1.3 Promote safe work environments and work culture.
- 1.4 Provide technical assistance and training to staff and contract providers in areas affecting quality of care.
- 1.5 Use data collection and analysis to support performance improvement activities and to make decisions based on outcome measurements.
- 1.6 Provide ongoing staff development and training.
- 1.7 Ensure compliance with federal, state, Civil Service, and internal policies and procedures.
- 1.8 Develop efficient and effective onboarding procedures for new hires.

Performance Indicators:

- Efficiency: Percentage of contract invoices for which payment is issued within 30 days of agency receipt
- Efficiency & Output: Percentage of state assets in the Asset Management system located/accounted for annually
- Quality: Number of findings in Legislative Auditor Report resulting from misappropriation of resources, fraud, theft, or other illegal or unethical activity.
- Efficiency: Administrative expenditures as a percentage of agency's budget

- Output: Number of impressions with completion of marketing strategies
- Output: Number of social media followers, likes and related engagement
- Output: Number of radio, television and related media interviews
- Quality: Increase in compliance rating for Office of Risk Management annual review
- Quality: Percent increase in raw score for quarterly reviews
- Efficiency: Percent decrease in time period from job requisition approval to the new hire start date
- Quality: Percentage of employee training requirements met
- Quality & Efficiency: Number of errors identified by Division of Administration



09-320 Office of Aging and Adult Services

Our Vision

A system where adults in need of long-term services and supports can live with dignity and independence in a safe and holistic environment.

Our Mission

To provide access to quality long-term services and supports for the elderly and people with adult-onset disabilities in a manner that supports choice, informal caregiving, and effective use of public resources.

Philosophy

In carrying out its vision and mission, the Office of Aging and Adult Services (OAAS) seeks to follow these guiding principles:

- to involve stakeholders in the development and implementation of new programs and policies;*
- to adopt rules, policies, and procedures that, while consistent with legal requirements, are also easily understandable, practical, and flexible;*
- to ensure that programs and services are designed using evidence-based practices and data-driven decision-making;*
- to meet, within legal and fiscal restraints and requirements, the needs of recipients while recognizing that a system of long-term care supports and services must be sustainable in order to meet the demand inherent with an aging population.*

Executive Summary

OAAS was created in 2006. Louisiana's support of community-based and residential options to institutions was growing and the Louisiana Department of Health (LDH) needed to align its infrastructure to address this growth. OAAS develops policies, procedures, rules, and programs to offer alternatives to nursing home care; to timely complete investigation of adult abuse, neglect, exploitation and extortion in the community; and to promote quality in facility-based long-term care services both in private nursing facilities and in the one facility operated by OAAS.

Agency Goals

Goal I - To promote and develop health and Long Term Supports and Services (LTSS) delivery systems that improve care and outcomes for the high risk, high cost population served by OAAS and achieve LTSS rebalancing consistent with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's decision in *Olmstead v. L.C.*

Goal II - To timely complete investigations of abuse, neglect, exploitation, and extortion of vulnerable adults.

Goal III - To administer and manage resident care programs at Villa Feliciano 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.

Goal IV - To administer and operate OAAS programs in a cost-effective manner while achieving high quality outcomes.

Program A: Administration, Protection, and Support

Program A Mission

To provide access to quality long-term services and supports in a manner that supports choice, informal caregiving, and effective use of public resources.

Program A Goals

- 1. Achieve and maintain a legally compliant and appropriately balanced LTSS system, which assures choice within a sustainable, cost-effective continuum of community-based services and facility-based services.*
- 2. Improve access, quality and outcomes for populations receiving and at risk of needing long-term supports and services.*
- 3. Ensure vulnerable adults are protected from abuse and neglect while living in community settings.*
- 4. Provide specialized facility-based care to persons whose needs are difficult to meet in private facilities.*
- 5. Administer and operate OAAS programs in a cost-effective manner while achieving high quality outcomes.*

Activity 1: Executive Administration

This Activity provides executive management, support, and direction to the Office of Aging and Adult Services (OAAS). OAAS operates LDH programs for the elderly and persons with adult onset disabilities. These programs include a 24-hour facility (Villa Feliciano Medical Complex), Adult Protective Services, Traumatic Head and Spinal Cord Injury Trust Fund, and operation of several community-based long-term care programs, which expend approximately \$344 million in Medicaid, funds (SFY 21). OAAS also performs medical certification for nursing home care totaling \$1.2 billion in Medicaid funds (SFY 21). The Executive Administration Activity is also responsible for providing programmatic expertise on aging and disability issues to LDH Executive Management, carrying out legislative directives, and directing implementation of LTSS reforms and program improvements. Not listed as separate

activities but still within the purview of Executive Administration, OAAS also manages two non-Medicaid independent living services programs.

Objective I: Ensure that OAAS operates in compliance with all legal requirements, that the Office accomplishes its goals and objectives to improve the quality of life and quality of care of persons needing LTSS in a sustainable way, reaching or exceeding appropriate national benchmarks by June 30, 2028.

Strategies:

- 1.1 Continue efforts to ensure OAAS policies, procedures, and work processes are efficient, effective, and compliant with all state and federal requirements.
- 1.2 Make judicious and accountable use of external and private sector resources through performance-based contracts, interagency agreements, and Memoranda of Understanding.
- 1.3 Implement, where possible, work process automation and system integration with the statewide enterprise architecture to support long-term care system access, quality management, and accountability.
- 1.4 Recruit, retain, and develop staff with skill sets necessary to respond to changes in LTSS and healthcare policy, technology, and delivery systems; and to support best-practice research, policy improvement, new program development, performance-based contracting, provider training and technical assistance, performance analysis, program and performance monitoring, quality management, and data-based decision-making.

Performance Indicators:

- Percentage of OAAS Performance Indicators that meet or exceed performance targets.
- Administrative cost as percentage of service cost.

Activity 2: Elderly and Adults with Disabilities Long Term Care

This Activity manages and operates community-based long term care programs for people with adult-onset disabilities, including Medicaid Home and Community Based Services (HCBS) waivers, Medicaid personal care services (LTPCS), the Program of All-inclusive Care for the Elderly (PACE), the LDH Permanent Supportive Housing Program, the Nursing Home Resident Trust Fund, the Compliance and Audit Team, the Money Follows the Person Demonstration Grant and the My Choice Louisiana initiative. This Activity also operates nursing home admissions, i.e., certification of individual applicants for nursing home care. This Activity provides state and regional office operations necessary to provide program planning, access, monitoring, quality assurance/improvement, and accountability for these programs as required under state and federal rules, statutes, and program requirements.

This Activity optimizes the use of community-based care while decreasing reliance on more expensive nursing home care. It does so by operating a variety of home and community-based long-term care programs that serve Medicaid participants at a lower average cost per person than Medicaid nursing home care. A challenge addressed by this Activity is that demand for community-based LTSS will continue to grow as the population ages, therefore expenditures on programs operated through this Activity are subject to increase. For this reason, the goal in delivering LTSS services to this population is to slow the rate of increase rather than seeking net

decreases in spending, and to serve as many people as possible within available resources. Maximization of federal funding is also an important strategy for addressing increased demand for the services provided through this Activity. This Activity is also responsible for researching, developing, and implementing more integrated approaches to care delivery for the high-risk populations of individuals dually eligible for Medicare and Medicaid and persons with adult-onset disabilities.

Programs and strategies used in this Activity are also a direct outgrowth of Louisiana's Olmstead plan, which calls for implementation of a broad array of community-based services and a multifaceted strategy for transitioning individuals from nursing homes to the community. The strategies used in this Activity are also consistent with best practices used by states that have achieved a cost effective "rebalancing" from institutional to community-based LTSS. The major programs operated through this Activity have proven effective in preventing institutionalization, with only a small percentage of program participants transitioning to nursing home care. Since SFY 2007 transitions from HCBS to long-term nursing home, residence remains very low, at only 2% per quarter.

Objective II: Optimize the use of community-based care while decreasing reliance on more expensive nursing home care to meet or exceed national averages for nursing home versus community-based spending by June 30, 2028.

Strategies:

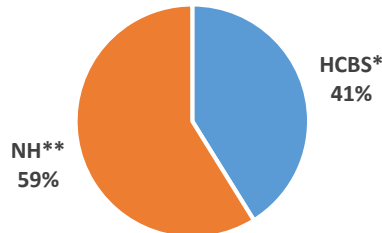
- 2.1 Maintain a diverse and flexible array of cost-effective services to achieve quality outcomes and serve as many individuals as possible within available budgetary resources.
- 2.2 Improve access to and coordination of Medicaid and non-Medicaid health and LTSS resources through implementation of more fully integrated delivery systems.
- 2.3 Assure the sustainability of nursing home transition and diversions through the Money Follows the Person demonstration, including transitions and diversions of persons with Serious Mental Illness as called for in the state's agreement with the U.S. Department of Justice.
- 2.4 Build upon the evidence-based, measurement-driven quality improvement, quality management, and accountability strategies currently in place for LTSS services and make performance and outcome data more readily available to multiple end-users.
- 2.5 Continue to pursue opportunities to maximize federal funding and match when such opportunities arise and are consistent with the mission and goals of LDH and OAAS.

Performance Indicators:

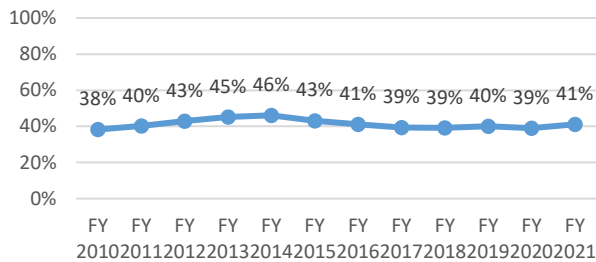
- Percentage of Medicaid spending for elderly and disabled adult long-term care that goes towards community-based services as compared to nursing homes.
- Average expenditure per person for community-based long-term care as a percentage of the average expenditure per person for nursing home care.
- Percentage of participants receiving Medicaid long term care in the community rather than in nursing homes.
- Program operation cost as a percentage of Medicaid service cost.

HCBS vs. Nursing Facility Recipients and Spending for FY21

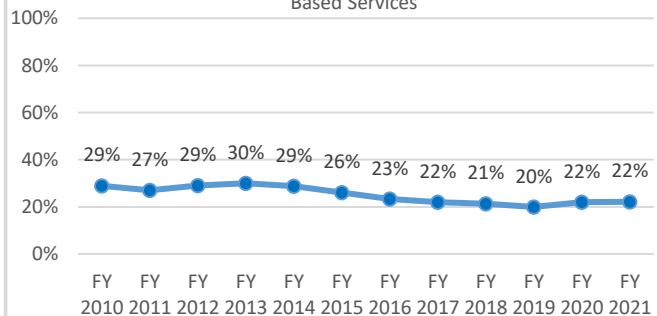
Recipient Counts
HCBS vs. Facility for FY 2021



Percentage of LTSS Recipients in Home and Community Based Services



Percentage of LTSS Spending in Home and Community Based Services



Data source: State Fiscal Year 2020/21 Year End Financial Report and Medicaid Data Warehouse

Objective III: Through the Elderly and Adults with Disabilities Long-Term Care Activity, expedite access to a flexible array of home and community-based services through June 30, 2028.

Strategies:

- 3.1 Maintain a diverse and flexible array of cost-effective services to achieve quality outcomes and serve as many individuals as possible within available budgetary resources.
- 3.2 Maintain fair and accountable allocation of resources for home and community-based services based on individual acuity as determined through objective and comprehensive assessment.

Performance Indicators:

- Number on registries for OAAS HCBS waivers.
- Percentage on registries for OAAS HCBS waivers who are receiving other Medicaid LTC.
- Number served in all OAAS HCBS programs.

Objective IV: To facilitate timely access to nursing facilities for eligible applicants through June 30, 2028.

Strategies:

- 4.1 Ensure that the Level I Pre-Admission Screening and Resident Review process appropriately identifies individuals with serious mental illness, intellectual disability, or a related condition who need further evaluation by the Office of Behavioral Health and/or the Office of Citizens with Developmental Disabilities.
- 4.2 Seek to further automate and streamline the admission review process and requests for continued stay.

Performance Indicator:

- Percentage of nursing facilities admissions applications determined within established timeframes for OAAS access systems.

Activity 3: Permanent Supportive Housing (PSH)

This Activity provides supportive services to help people with disabilities – particularly those who are or who are at risk for institutionalization or homelessness - have successful tenancies in mainstream affordable housing. OAAS operates the PSH program under a Cooperative Endeavour Agreement with the Louisiana Office of Community Development (OCD) Louisiana Housing Corporation. Louisiana's PSH program is a cross-disability program that facilitates access to stable housing and preventive services for a population that otherwise makes disproportionate use of high cost emergency and nursing home services. Louisiana's PSH program is considered a model for cross-disability implementation at the state level and has been evaluated by the Robert Wood Johnson Foundation and others for purposes of replication in other states and communities.

Objective V: Through statewide expansion of the Permanent Supportive Housing Activity, stabilize and reduce acute and institutional care for over 3,500 households of elders and persons with disabilities through June 30, 2028.

Strategies:

- 5.1 Provide access to affordable, community-based housing.
- 5.2 Oversee application process and waiting list to ensure program eligibility and to meet overarching policy goals of LDH.
- 5.3 Closely coordinate housing referral and placement to decrease instances of homelessness and unnecessary institutionalization.
- 5.4 Provide individualized services to support housing acquisition and retention and facilitate access to appropriate medical and social services.
- 5.5 Assist participants with obtaining SSI and Medicaid eligibility.
- 5.6 Complete statewide program expansion.

- 5.7 Implement plan for sustainability of PSH administrative functions once Community Development Block Grant funds are exhausted.

Performance Indicators:

- Percentage of participants who remain stabilized in the community.
- Percentage of participants who obtain a source of, or increase in, income.

Activity 4: Traumatic Head and Spinal Cord Injury (TH/SCI) Trust Fund

The TH/SCI Trust Fund allows survivors of traumatic head and spinal cord injury to avoid unnecessary and costly institutionalization by providing resources or services that they are not otherwise eligible for through any other funding source. The Trust Fund promotes the health of eligible Louisiana citizens by providing services, such as specially designed medical beds, maintenance therapies, and remote in-home client monitoring systems that prevent or delay the onset or progression of diseases and excess disability associated with such injuries. The TH/SCI Trust Fund was established in the 1993 Regular Session of the Louisiana Legislature as a special fund in the state treasury consisting of monies collected from an additional fee imposed on three specific motor vehicle violations (DWI, reckless operation and speeding).

Objective VI: Through the Traumatic Head and Spinal Cord Injury Trust Fund Activity, to assist survivors of traumatic head and/or spinal cord injuries with improving their level of functioning and independence in their community while maximizing the use of their funds; and to serve as many as possible at the current level of funding by aligning policy and procedures with the mission of the program.

Strategies:

- 6.1 Achieve better coordination of care between the THSCI Trust Fund program, Medicaid-related programs, and other programs where similar services may be provided.
- 6.2 Continue to revise policies, procedures and statutes to more effectively serve additional people within available levels of funding.

Performance Indicators:

- Percentage of THSCI Trust Fund expenditures going to direct services.
- Number of people served by the THSCI Trust Fund.
- Number of people on the waiting list for THSCI Trust Fund assistance.

Activity 5: Adult Protective Services

Adult Protective Services is committed to preserving and protecting the rights of vulnerable adults with disabilities in need of assistance due to abuse, neglect, self-neglect and/or exploitation in accordance with the provisions of LA R.S. 14:403.2 and LA R.S. 15:1501-1511.

This Activity assists and enables vulnerable adults ages 18-59, emancipated minors, and participants who reside in LDH administered facilities to live free from harm due to abuse, neglect, exploitation, or extortion. Adult Protective Services include but are not limited to:

- receiving and screening information on allegations of abuse, neglect, exploitation and/or extortion;
- conducting investigations and assessments of those allegations to determine if the situation and condition of the alleged victim warrants corrective or other action;
- stabilizing the situation;
- developing and implementing plans for preventive or corrective actions;
- referring for necessary on-going services and/or to case management;
- ensuring services are obtained;
- initiating and/or referring for necessary civil legal remedies; and
- referring cases as needed or required to law enforcement and/or the district attorney and cooperating in court proceedings.

Objective VII: The Adult Protective Services Activity, through the application of best practice standards and the policies established by LDH, will promote safety, independence, and quality-of-life for adults with disabilities who are at risk of abuse, neglect, exploitation or extortion through June 30, 2028.

Strategies:

- 7.1 Manage resources to ensure adequate staffing to serve the targeted population.
- 7.2 Create and implement policies to ensure that the program is held to high standards of integrity.
- 7.3 Provide training, supervision, and consultation to staff who conduct community and facility investigations.
- 7.4 Use the centralized reporting system to ensure standardized screening, triaging, and case assignment protocols.
- 7.5 Use standardized practices to collect and analyze information when determining whether or not maltreatment has occurred.
- 7.6 Follow the policies and procedures related to open case reviews and case closures to ensure safety risks are being reduced or removed.
- 7.7 Collect and analyze data related to performance.
- 7.8 Utilize systems to allow for collaboration and consultation with other professionals who are interested in the amelioration of abuse to vulnerable adults.

Performance Indicators:

- Percentage of investigations completed within established timeframes.
- Percentage of cases requiring a service plan that were closed.
- Number of clients served.

Program B: Villa Feliciana Medical Complex

Program B Mission

Villa Feliciana Medical Complex is a state owned and operated Medicare and Medicaid certified long-term care facility with a mission of providing specialized care and rehabilitative services to medically complex residents.

Program B Goals

- 1. Provide management leadership and administrative support necessary for the delivery of resident care services.*
- 2. Administer and manage resident care in a manner that ensures compliance with applicable standards of care.*
- 3. Provide quality health care services to residents through the identification of need and efficient and effective delivery of services.*

Villa is a 24-hour long-term care facility that provides quality, comprehensive, in-patient health care services. Villa works to prevent the progression of diseases through appropriate medical care, proper nutrition, exercise, therapy, regular check-ups and routine screenings.

Villa contributes to the state goals by decreasing the percentage of avoidable expenditures for the care of citizens who have acute and chronic medical conditions through the provision of comprehensive facility-based services. Villa reduces fragmentation of care, duplication of efforts and unnecessary medical treatments, emergency room visits, and hospitalizations. Villa serves as a training site for students from several Louisiana Technical Colleges, thereby helping to address healthcare labor shortages.

Villa serves as a safety net facility. Many residents have no other placement options due their acuity level and their need for effective disease management not generally offered by private long-term care facilities. Villa also provides care to patients from Eastern Louisiana Mental Health System (ELMHS) including forensics patients who require more medical care than ELMHS can provide. Villa is also occasionally named in court-ordered placements for individuals on parole or on medical leave from the Department of Corrections.

Villa provides on-site medical services specifically structured to meet special health care needs. For example:

Villa provides care to residents under judicial commitment who require long-term care in a secure environment.

- Villa is the only facility in Louisiana that provides in-patient care for clients with tuberculosis. Most of Villa's TB residents have been court-ordered to Villa due to their non-compliance with their treatment regimen in their local community. They remain at Villa until their treatment is complete and they are no longer a public health threat.

Objective I: To provide high quality medical services and achieve excellent resident outcomes in a cost effective manner through June 30, 2028.

Strategies:

- 1.1 Identify residents' medical needs.
- 1.2 Train direct-care staff in specialty areas.
- 1.3 Conduct periodic physical plant inspections to insure all needs are identified and documented.
- 1.4 Maintain education requirements for professional staff.
- 1.5 Maintain suggested staffing for resident care.

Performance Indicators:

- Percent compliance with CMS license and certification standards
- Staff/client ratio

Objective II: To provide management leadership and administrative support necessary for the delivery of resident care services and to provide for the efficient and effective use of resources in meeting all mandated regulatory requirements each year through June 30, 2028.

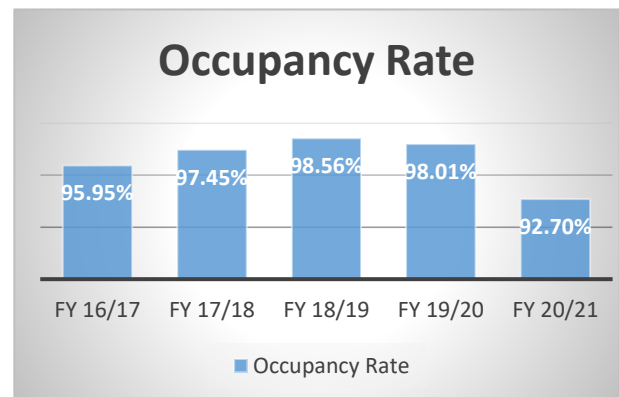
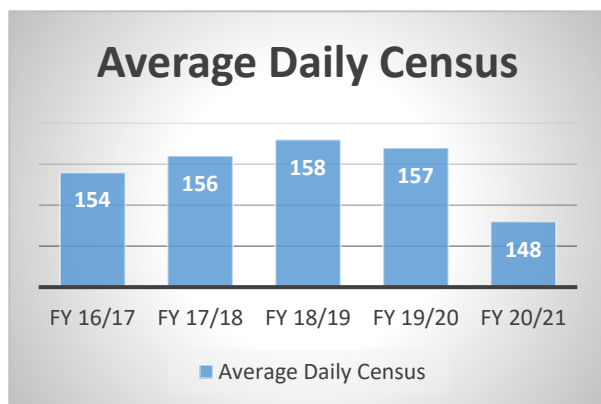
Strategies:

- 2.1 Comply with all requirements mandated by external entities.
- 2.2 Adhere to sound management practices that promote the efficient and cost effective care of facility residents.
- 2.3 Maintain a resident census sufficient to fund all facility expenditures.

Performance Indicators:

- Cost per client day.
- Average daily census/Occupancy Rate.
- Total clients served.

Average Daily Census and Occupancy Rates are lower in FY21 due to COVID-19.



Louisiana Emergency Response Network Board



Mission

The mission of the Louisiana Emergency Response Network (LERN) is to defend the public health, safety, and welfare by protecting the people of the state of Louisiana from unnecessary deaths and morbidity due to trauma and time-sensitive illness.

Philosophy/Values

The Louisiana Emergency Response Network, as a statewide comprehensive and integrated system for trauma, stroke, and STEMI is dedicated to providing access to high quality, definitive care for all in the state of Louisiana. LERN is committed to proactively building integrated systems that are responsive to the provider communities and citizens around the state. LERN is driven by the basic principle that any preventable death resulting from treatment delay is unacceptable.

Executive Summary

The Louisiana Emergency Response Network is charged with developing a statewide comprehensive and integrated network that decreases deaths and incidents of morbidity and mortality due to trauma and time-sensitive illness in Louisiana. LERN continues the development and implementation of systems for trauma, stroke, STEMI and disaster response. In the vast majority of cases, the difference between life and death hinges on a well-coordinated team response and specialized medical training plus the public awareness and modern technology to tie it all together. It is vitally important going forward that LERN is funded to a level that facilitates our ability to quantify our return on investment for these systems we labored to build over the past years.

LERN continues to build upon lessons learned post-hurricanes Katrina, Rita, Ike, Gustav, Isaac, Harvey, Nate, Laura, Delta, Ike and the flood of 2016. Disaster planning and response are an integral part of LERN's day-to-day operations. LERN assists in everything from small scale Mass Casualty Events (MCI) via routing patients to definitive care, sending electronic notifications via collaboration with the Designated Regional Coordinator Network (DRC Network) to larger events by leading the Emergency Medical Services Tactical Operations Unit (EMS-TOC). LERN stands ready to serve when called upon. LERN participates in regional drills throughout the state with key stakeholders, and provides MCI education in an effort to ensure success and facilitate a coordinated, efficient response during disasters – be it large or small scale.

LERN was granted the necessary funding to begin the implementation of a system that coordinates the patient's day-to-day emergent care needs with the closest most appropriate facility and the resources to provide definitive trauma and time-sensitive care. Over the past 11 years we have increased the number of trauma centers in the state from two to ten, added the development and

implementation of stroke, STEMI and Burn systems to our responsibility and assumed an expanded role in Disaster Response. From 2006 through 2019, LERN operated with the same seven FTEs initially allocated in 2006 when the agency started. In 2020 LERN added a Health Data Manager to our team. LERN manages the State Trauma Registry, the State EMS Registry, the State Stroke Registry, the State STEMI Registry and the LERN Call Center Registry. The addition of the Health Data Analyst to help manage these registries has been vital in informing our decision making. The LERN Board is grateful to the current administration for recognizing the need to further expand LERN's staff by approving two job appointments – for a Statewide Education Manager and a Disaster Preparedness Manager. These additional employees will help LERN fulfill our mission.

LERN's nine Regional Commissions continue to engage local pre-hospital providers, doctors and nurses, and homeland security professionals in the development and implementation of trauma, stroke, and STEMI systems in their region. Through these commissions, partnerships between public and private health care entities continue their collaboration to meet the mission of LERN. These committed individuals working together demonstrate Louisiana's commitment to implement best-in-class, evidence-based trauma, STEMI, and stroke care systems. There is no question that this work translates into saved lives. We must get to a point where we use our data to effectively demonstrate this.

LERN has participation agreements with EMS and hospital providers in all regions of the state. These agreements facilitate the use of LERN's pre-hospital destination protocol which is designed to deliver trauma patients to definitive care. LERN will continue to refine integration with the Governor's Office of Homeland Security, specifically ESF-8, to ensure that the communication and information sharing systems between state emergency operations centers and regional response systems are comprehensive and effective.

LERN Goals

- Goal I** Decrease risk adjusted trauma-related deaths and incidents of morbidity and mortality due to trauma in Louisiana.
- Goal II** Maximize the return on investment (ROI) of state dollars and supplement of general fund dollars with alternative funding sources.
- Goal III** Ensure that all citizens gain access to the statewide networks for trauma and time sensitive related illnesses.
- Goal IV** Establish and codify protocols that specify the role of LERN in ESF-8 activities.

Louisiana Emergency Response Network

The Louisiana Emergency Response Network (LERN) is an agency of state government created by the Louisiana Legislature in 2004 and is charged with the responsibility of developing and maintaining a statewide system of care coordination for patients suddenly stricken by serious traumatic injury or time-sensitive illness (such as heart attack and stroke). LERN is a system also designated to serve as a vital healthcare resource in the face of larger scale emergencies and natural disasters.

LERN Goals

Goal I

Decrease risk adjusted trauma-related deaths and incidents of morbidity and mortality due to trauma in Louisiana.

Objective I: Decrease the age adjusted death rate due to trauma in Louisiana by 5% by 2028.

Strategies:

- 1.1 Utilize the expertise of the LERN Trauma Medical Director to facilitate the Establishment of a verified trauma center in each of the LDH regions by 2028.
- 1.2 Operate first class Communication Center to efficiently route injured patients to definitive care hospitals.
- 1.3 Conduct annual strategic prioritization meetings to review the LERN strategic priorities and update action steps to achieve goals.
- 1.4 Further maturation of the Trauma Collaborative to define and implement new Statewide Clinical Care Guidelines or other protocols to improve timeliness and appropriateness of trauma care.
- 1.5 Provide Trauma nursing education in each LDH region.
- 1.6 Support dissemination of the Rural Trauma Team Development Course (RTTDC) to rural areas of the state.
- 1.7 Teach Stop the Bleed courses in every region.

Performance Indicators:

- Number of state designated trauma centers. (General Performance Indicator). Figure 1 indicates the current verified trauma centers in Louisiana.
- Percentage of time where traumatically injured patients that were directed to an Emergency Department for definitive care did not require transfer to another facility for higher level resources – goal is 95% annually. Figure 2 indicates CY 21 performance. (Key indicator)

- Percentage of Louisiana citizens with access to a Level I, II, or III trauma center within a 60 minute drive time. (General Performance Indicator)
- Number of LERN directed/facilitated TNCC and ENPC classes in all 9 LDH regions annually. (General Performance Indicator)
- Number of LERN directed Stop the Bleed classes in all 9 LDH regions annually. (General Performance Indicator)

Figure 1:

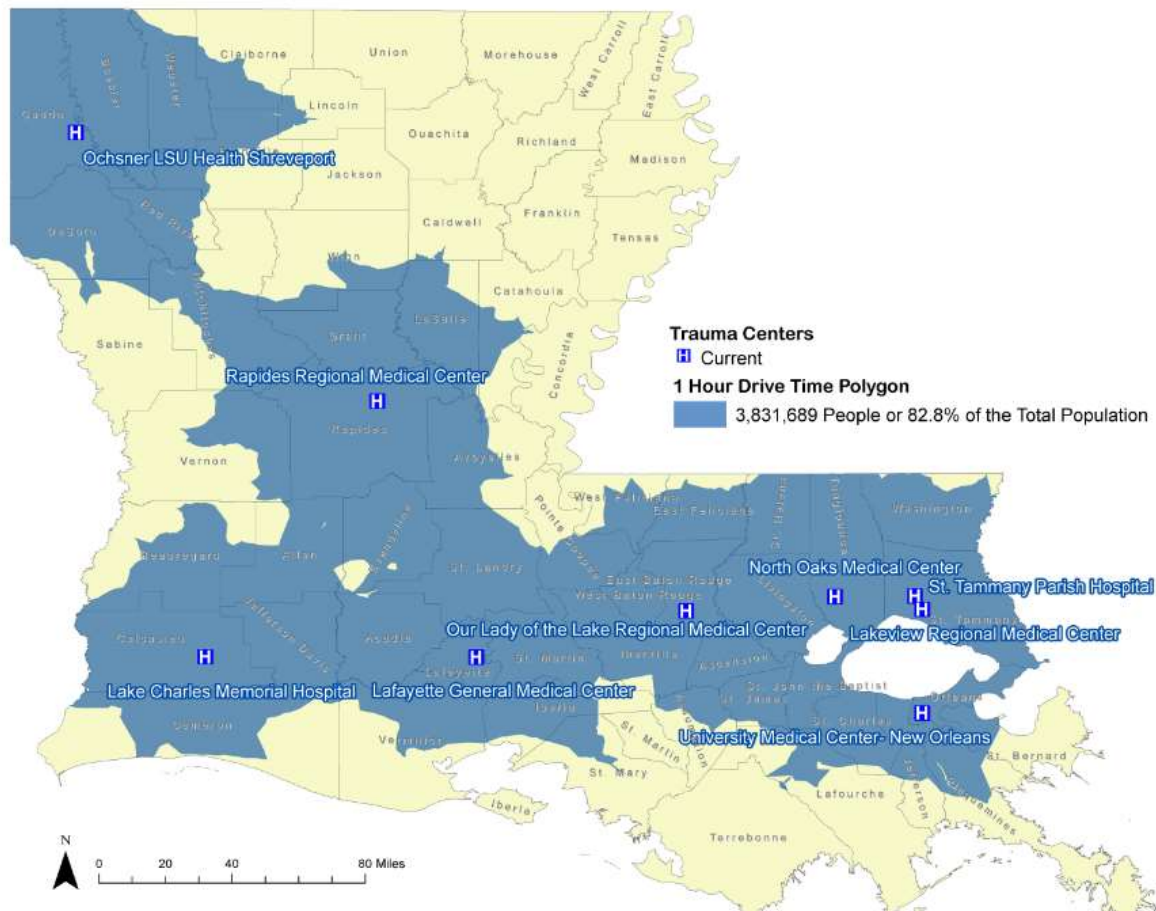
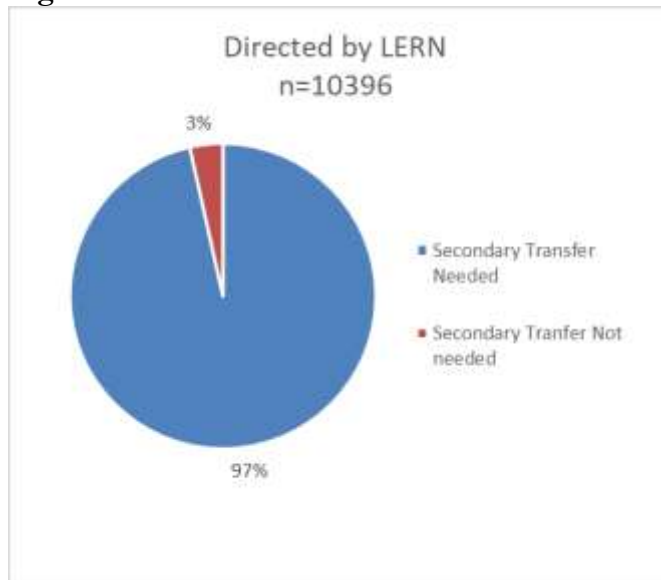


Figure 2:



Source for Figure 2 is LERN Call Center Data base.

Goal II:

Maximize the return on investment (ROI) of state dollars and supplement of general fund dollars with alternative funding sources.

Objective II: Identify and pursue potential dedicated funding options external to the State General Fund.

Strategies:

- 2.1 Identify grant sources to secure federal and private foundation dollars to support LERN's mission.

Performance Indicator:

- Non-state dollars generated to support LERN activities. (General Performance Indicator)

Goal III:

Ensure that all citizens gain access to the statewide networks for trauma and time sensitive related illnesses.

Objective III: Through the LERN Central Office, continue the operational activity of the LERN Call Center located in Baton Rouge to encompass 100% of the citizens of Louisiana in directing the transport of traumatically injured patients and stroke and STEMI patients to definitive by June 30, 2028.

Strategies:

- 1.1 Continue operation of the LERN Communication Center with at least quarterly testing of redundancy plan.
- 1.2 Utilize LERN medical directors for trauma, stroke, and STEMI for annual review and updating of LERN Board approved destination protocols as indicated.
- 1.3 Bi-monthly performance improvement case review meetings with LERN staff, Call Center staff, and LERN Medical Directors to ensure proper oversight and resolution to identified issues.
- 1.4 Maintain TRCC grant funding to employ EMS Data Manager, responsible for onboarding new EMS providers to submit data to the state EMS registry and to validate existing data.

Performance Indicators:

- Percentage of time where traumatically injured patients that were directed to an emergency department for definitive care did not require transfer to another facility for higher level resources – goal is 95% annually. Figure 2 indicates CY 21 performance. (Key Indicator)
- Percentage of hospitals having emergency room services that participate in the LERN Network as evidence by the % of Hospitals with signed LERN participation agreements. (Key Indicator)
- Percentage of EMS agencies that participate in the LERN Network as evidence by % of EMS agencies with signed LERN participation agreements. (Key Indicator).
- Percentage of EMS agencies that submit data to the State EMS Registry. (Key Indicator)

Objective III: Develop a statewide system of stroke care to improve outcomes for Louisiana citizens regardless of where they live in the state.

Strategies:

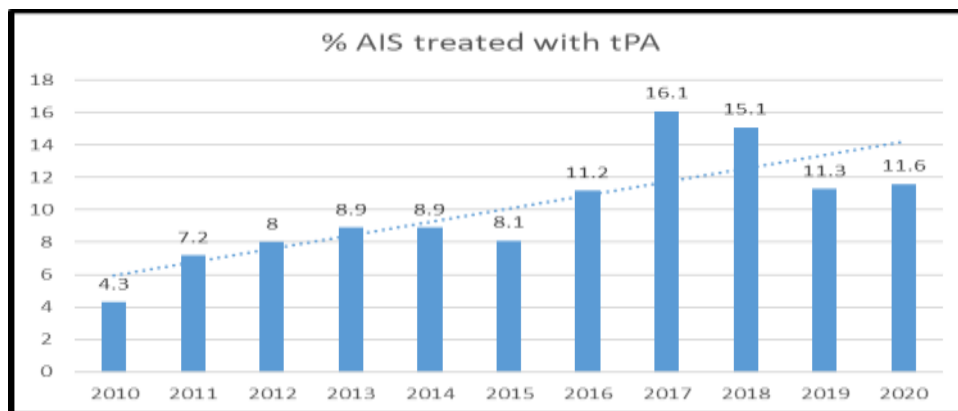
- 2.1 Maintain 100% compliance with required data collection from all participating stroke centers.
- 2.2. Provide support and remediation to help prevent demotion of Acute Stroke Ready Hospitals to Stroke Bypass Centers.
- 2.3. Reduce Door In Door Out (DIDO) to less than 90 minutes.

- 2.4 Begin teaching Acute Stroke Life Support. Teach course in every region by end of 2028.
- 2.5 Work with hospitals to ensure all have individualized protocol for how to address: Wake up stroke, Intracerebral hemorrhage (ICH), Subarachnoid hemorrhage (SAH), suspected pediatric stroke, and coagulopathy reversal.

Performance Indicators:

- Percentage of stroke centers submitting data to LERN. (General Performance Indicator)
- Number of Comprehensive, Primary Stroke or Thrombectomy Certified Stroke Centers in Louisiana. Can be combination of the two. (General Performance Indicator)
- Percentage of patients with Acute Ischemic Stroke who are treated with tPA. (General Performance Indicator)

Figure 3:



Source:
Louisiana Inpatient
Hospital Discharge
Data.

Objective III: Develop a statewide system of STEMI care to improve outcomes for Louisiana citizens regardless of where they live in the state.

Strategies:

- 3.1 Increase public awareness of heart attack signs and symptoms and the importance of calling 911.
- 3.2 Identify optimal STEMI registry for Louisiana and facilitate data collection and submission by 100% of Receiving centers by 2028.

Performance Indicator:

- Number of STEMI Receiving Centers submitting data to state STEMI Registry (General Performance Indicator)

Goal IV:

Establish and codify protocols that specify the role of LERN in ESF-8 activities.

Objective IV: Adoption of LERN MCI procedures by each LDH region as indicated by inclusion in their regional disaster plans.

Strategies:

- 4.1 Utilize the regional commission structure and regional partners to ensure involvement in one MCI/Disaster drill annually in each region of the state.
- 4.2 Continue EMS education on MCI procedures statewide.
- 4.3 Continue LERN's role in ESF-8 activities as manager of EMS Tactical operations Center.
- 4.4. Conduct EMS TOC tabletop exercise prior to hurricane season.

Performance Indicators:

- Percentage of LDH regions participating with LERN in regional MCI drills. (General Performance Indicator)
- Number of regions who participate in MCI Boot camp. (General Performance Indicator).

09-325

Acadiana Area Human Services District



ACADIANA AREA
HUMAN SERVICES DISTRICT

Mission

The mission of Acadiana Area Human Services District (AAHSD) is to improve the quality of life for the citizens of Acadiana who have behavioral health and/or intellectual/developmental disabilities. To this end, a comprehensive system of care is offered which provides research-based prevention, early intervention, treatment and recovery support services to citizens of Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion parishes, directly and through community collaborations.

Vision

The vision of Acadiana Area Human Services District (AAHSD) is to become the preeminent provider of community-based supports and human services which promote the independence, respect, and inclusion of intellectual/developmental disabilities.

Value

The value of Acadiana Area Human Services District (AAHSD) are Accountability- To be good stewards of our resources and to exceed all contractual. Legal and regulatory requirements in providing services. Transparency- To operate in such a manner as to be above reproach in all of our governance and operational processes. Value- To achieve optimal outcomes by implementing cost-effective, evidence-based practices in a timely manner.

Philosophy

AAHSD shall operate as an organized professional entity of the health care system functioning as an integral part of the interdisciplinary health care team dedicated to total patient care in the community.

Our purpose is to be helpful and innovative in the pursuit of quality behavioral health care for our consumers. We serve as an advocate on behalf of our consumers and assist in planning a course of care while in treatment and at home. Our goal is to always maintain a high level of professional practice, cooperation and courtesy in contact with our consumers, families, community, and other health care providers.

Further, we believe that it is the responsibility of the District to garner resources, identify innovative programs, and make available to its consumers a comprehensive array of research-based services offered in an integrated system that promotes consumer choice while pursuing the goal of wellness.

Executive Summary

The Louisiana State Legislature established the Acadiana Area Human Services District under the provisions of the Louisiana revised statutes (LSA-RS), per Act 373 of the 2008 Regular Session and updated by Act 73 of the 2017 Regular Session to provide administration, management, and operation

of behavioral health (addictive disorders and mental health) and developmental disabilities services to the residents of Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion parishes. Direct oversight of these services was previously provided through the Department of Health and Hospitals (LDH).

Governance of AAHSD is by a ten (10) member Board of Directors. The Board is comprised of one resident from each parish as appointed by their parish governing authority, and three residents from the 'region' as appointed by the Governor. Each board member must possess experience in the area(s) of behavioral health or developmental disabilities and represent parents, family members, consumers, advocacy groups, or serve as a professional in one of the areas. All board members serve without compensation (reimbursement for travel/mileage is allowed, as funds are available).

Administration of the AAHSD is headed by an Executive Director, who is selected by the Board of Directors and is supported in administration and day-to-day operations by a Senior Management Team. This leadership team strives to foster a culture of accountability and collaboration in an environment focused on evidence-based and best practices and the ongoing assessment of needs throughout the community. Success is defined by positive individual and programmatic outcomes, consumer satisfaction, and increased efficiencies and cost-effectiveness in the provision of services.

Geography

AAHSD serves a seven-parish area – Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion – and has service sites in Crowley (A), Lafayette (L), New Iberia (I), Opelousas (StL), and Ville Platte (E). This area covers approximately 5,000 square miles (approximately 12% of State total) and has a population of approximately 600,000 persons (from 2020 US Census estimates) (approximately 13% of State total). Of this population, AAHSD has an inherent responsibility to the medically indigent (uninsured and under-insured and those with Medicaid) and to all individuals who present at our service sites in crisis or seeking non-emergency services.

Organizational Goals

1. To provide comprehensive 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, co-occurring disorders, and/or developmental disabilities.
2. To improve individual outcomes through effective implementation of evidenced-based and best practices and data-driven decision-making.
3. 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.

ACTIVITY: ADMINISTRATION

Goal To develop clear policy objectives, well-defined local roles and responsibilities, and measures to ensure accountability of the provision of quality services to consumers.

Objective 1: To provide programmatic leadership and direction to the programs of behavioral health (addictive disorders and mental health) and developmental disabilities services under AAHSD; to continue the operational activity of the AAHSD administrative office in relation to the Readiness Assessment Criteria and other regulatory/licensure processes and according to the terms of the Memorandum of Understanding (MOU) each year through June 30, 2028.

Strategies:

- Strategy 1: Maintain compliance with Federal and State regulations governing behavioral health and developmental disabilities services; to include financial monitoring/reporting.
- Strategy 2: Maintain appropriate credentialing for organization and individual providers as outlined by SMO.
- Strategy 3: Maintain appropriate national accreditation as outlined by SMO.
- Strategy 4: Produce an accurate and timely monthly expenditure report reflecting the current budgetary position and proposing any necessary adjustments. To also produce monthly contract reports to include the current status and expenditures for each program.
- Strategy 5: Actively seek input from stakeholders and consumers to identify service gaps and to initiate program development or modification as appropriate. Input will be gathered on an ongoing basis in a variety of means, to include at least an annual 'community forum'.
- Strategy 6: Provide ongoing staff development activities to enhance skill sets and maintain appropriate credentials for service provision.

Performance Indicators:

- Percentage of Acadiana Area Human Services District clients who state they would continue to receive services at our clinics if given the choice to go elsewhere.
- Percentage of Acadiana Area Human Services District clients who state they would recommend the clinics to family and friends.
- Total number of individuals served in the Acadiana Area Human Services District.
- Total number of enrollees in prevention programs.

ACTIVITY: BEHAVIORAL HEALTH

Goal 1 To provide behavioral health treatment services as part of the State's continuum of care (per the Human Services Accountability and Implementation Plan) in Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion parishes.

Goal 2 To improve accessibility for emergency and non-emergency behavioral health services.

Goal 3 To increase stakeholders' involvement in planning, education, and decision-making within the range of services offered by AAHSD.

Objective 1: Each year through June 30, 2028, AAHSD will work as part of the State's continuum of care that centers on behavioral disorders, addictive disorders, and co-occurring disorders.

Strategies:

- Strategy 1: AAHSD will assume administrative, fiscal, and programmatic responsibilities for all community-based behavioral health services within its seven-parish area, as agreed upon through contract with LDH.
- Strategy 2: Implement an effective fiscal and programmatic monitoring system that ensures the quality, quantity, and appropriateness of services delivered by all contract providers.
- Strategy 3: Assess current access procedures comparative to national models to determine best practices based upon procedures, staffing patterns, and technical support.
- Strategy 4: Establish and implement standardized screening, registration, admission, and intake procedures (along with relevant documentation).
- Strategy 5: Actively seek input from stakeholders and consumers to identify service gaps and to initiate program development or modification as appropriate. Input will be gathered on an ongoing basis in a variety of means, to include at least an annual ‘community forum’.
- Strategy 6: Maintain close working relationship with and support the work of the ‘regional advisory committee’ in their efforts to advocate for consumers and families.

Performance Indicators:

- Number of adults served with MH services in all Acadiana Area Human Services District Behavioral Health clinics.
- Number of children/adolescents served with MH services in all Acadiana Area Human Services District Behavioral Health clinics.
- Percentage of adults receiving MH services who report that they would choose services in this agency if given a choice to receive services elsewhere.
- Percentage of MH clients who would recommend services in this agency to others.
- Percentage of MH cash subsidy slots utilized.
- Total number of individuals served by outpatient mental health in Acadiana Area Human Services District.
- Total number of individuals served by inpatient Addictive Disorders in Acadiana Area Human Services District.
- Total numbers of individuals served by outpatient Addictive Disorders in Acadiana Area Human Services District.

Objective 2: Each year through June 30, 2028, AAHSD will provide best practices and evidence-based practices to individuals, families, and groups.

Strategies:

- Strategy 1: Implement behavioral health treatment and recovery support services from an effective practice perspective within clinics and through contract providers.
- Strategy 2: Implement an effective fiscal and programmatic monitoring system that ensures the quality, quantity, and appropriateness of services delivered by all contract providers.

- Strategy 3: Develop and implement a meaningful/relevant QI process to systematically review the quality, appropriateness, and utilization of the services provided.

Performance Indicators:

- Percentage of successful completions (24-hour residential programs) - AD Program

ACTIVITY: DEVELOPMENTAL DISABILITIES

Goal 1 To provide access to appropriate, comprehensive community based supports for individuals with disabilities, their families and/or support system(s) such that they will be able to be maintained within their communities.

Goal 2 To provide quality services and supports information and opportunities for choice for individuals with developmental disabilities and their families.

Goal 3 To increase stakeholders' involvement in planning, education, and decision-making within the range of services offered by AAHSD.

Objective 1: Foster and facilitate independence for persons with disabilities through the availability of home and community based services each year through June 30, 2028.

Strategies:

- Strategy 1: Serve as the Single Point of Entry (SPOE) into the Developmental Disabilities Services System providing support coordination services to individuals and their families through community resources.
- Strategy 2: Identify State agencies and community organization resources in order to better support people with developmental disabilities to live full community lives and support partnerships with and referrals to these agencies and/or organizations.
- Strategy 3: Monitor program utilization, effectiveness, and collect performance indicator data.
- Strategy 4: Develop and implement policies and procedures for adult waiver participants to have pathways to community employment.
- Strategy 5: Meet quarterly with service providers and families to discuss goals and services and to resolve barriers to achieving goals.

Performance Indicators

- Number of people receiving individual and family support services.
- Number of people receiving flexible family fund services.
- Percentage of eligibility determinations determined valid according to the Flexible Family Fund promulgation.

Objective 2: Each year through June 30, 2028, AAHSD will conduct targeted collaboration with consumers, family members and community partners to identify individuals with disabilities who may be eligible for supports offered through AAHSD.

Strategies:

- Strategy 1: Community Education & Awareness events sponsored by AAHSD to educate individuals, family member, community organizations, school systems and the medical community regarding service access.
- Strategy 2: Actively seek input from stakeholders and consumers to identify service gaps and to initiate program development or modification as appropriate. Input will be gathered on an ongoing basis in a variety of means, to include at least an annual ‘community forum’.

Performance Indicator:

- Number of persons receiving Developmental Disabilities services per year.



09-326 Office of Public Health

Vision

The LDH Office of Public Health, characterized by a trained and highly motivated workforce, will employ science-based best practices to ensure that all people in Louisiana have the opportunity to grow, develop, and live in an environment that promotes the physical, behavioral and social health of individuals, families and communities.

Public Health professionals are motivated daily by how individuals and communities are working together to improve their health. As custodians of the public's trust and money, we strive to stay connected to what is most important to improve the health of individuals and families.

Mission

The mission of the Louisiana Department of Health (LDH) Office of Public Health (OPH) is to protect and promote the health and wellness of all individuals and communities in Louisiana. We accomplish this through education, promotion of healthy lifestyles, preventing disease and injury, enforcing regulations that protect the environment, sharing vital information and assuring preventive services to uninsured and underserved individuals and families.

Philosophy/Values

- The Office of Public Health defines health as physical, mental, and social well-being.
- We are dedicated to assisting and serving all people with compassion and dignity.
- We value, respect, and promote diversity.
- We value individuals and communities as core partners in protecting and promoting health.
- We value the unique perspectives and contributions of all employees.
- We are committed to fostering an environment where all employees are empowered to challenge current progresses and assumptions in an effort to continually improve quality and performance.
- We demonstrate integrity, accountability, professionalism, and transparency.

Executive Summary

The Office of Public Health is responsible for protecting and promoting the health and wellness of all individuals and communities in Louisiana through promotion of healthy lifestyles; prevention of disease and injury; safeguarding water, food, and the environment; leading the state's health data strategy; and ensuring readiness for hurricanes, disasters, and threats to Louisiana in conjunction with other state departments.

OPH's departments (referred to as "Bureaus") are organized under three distinct "Centers," each led by a Deputy Assistant Secretary. This structure allows all OPH programs to benefit from direction and guidance of senior leadership that comprises the OPH management team. The structure coalesces Bureaus with similar mission under one leader and allows for an increase in effective collaboration

within the Office. The Assistant Secretary is at the helm, overseeing the three Deputy Assistant Secretaries and respective Center of Community and Preventive Health, Center for Finance and Operations, and the Center for Community Preparedness and Health Protection. In addition, the Assistant Secretary provides oversight to a cadre of professional staff including a Senior Advisor, a Special Projects Manager, and the COVID Testing Coordinator. This enhanced organizational structure affords OPH the opportunity to aspire to its vision and to accomplish its mission as encompassed by the Assistant Secretary's value strategy of maintaining health and preventing illness.

The Center for Community and Preventive Health (CCPH) is responsible for ensuring clinical preventive health services; conducting infectious and communicable disease surveillance and outbreak investigations; and providing clinical and environmental laboratory services statewide.

The Center for Finance and Operations (CFO) is responsible for the day-to-day operations of OPH including managing the budget. In addition, vital records and statistics are provided to the public and health data are collected, analyzed and disseminated. Training, testing, and licensing of emergency medical professionals are also provided.

The Center for Community Preparedness and Health Protection (CCPHP) is responsible for ensuring the preparedness and resiliency of the state public health organizations for all potential public health emergencies. CCPHP Sanitarian Services conducts reviews and provides oversight to activities related to reducing risks associated with environmental hazards. Engineering Services reviews plans and permits new construction or modification of drinking water facilities, wastewater facilities, and public pools as well as inspect, sample and supervise the public water supply. The OPH Laboratory protects the health and safety of the public by providing accurate and timely testing of specimens and provide laboratory results to state officials, public health programs, and healthcare providers. The CCPHP is also responsible for the agency's performance and the public health accreditation efforts.

The successful implementation of the OPH Strategic Plan reaffirms the goals, objectives and strategies and creates a framework that demonstrates a commitment to the mission, vision, and values of the agency. The accomplishments of the goals and objectives set forth in the OPH Strategic Plan are exemplified in the cross functionality of the OPH programmatic work. The OPH Strategic Plan has been a critical tool to evidence the effective work of OPH, and how it has provided residents a healthier Louisiana. Significantly, OPH's achievement of national, voluntary public health agency accreditation by the Public Health Accreditation Board (PHAB) solidifies its stature among other accredited health departments as exemplary in advancing public health performance. Accredited health departments share the benefit of greater accountability and transparency, improved management processes by leadership, and enhanced quality improvement and performance improvement opportunities.

To be effective, public health must balance investment in new approaches with support for core functions of public health, namely assessment, assurance, and policy development. Public Health accreditation and Public Health 3.0 serve as an impetus for the value strategy through cross-sector collaboration, the development and implementation of human resources policies that are helpful and beneficial to women and families through agency workforce development initiatives—namely, telework policies, flexible work schedules, equity and diversity training, and data sharing to inform OPH's and LDH's strategic priorities.

Over the past two years, OPH has had many organizational shifts as part of the COVID-19 response. One challenge in particular has been developing and maintaining the infrastructure to manage large

sums of federal funding. If OPH did not have the adequate infrastructure in place to manage our grants (or their deliverables), it would become increasingly difficult to meet the grant requirements and efficiently leverage those resources.

Agency Goals

Goal I

Increase operational capacity and infrastructure to ensure efficient and effective utilization of resources.

Goal II

Operate as a cross-functional, cohesive agency throughout all programs, services and regions, while being reliable and responsive, and meeting national standards.

Goal III

Develop, maintain, and facilitate partnerships for the alignment of efforts and overall impact on health and wellness of individuals and communities.

Goal IV

Attract and retain a competent and diverse staff throughout our workforce to maximize productivity, deliver high quality service, and improve outcomes.

Goal V

Lead and continually improve a public health system that identifies and reduces inequities to improve health outcomes and quality of life in Louisiana.

Goal VI

Leverage health information technology and maintain a modern IT infrastructure to maximize use and integration of data to drive decision-making.

Key Initiatives

In addition to the above goals, OPH's work over the next several years will focus on the following:

State Health Improvement Plan:

As an accredited health department, LDH/OPH is required to produce a State Health Assessment (SHA) and a State Health Improvement Plan (SHIP) every five years. The current SHA was published as an interactive dashboard in 2021 at www.LouisianaSHA.com. The revised SHIP is currently under development. According to the [Association of State and Territorial Health Officials](#), "The SHIP is a long-term, systematic plan to address issues identified in the SHA. The purpose of the SHIP is to describe how the health department and the community it serves will work together to improve the health of the population of the jurisdiction that the health department serves."

After a statewide community engagement process, OPH and partners identified the key priority areas around which the SHIP will be developed, which are:

1. Chronic Disease
2. Behavioral Health
3. Maternal and Child Health
4. Community Safety

Accordingly, over the next five years, OPH will be leveraging the State Health Improvement Plan and collaborating with statewide partners to make improvements in these areas.

LDH Business Plan:

Together: Building a Stronger LDH and a Healthier Louisiana is the Louisiana Department of Health's first business plan in nearly a decade and defines how the agency will measurably improve our programs, services, and outcomes in FY22. OPH will contribute to the successful implementation of this Business Plan, which includes the following four major commitments:

- Improving the health and well-being of Louisianans with an emphasis on prevention
- Reshaping the #TeamLDH work culture
- Enhancing customer service, partnerships, and community relations
- Being transparent, accountable, and compliant with state and federal regulations

Public Health Reaccreditation:

According to the Public Health Accreditation Board, the purpose of the national voluntary public health accreditation program is to promote a high-performing governmental public health system that will make the United States a healthier nation. Accreditation promotes public trust and demonstrates a commitment to quality and performance improvement to better serve the community.

The Office of Public Health achieved accredited status in March of 2019 and will be applying for reaccreditation in 2024. Reaccreditation is necessary for a health department to continue to be designated as accredited. Reaccreditation focuses on assessment of an accredited health departments continued improvement and advancement thereby becoming increasingly effective at improving the health of the population they serve.

Monitoring and Evaluation of Information and Records Retention

Monitoring and evaluation are essential to advance OPH strategies for sound management and agency learning. These tools are important for decision-making, including decisions to improve, discontinue or adjust an evaluated intervention or policy, decisions about management structure, funding agencies, and policy makers.

Responsible persons must generally retain programmatic records, supporting documents, statistical records, and other relevant material such as process documentation, operational plans, or other records reasonably considered relevant to this strategic plan for a period of three years. The retention period will be calculated from the date the department's strategic plan is submitted to the Louisiana Division of Administration. In the event of litigation, claim, financial or program management reviews, or an

audit is started before the expiration of the three-year period, records must be retained until all litigation, claims, reviews, or audit findings involving the records have been resolved and final action taken.

Program A: Public Health Services

The Office of Public Health has one appropriated program titled Public Health Services. This program focuses on fifteen specific program objective areas including the following: vital records and statistics, emergency medical services, community preparedness, family health, immunizations, nutrition services, STD/HIV, infectious disease epidemiology, laboratory services, environmental epidemiology and toxicology, primary care & rural health, chronic disease prevention and health promotion, sanitarian services, and engineering services. Goals, objectives, strategies, and performance information are included for each program objective area.

Program A Mission

The mission of Public Health Services is to protect and improve the health and well-being of Louisiana's residents, visitors, and native-born Louisianans who no longer reside in the state by:

- Improving the Health of Louisiana's residents by promoting healthy lifestyles, providing preventive health education and data necessary to enable individuals and communities to assume responsibility for their own health, and assuring the availability of essential preventive health services.
- Operating a centralized vital event registry that provides efficient access to, collection and archival of vital event records.
- Collecting, analyzing, and reporting statistics needed to determine and improve population health status.
- Protecting the health of Louisiana residents and its visitors by providing educational resources, regulatory oversight, and preventive measures necessary to reduce the incidence of food/water-borne illnesses and other preventable diseases/conditions most commonly associated with unsafe food, water, milk, seafood, molluscan shellfish, drugs, cosmetics, onsite wastewater, biomedical waste, public institutions, commercial body art, commercial tanning, and beach recreational waters.
- Preventing illness and death that can occur from waterborne disease outbreaks or exposure to contaminated drinking water or raw sewage.
- Improving the health of Louisiana residents by assisting public water systems with delivering safe and affordable drinking water.

Program A Goals

OPH is dedicated to the development, implementation and management of public health services for the residents of Louisiana. The agency will continue to deliver Maternal Child Health Services, Nutrition Services (Women, Infants and Children, WIC Services), Family Planning Services, Children Special Health Services, Early Steps Program Services, Immunization Services, Tuberculosis Services and Genetic Disease Monitoring Services. OPH promotes the physical, mental, and social health of infants, children, adolescents, women, families and communities through these services via health information/statistics, environmental health, chronic disease/health promotion, preventive health, epidemiology/surveillance, and access to essential health care services.

Objective I: Vital Records

Public Health Services, through its vital records and statistics activity, will process Louisiana vital event records and requests for certified copies of document services annually through June 30, 2028.

Strategies:

- 1.1 Collaborate with and provide educational opportunities to individuals and organizations charged with originating vital records.
- 1.2 Promulgate clear, concise administrative rules and written guidelines for use by individuals and organizations charged with originating vital records.
- 1.3 Facilitate the continued movement to electronic vital event registration.
- 1.4 Continue to expand options for residents to order certified copies of vital event records.

Performance Indicators:

- Percentage of emergency document requests filled within 24 hours
- Percentage of mail requests filled within two weeks
- Percentage of counter services customers served within 30 minutes

General Performance Information

- Birth record intake
- Death record intake
- Marriage record intake
- Divorce record intake
- Abortion record intake
- Fetal death record intake
- Total number of birth, death, fetal death, marriage, divorce, abortion and still birth certificates accepted
- Total number of birth, death, fetal death, marriage, divorce, abortion and stillbirth certificates sold

Objective II: Emergency Medical Services

Public Health Services, through its Emergency Medical Services activity, will mobilize partnerships, develop policies and plans, enforce laws and regulations, and assure that EMS practitioners and providers comply with current statutes through June 30, 2028.

Strategies:

- 2.1 Maximize productivity, deliver high quality services, and improve outcomes by mobilizing partnerships, developing policies and plans, enforcing laws and regulations, and assuring that EMS practitioners and providers comply with current statutes.
- 2.2 Ensure quality education programs are available to the potential workforce by providing quality assurance measures.
- 2.3 Provide credentialing to EMS Practitioners and Providers in a timely manner.
- 2.4 Administer the National Registry Psychomotor Examination to eligible candidates who seek to attain certification and licensure as an EMS Practitioner.
- 2.5 Process affirmative criminal background investigations on behalf of the EMS Certification Commission.

- 2.6 Assist telecommunicators with registering the required telecommunications training in the Information Management System.

Performance Indicators:

- Percentage of EMS Education Programs that have undergone Quality Assurance Measures (e.g., scholastic audits, site visits)
- Percentage of National Registry of Emergency Medical Technicians (NREMT) Psychomotor Exam applications processed within 2 business days of completion of the application
- Percentage of EMS Practitioner applications processed within 2 business days of completion of application
- Percentage of EMS Provider license renewal applications processed within 30 days of the expiration of the current license
- Percentage of affirmative criminal background investigations initiated on behalf of the EMS Certification Commission
- Percentage of telecommunicators registering completion/maintenance of required telecommunications training in the Bureau of EMS Information Management System

Objective III: Community Preparedness

Public Health Services, through its Bureau of Community Preparedness, will develop effective public health emergency management and response programs statewide that will decrease morbidity and mortality during emergencies and disaster events as well as develop effective public health emergency management and response programs each year through June 30, 2028.

Strategies:

- 3.1 Ensure that Louisiana meets the Centers for Disease Control and Prevention's Operational Readiness Review (ORR) for Strategic National Stockpile planning.

Performance Indicator:

- Obtain a minimal level (43%) of established (CDC's expected level of effectiveness) in the development /maintenance of state and local public health emergency management and response programs.

Objective IV: Bureau of Family Health

Public health services, through its Bureau of Family Health, will promote optimal health for all Louisiana women, children, teens and families each year through June 30, 2028.

Strategies:

- 4.1 Provide reliable data to monitor health and well-being, guide programs, and inform public policy.
- 4.2 Provide preventive and educational services that are grounded in best practices and evidence to promote optimal health and well-being.
- 4.3 Improve access to medical, behavioral health and supportive services, and community health through policy and educational initiatives.

- 4.4 Partner with communities, government, and academia to advance common goals.

Performance Indicators:

- Number of Maternal, Infant, Early Childhood home visits, including Nurse-Family Partnership (NFP) and Parents as Teachers (PAT)
- Number of students with a signed consent to allow access to School-Based Health Center (SBHC) services
- Percentage of patients receiving a preventive health visit at least once in the last measurement year
- Percentage of students who receive an annual risk assessment

General Performance Information

- Percentage of infants born to mothers beginning prenatal care in the first trimester
- Percentage of children with special health care needs receiving care in a Medical Home
- Number of Adolescent School-Based Health Centers
- Percentage of School-Based Health Centers (SBHCs) that demonstrate progress with a documented continuous quality improvement (CQI) plan
- Number of patient visits to Adolescent School-Based Health Centers
- Percentage of students aged > 12 years with documentation of a screening for clinical depression using an age appropriate, standardized tool and follow-up plan documented if positive screen
- Percentage of students with a BMI (Body Mass Index) greater than 85% receiving nutrition and physical activity counseling

Objective V: Immunization Program

Public Health Services, through its Immunization Program activity, will control or eliminate preventable diseases by providing vaccine to susceptible persons each year through June 30, 2028.

Strategies:

- 5.1 Continue to conduct annual immunization evaluations using the immunization information system, Louisiana Immunization Network (LINKS) to inform and focus efforts to improve immunization coverage rates.
- 5.2 Participate in national collaborations and continue regular and ongoing in-service training to all Immunization Program staff.
- 5.3 Conduct annual immunization audits of randomly selected private Vaccine for Children providers to assure compliance with vaccine storage and handling mandates to maintain vaccine effectiveness.
- 5.4 Continue Immunization in-services for the private sector and other interested vaccine providers for Immunization best practices.
- 5.5 Continue to build and sustain the Louisiana Shots for Tots Coalition and other work group efforts to improve childhood immunization levels. (The coalition should include partnerships between public health and private organizations both inside and outside of the health care sector.)
- 5.6 Provide for vaccines to public and private providers through the Louisiana Vaccines for Children (VFC) Program meeting all national VFC participation requirements.

- 5.7 Recruit private provider participation in VFC and LINKS.
- 5.8 Continue collaborative efforts with LDH Medicaid, community organizations, and private providers to increase the number of community providers using LINKS to promote timely immunizations of all Louisiana children.
- 5.9 Maintain collaborative efforts with the Department of Education to ensure compliance with the State Immunization requirements for school entry requirements for first-time enterers and adolescents.

Performance Indicators:

- Percent of children, 19 to 35 months of age, up to date for 4-Diphtheria-Tetanus-Pertussis; 3-Polio; 1-Measles-Mumps-Rubella; 3-Haemophilus influenza type b; 3-Hepatitis B; 1-Varicella; and 4-Pneumococcal Conjugate Type B vaccines
- Percent of kindergartners up to date with 4-Diphtheria-Tetanus-Pertussis; 3-Polio; 2-Measles-Mumps-Rubella; 3-Hepatitis B; 2-Varicella
- Percent of 6th graders, 11-12 years of age, up to date with 1 Meningitis, 1 Tetanus diphtheria a cellular pertussis, 2-Varicella; 3-Hepatitis B; 1-Measles-Mumps-Rubella
- Percent of adolescents, 13 to 17 years of age, up to date for Human papillomavirus completed series (2-HPV for <15 years or 3-HPV \geq 15 years)

General Performance Information:

- Percentage of 11th graders or at age 16 years of age with 2 Meningococcal conjugate vaccine (MenACWY)
- Percentage of persons 6 months of age and older with Flu vaccination last flu season

Objective VI: Nutrition Services

Public health services, through its Nutrition Services activity, will provide nutrition education and supplemental foods to eligible senior residents, women, infants and children while serving as an adjunct to health care during critical times of growth and development. The Nutrition Services activity aims to improve health status and prevent health problems in all population groups served through its programs each year through June 30, 2028.

Strategies:

- 6.1 Identify additional WIC providers for the most underserved areas of the State in order to serve as many eligible participants as allowed by the annual USDA grant.
- 6.2 Continue to build upon and expand activities outlined in the WIC State Agency's USDA-approved Breastfeeding Peer Counseling Implementation Plan based on the biennial USDA grant.
- 6.3 Investigate new technologies to provide high quality clinical services, food distribution, and shopping experiences to WIC and CSFP participants.
- 6.4 Engage in outreach activities through the Commodity Supplemental Food Program (CSFP) grant sub recipient, Food for Families/Food for seniors, to meet the yearly USDA assigned caseload and provide benefits to underserved areas of the State.

Performance Indicators:

- Number of monthly WIC participants

- Number of monthly CSFP participants served
- Percentage of postpartum women enrolled in WIC who breastfeed

General Performance Information:

- Percentage of WIC eligible clients served
- Number of WIC vendor fraud investigations

Objective VII: Infectious Disease

Public Health Services, through its Infectious Diseases Control activities, will prevent the spread of communicable diseases, including but not limited to, HIV/AIDS, tuberculosis (TB), gonorrhea, chlamydia, and syphilis, through screening, education, health promotion, outreach, surveillance, prevention, case management and treatment each year through June 30, 2028.

Strategies:

Tuberculosis

- 7.1 Evaluate TB performance indicators on a patient-by-patient basis assuring efficient and effective contact management.
- 7.2 Evaluate TB performance indicators on a case-by-case basis assuring completion of treatment in 12 months.
- 7.3 Evaluate TB performance indicators on a case-by-case basis assuring conversion of sputum culture within two months of start of treatment.

STD/HIV/Viral Hepatitis

- 7.4 Conduct disease surveillance, monitor, and report on characteristics and trends of HIV, Hepatitis and STDs in Louisiana. This is done in order to take public health action, to inform intervention planning and resource allocation, and to assess progress in reducing HIV, Hepatitis and STD infection.
- 7.5 Evaluate the effectiveness, accessibility, and quality of HIV, Hepatitis and STD, prevention, identification, and treatment.
- 7.6 Inform, educate, and empower people and communities about HIV, Hepatitis and STD, in order to promote behaviors and environments that eliminate or reduce the risk of acquisition and transmission.
- 7.7 Promulgate policies and best practices for the prevention, identification, and treatment of HIV, Hepatitis and STD.
- 7.8 Conduct disease investigation to notify persons of exposure to HIV and STD and assure testing and treatment.
- 7.9 Link people to needed HIV, Hepatitis and STD-related medical care and prevention services.
- 7.10 Support and promote targeted testing and routine screening for HIV and STD.
- 7.11 Conduct science-based and community-informed planning for HIV and STD.

Performance Indicators:

Tuberculosis

- Percentage of TB infected contacts who complete treatment
- Percentage of culture confirmed cases completing treatment within 12 months
- Percentage of pulmonary culture confirmed cases converting sputum culture within two months

Performance Indicators:*STD/HIV/Viral Hepatitis*

- Percentage of newly diagnosed HIV clients linked to HIV-related medical care within 30 days of diagnosis
- Percentage of persons living with HIV whose most recent viral load in the past 12 months was <200 copies/mL
- Percentage of primary and secondary syphilis cases treated within 14 days of specimen collection

General Performance Information:*STD/HIV/Viral Hepatitis*

- Number of people living with HIV in Louisiana
- Number of new HIV diagnoses in Louisiana
- Number of HIV tests conducted at publicly-funded sites
- Number of primary and secondary syphilis cases
- Number of new confirmed Hepatitis C diagnoses in Louisiana

Objective VIII: Infectious Disease Epidemiology

Public Health Services, through the Infectious Disease Epidemiology (IDEpi) activity, will conduct surveillance of infectious diseases to decrease the burden of infectious diseases (excluding TB, STD and HIV), conduct outbreak investigations and maintain public health preparedness against infectious diseases each year through June 30, 2028.

Strategies:

- 8.1 Study the distribution and determinants of infectious diseases in the community through disease reporting.
- 8.2 Conduct infectious disease outbreak investigations.
- 8.3 Institute infectious disease prevention and control measures across community settings.
- 8.4 Maintain a state of public health preparedness against the threat of communicable diseases following disasters or bioterrorism events.
- 8.5 Coordinate special programs that prevent the spread of communicable diseases.
- 8.6 Train public health staff and healthcare providers on infectious disease prevention and control.
- 8.7 Issue regular updates on disease activity for select conditions of heightened public health interest for dissemination to the public.
- 8.8 Maintain the web-based Infectious Disease Reporting Information System (IDRIS) including integration of electronic laboratory reports.
- 8.9 Conduct syndromic surveillance utilizing Essence, the Centers for Disease Control and Prevention's syndromic surveillance system, to rapidly identify potential disease clusters.
- 8.10 Maintain antimicrobial resistance surveillance across Louisiana acute care hospitals.
- 8.11 Maintain enhanced surveillance for arboviral diseases throughout Louisiana and coordinate with mosquito control districts to guide mosquito abatement activities in response to human arboviral cases.

- 8.12 Conduct epidemiologic investigations for select cases of food-borne and water-borne disease, including submission of clinical specimens to the OPH Laboratory for molecular testing as needed for outbreak detection purposes.
- 8.13 Maintain a robust system for monitoring COVID-19 and influenza activity and conducting virologic surveillance.

Performance Indicators:

- Initiate investigation within 10 working days of report to IDEpi
- Completed case investigation within 10 working days of starting investigation
- Percent of outbreaks with determined etiology

Objective IX: Laboratory Services

Public Health Services, through its Laboratory Services activity, will assure timely testing and reporting of laboratory results of the following:

- the testing of environmental samples for chemical, radiologic and microbiological pollutants, and contaminants in water, food, milk and dairy, molluscan and shellfish samples;
- the testing of clinical samples for surveillance and diagnosis of a variety of pathogenic agents/organisms that may cause outbreaks or pose a danger to public health; and screening all babies born in Louisiana for genetic disorders;
- the testing for rabies; and
- the testing of samples for chemical and bioterrorism agents.

Strategies:

- 9.1 Maintain current accreditations and certifications to ensure quality of testing results.
- 9.2 Provide ISO/IEC 17025:2017 accredited food testing for the Food and Drug Program.
- 9.3 Maintain a Laboratory Response Network bioterrorism response BSL3 laboratory in Louisiana for both clinical and environmental samples.
- 9.4 Develop and maintain capability for the full spectrum of radiological testing and methodology.
- 9.5 Maintain a state of readiness and provide rapid testing capability for evaluation and response to emergency events that may affect the quality of drinking water and/or public health.
- 9.6 Investigate approved alternate technologies for improving the analysis speed and efficiency in laboratory test methods.
- 9.7 Maintain or increase diagnostic capability for infectious disease testing.
- 9.8 Maintain or increase clinical and food testing of suspect outbreak samples in partnership with Infectious Disease Epidemiology.
- 9.9 Maintain enhanced testing to provide Infectious Disease Epidemiology up to date information necessary by performing Whole Genome Sequencing (WGS).

Performance Indicators:

- At least 95% of specimens submitted to the OPH Laboratory meet acceptance criteria for testing

General Performance Information:

- Number of lab tests tested

Objective X: Environmental Epidemiology and Toxicology

Public Health Services, through its Environmental Epidemiology and Toxicology activity (SEET), will identify toxic chemicals in the environment; evaluate the extent of human exposure and the adverse health effects caused by them; make recommendations to prevent and reduce exposure to hazardous chemicals; and promote public understanding of the health effects of chemicals in the environment each year through June 30, 2028.

Strategies:

Environmental Epidemiology and Toxicology is Louisiana's statewide public health program for hazardous chemicals. The program includes the following sub-programs: Indoor Environmental Quality Education, Environmental Health Advisories, Pesticide Surveillance, Disease Cluster Investigations, Occupational Health Surveillance, Chemical Events Exposure Assessment, Environmental Public Health Tracking, Private Well Initiative, Public Health Assessments and Consultations, and Health Education/Community Outreach, with the support of Geographical Information System (GIS) technology.

- 10.1 Mitigate environmental risks that are important to the long-term health and well-being of Louisiana's residents.
- 10.2 Review approximately 8,500 annual notifications of chemical incidents from the National Response Center, the Louisiana State Police and the Poison Center to evaluate the public health threat of these events and notify affected communities, hospitals, and physicians about the event and chemicals involved.
- 10.3 Investigate disease clusters (e.g. cancer, reproductive, neurological, and respiratory diseases) reported by residents and public officials.
- 10.4 Make recommendations for the issuance of seafood consumption and other advisories in collaboration with the Louisiana Departments of Environmental Quality, Wildlife and Fisheries, and Agriculture and Forestry. Conducts selected blood mercury screenings and seafood consumption surveys for targeted communities.
- 10.5 Develop strategies for disseminating environmental health messages to key public groups (childcare providers, healthcare providers, academicians, students, primary and secondary educators, community based organizations and residents) utilizing appropriate communication channels.
- 10.6 Develop an environmental public health tracking network focused on Louisiana that presents health, exposure, population data (e.g., Census Bureau), environmental hazard information and data of community interest. The surveillance develops public health indicators using Centers for Disease Control and Prevention guidance and provides online queries and displays of these data as graphs, maps and tables. In partnership with the Bureau of Health Informatics, agency and external partners, SEET has enhanced and innovated Louisiana's environmental public health tracking network. It currently includes an integrated, updated and interactive website and Data Explorer with dual, linked views. End users have the ability to search, download and print data and images (<http://ldh.la.gov/tracking>). Data available on this network currently include health indicators: asthma, heart attack, heat stress, cancer, reproductive and birth outcomes, carbon monoxide poisoning, occupational health, and other health outcomes of state interest. Environmental data include outdoor air, drinking water quality, and climate-related with several additional environmental indicators of state and local interest in development. To expand the program reach and impact, SEET partners to move data and science activities into public health interventions and outreach/communications.

- Projects set forth strategies for linking hazard, exposure and health data to advance environmental health knowledge, environmental epidemiology and tracking science.
- 10.7 Analyze environmental and health data about chemical contamination at Superfund sites and other hazardous waste sites to determine whether contact with contaminants might cause harm to people. Recommend actions to reduce exposure and/or provide further information, such as health studies or surveillance. Approximately 3-4 health consultations are written per year.
- 10.8 Obtain and evaluate all laboratory reports for heavy metal and carbon monoxide exposures that are reportable conditions. Investigate all cases meeting elevated criteria for source of exposure and provide educational materials.
- 10.9 Respond to public inquiries on indoor environmental quality and provide follow-up information within two business days. Provide telephone consultations, environmental educational material, and targeted outreach to communities, local school administrators, staff, students, and parents about the benefits of improved indoor environmental quality (IEQ). Respond to over 750 calls annually with most of them regarding mold issues in residential and public buildings.
- 10.10 Reduce injuries, illnesses, and deaths among Louisiana workers through the collection, interpretation, and dissemination of state-specific surveillance data that can be used to target outreach and prevention activities and inform policy recommendations. This is accomplished by compiling, analyzing, and interpreting occupational health surveillance data from multiple data sources to identify trends and high risk occupations and industries; collaborating with a diverse range of local and state agencies and other organizations to develop and implement prevention strategies; and translating findings from surveillance data analyses and case findings into practical interventions, prevention strategies, and policy recommendations by presenting findings in a variety of formats using various communication channels.
- Implement and execute a Louisiana Fatality and Control Assessment Evaluation (FACE) Program building upon the National Institute for Occupational Safety and Health (NIOSH) FACE model. This includes the implementation and maintenance of a multisource surveillance system of work-related traumatic injury fatalities occurring in Louisiana, and the performance of case-based investigations, using recommended procedures, for NIOSH FACE targeted cases and Louisiana-level targeted cases. NIOSH target cases may change for year-to-year. Louisiana-level targeted cases will be determined using state death record data. Engage with outside agencies and organizations to develop and implement prevention strategies, and collaborate with partners to develop the appropriate methods for communicating occupational safety and health messages to target audiences.
- Implement and maintain a multisource surveillance system of heat-related morbidity and mortality. Case follow-back and investigations capture exposure and work-related information. Surveillance system provides comprehensive and timely data to characterize non-occupational and occupational heat-related illness including identification of high-risk industries and occupational groups, worker characteristics, and risk factors. Collaborate with local climate agencies and research centers to develop methods to analyze climate and health outcome data. Support and conduct innovative and novel data analysis projects that leverage surveillance data, subject matter expertise, and unique partnerships. Convene and facilitate education and training opportunities for target audiences.

- 10.11 Obtain and investigate all reported pesticide exposures that meet state reportable disease criteria. Review health and exposure information for cases, compile state statistics, and make recommendations to prevent and reduce pesticide exposure. The Office of Public Health has an interagency agreement with the Louisiana Department of Agriculture and Forestry, to jointly investigate pesticide exposure complaints filed with LDAF and to notify residents who are hypersensitive to pesticides.
- 10.12 Implement services that increase access to safe conditions for private water wells and other sources not protected by the U.S. Environmental Protection Agency's Safe Drinking Water Act. This is accomplished by identifying, securing, and analyzing environmental health datasets to address, prevent and control potential health hazards. The Private Well Initiative (PWI) program develops strategic partnerships to make data available to the public and environmental health practitioners. PWI's Louisiana Private Well Owner Network was created to educate private well stakeholders on the importance of water sampling, well maintenance and stewardship and connect them to resources to increase access to safe water.

Performance Indicators:

- Number of health consults and technical assists
- Number of emergency reports screened from the Louisiana State Police, National Response Center and the Poison Center

General Performance Information:

- Number of indoor environmental quality phone consults

Objective XI: Primary Care and Rural Health

Public Health Services, through its Bureau of Chronic Disease Prevention and Healthcare Access, will provide support to communities, federally qualified health centers, physician practices, rural health clinics and small rural hospitals including critical access hospitals in order to expand and sustain access to primary and preventive health services in rural and underserved communities of Louisiana each year through June 30, 2028.

Strategies:

- 11.1 Sustain and increase access to primary care provided in rural communities and increase rural communities' capacity to make informed health-related decisions.
- 11.2 Support recruitment and retention of primary health care providers in health professional shortage areas (HPSA) across the state.
- 11.3 Support the designation of health professional shortage areas (HPSA) that enable state government, agency, and community access to over 36 federal programs.
- 11.4 Increase critical access hospitals publicly reporting data to Hospital Compare on relevant process of care quality measures inpatient and outpatient care, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience of care survey results.

Performance Indicators:

- Number of providers that have received education through conferences or Bureau of Primary Care and Rural Health (BPCRH) trainings
- Number of National Health Services Corps providers practicing in Louisiana

- Percentage of State Loan Repayment Program funds awarded to new and existing primary health service providers recruited and retained to work in Health Professional Shortage Areas
- Percentage of health professional shortage areas analyzed and submitted to the Health Resources and Services Administration by the federal deadline

General Performance Information:

- Number of parishes and/or areas designated as Health Professional Shortage Areas (HPSAs) by the federal government
- Number of critical access hospitals (CAHs) reporting HCAHPS data
- Percentage of Federally Qualified Health Centers (FQHCs) receiving technical assistance (TA)
- Percentage of Rural Health Clinics (RHCs) receiving technical assistance (TA)

Objective XII: Chronic Disease Prevention and Health Promotion

Public health services, through its Bureau of Chronic Disease Prevention and Health Access, will improve the health of Louisiana by preventing chronic diseases and their risk factors through promoting healthy behaviors, utilizing evidence-based interventions and leveraging resources through collaborative private, public partnerships to maximize health outcomes among our residents each year through June 30, 2028.

Strategies:

- 12.1 Reduce disease, disability and death related to tobacco use by increasing statewide initiatives, cessation programs, school programs, media campaigns/marketing, and educational programs.
- 12.2 Reduce disease, disability, and death from chronic diseases by increasing statewide initiatives in schools, worksites, communities, and healthcare settings.

Performance Indicators:

- Number of registered callers to the Louisiana Tobacco Quitline

General Performance Information:

- Percentage of organizations designated as “Wellspots” reporting implementation of comprehensive tobacco or smoke-free workplace policies
- Percentage of organizations designated as “Wellspots” reporting implementation of a worksite wellness program
- Percentage of school districts receiving professional development and technical assistance on comprehensive school wellness best practices

Objective XIII: Sanitarian Services

Public Health Services, through its sanitarian services activity, will protect public health through regulatory oversight and preventative measures, which include education of the public, plans review, inspection, sampling, and enforcement activities each year through June 30, 2028.

Strategies:

- 13.1 Deliver inspection services, through improved logistics, to more efficiently utilize field staff and travel resources.

- 13.2 Establish training module to develop new and existing sanitarians both technically as well as professionally.
- 13.3 Identify and establish partnerships with federal agencies, other states, local government or the private sector to more effectively identify new strategies to obtain greater efficiencies through the consolidation of efforts.

Performance Indicators:

- Yearly mortality count attributed to unsafe water, food and sewage
- Percentage of permitted facilities in compliance quarterly due to inspections
- Percentage of required samples in compliance
- Percentage of sewage systems properly installed

General Performance Information:

- Number of food-related complaints received from the public
- Number of food, water, sewage-borne illnesses reported
- Percentage of establishments/facilities in compliance
- Number of inspections of permitted establishments/facilities
- Number of samples taken
- Number of sewage system applications taken
- Number of new sewage systems properly installed
- Number of existing sewage system inspections
- Number of plans reviewed

Objective XIV: Engineering Services

Public Health Services, through its engineering and loan activities, will provide a regulatory framework to assure that the public is not exposed to contaminated drinking water or to raw sewage by contact or inhalation, which can cause mass illness or deaths each year through June 30, 2028.

Strategies:

- 14.1 Enforce compliance with federal regulations and the State Sanitary Code by: performing plan reviews, conducting sanitary surveys of drinking water systems, monitoring and testing drinking water quality, training and certifying operators of water and wastewater systems, performing public education, and staffing the ESF 12 Water and Wastewater Utilities desk at Governor's Office of Homeland Security and Emergency Preparedness.
- 14.2 Administer the loan program effectively and efficiently to provide the maximum amount of Capitalization Grant Dollars for low-interest loans to Louisiana public water systems.
- 14.3 Administer the Technical Assistance program effectively and efficiently to provide technical assistance to as many public water systems with a population of 10,000 or less as possible.
- 14.4 Administer the Capacity Development Program effectively and efficiently to provide public water systems with the tools and financial assistance they need to obtain and maintain technical, financial, and managerial capacity needed to ensure a supply of safe drinking water for Louisiana residents.
- 14.5 Provide funding to the Operator Certification Program and the Safe Drinking Water Program within the Office of Public Health to assist with Drinking Water Initiatives.

Performance Indicators:

- Percent of the population served by community water systems that receive drinking water that meets all applicable health-based drinking water standards
- Percentage of community water systems that have undergone a Class 1 sanitary survey within the past three years as required by state and federal regulations
- Percentage of water and sewer plans reviewed within 60 days of receipt of submittal
- Number of Louisiana public water systems provided financial and technical assistance

General Performance Information

- Percentage of Surface Water Public Water Systems monitored annually for chemical compliance.
- Total number of CEU hours received by certified public water and community sewage operators from LDH approved training courses
- Number of low-interest loans made
- Number of public water systems provided technical assistance
- Number of water systems provided capacity development technical assistance
- Number of public water systems in Louisiana

LaPAS Data Analysis

LaPAS indicators are updated in the LaPAS database on a quarterly basis. However, they are monitored by programs on an ongoing basis. For FY2021, approximately, eighty-one percent (81%) of Key (K) and Supporting (S) LaPAS performance metrics were achieved or were exceeded during State Fiscal Year 2021, while nineteen (19%) of “K” and “S” level indicators were not met in the same period. Indicators not met were primarily impacted by COVID-19 and the natural disasters in FY2020-2021. Programs have an opportunity to adjust targets and performance standards based on performance data.

Data Caveats:

- 2021 (4th Quarter) is the only fully comparable period given the various levels of the indicators.
- The target met or exceeded categories are combined to include indicators that had no variance and those that were within the 5% range.



09-330 Office of Behavioral Health

Vision

People can and do recover from mental illness and addictive disorders. Through the delivery of timely and person-centered clinically effective behavioral health and healthcare and supports, citizens of Louisiana will experience positive behavioral health outcomes and contribute meaningfully to our State's growth and development.

Mission

OBH's mission is to work collaboratively with partners to develop and implement a comprehensive integrated system of behavioral health and healthcare, social support, and prevention services that promote recovery and resilience for all citizens of Louisiana. OBH assures public behavioral health services are accessible, family-driven, have a positive impact, are culturally and clinically competent, and are delivered in partnership with all stakeholders.

Philosophy/Values

OBH believes we can make a difference in the lives of children and adults in the state of Louisiana through a trauma-informed and recovery-oriented system of care. People recover from both mental illness and addictive disorders when given the proper care and a supportive environment, including culturally and linguistically diverse services.

Behavioral health healthcare, social supports, and prevention services assist and enable individuals to exercise self-determination in their lives, allowing them to achieve their maximum potential through increased independence, productivity, and inclusion in their communities. It is OBH's conviction that the community where the person chooses to live and work is an appropriate place to provide treatment, supports, and services that are family-driven. OBH believes care and supports that may enable children to live in stable home environments with enduring relationships regardless of the severity of presenting challenges. The use of existing natural supports and community resources must be promoted.

Executive Summary

OBH is committed to the efficient and effective use of the state's scarce behavioral health resources to adequately provide for the peace, health, safety, and general welfare of the public, by ensuring:

- Accountability of efficient and effective services through quality and performance measures, statewide standards for monitoring quality of service and performance, and reporting of quality of service and performance information.
- Creation and implementation of minimum service delivery standards.
- Coordination of integration of behavioral health and primary healthcare and continued collaboration with agency contract providers, advocacy groups, Local Governing Entities, regional support networks, and public and private agencies in order to reduce duplication in

service delivery and promote complementary services among all entities that provide behavioral health services to adults and children throughout the state.

- Implementation of a system of reimbursement by the Medical Assistance Program to private hospitals and to state hospitals for covered Medicaid services that, to the extent possible, allocates funding in the areas of the state based on needs, population, and acuity level.
- Performance monitoring and evaluation regarding the effectiveness of services being provided and achievement of outcome measures

OBH will continue to develop goals, objectives, and priorities for the creation of innovative programs that promote and improve the behavioral health of the citizens of the state and seek to achieve increased access to services and for underserved groups, increased quality of services and better outcomes, cost-effectiveness and efficiency of services and programs, interagency collaboration, and promotion of emerging best practices and increased quality of care in the delivery of behavioral health services.

The transformational priorities for the agency, which reflect the agency's mission and vision and carry the highest potential impact, are:

- **Reorganization of Business Operations**

OBH has experienced several significant transitions, including a merger of mental health and addictive disorders offices, delivery of services through a Medicaid managed care model, and integration of behavioral health services into Healthy Louisiana, Department of Justice interventions and the onset of a nationwide opioid epidemic. A review of agency functions is necessary to maximize efficiencies and promote coordination among LDH offices. OBH management, with LDH guidance, will fully implement reorganization of agency functions and structure to expand services as outlined in the priorities and to accommodate quality monitoring and collaboration with Medicaid integration and expansion.

- **Access to Behavioral Health Services**

OBH will lead efforts to increase access to behavioral health services by promoting early identification of behavioral health concerns, especially through leveraging integration to help physicians and behavioral health specialists collaborate to identify and treat behavioral health concerns (inclusive of trauma exposure) at the earliest opportunity. Strategies may include supporting primary care physicians through behavioral health consultation, as well as increasing access to high-quality evidence-based behavioral therapies for young children.

Additional strategies employed to address the increased volume on the behavioral health system with Medicaid Expansion and long term effects of the COVID 19 pandemic will be the integration of Peer Support throughout the system of care. The use of trained, credentialed peers is a critical component to a recovery-oriented system of care and results in improvements in client engagement, treatment outcomes, and recovery. As an enhancement to traditional treatment services, peer support services allow for more effective and targeted interventions resulting in improved care and an increased capacity of the system to serve a broader array of individuals.

To increase access to effective behavioral health supports and services, OBH will work with Medicaid, advocates, providers, and Healthy Louisiana managed care partners to implement strategies to retain and increase the behavioral health workforce. Workforce development

efforts will include training and support for providers of evidence-based therapies addressing issues emerging in early childhood, trauma exposure, and other psychiatric and addictive service needs. OBH will lead efforts to provide training and support for providers of peer recovery supports, including mentoring and coaching opportunities. Expanding the workforce of providers of behavioral healthcare may also include further utilization of provider types such as provisionally licensed social workers.

- **Substance Use Disorder System Enhancements**

OBH recognizes the impact of Substance Use Disorders (SUDs) on Louisiana's individuals, families, and communities, and strives to enhance policies, regulations and protocols to reduce the prevalence of SUDs. OBH will focus on several priority areas to achieve this goal. These include enhancement of Medication Assisted Treatment (MAT) services, treatment capacity for pregnant women, reduction of prescription drug/opioid overdose-related deaths, and development of residential treatment programs for pregnant women and children at risk of Neonatal Abstinence Syndrome (NAS).

- **Inpatient Psychiatric Hospital Needs**

OBH is committed to providing access to treatment in the least restrictive and least costly setting possible for all clients, and optimizing clients to flow throughout the system, as each moves toward recovery in their own homes and communities, whenever possible. ELMHS and Central Louisiana State Hospital (CLSH) currently maintain 100% utilization of existing bed space; OBH will pursue strategic and financially feasible measures to provide necessary inpatient, jail-based, and community resources in order to accommodate the increasing forensic population. These measures may include partnerships with Cooperative Endeavor Agreement (CEA) hospitals to provide services to civil clients, and increasing resources in order to accommodate jail-based competency restoration in lieu of hospital restoration in the regional areas and parishes that have the highest number of referrals.

An ongoing priority of OBH will be to increase communication with justice-involved populations through the courts, the Department of Corrections (DOC), and the Office of Juvenile Justice (OJJ) regarding the services provided by OBH and Medicaid managed care. OBH will promote certification in Juvenile Competency Restoration to increase the number of providers across the state and continue oversight of the provision of competency restoration services.

OBH will increase collaboration with the DOC to provide services to reduce recidivism and to monitor compliance of consent decree requirements. This includes determining if patients were evaluated in a timely manner, received twice weekly competency restoration sessions while in jail, and were placed within the established guidelines. Through collaboration with the staff at Eastern Louisiana Mental Health System (ELMHS), compliance with the consent decree will be maintained.

- **Pursuing a culture of wellness for Louisiana citizens**

Integrated physical and behavioral healthcare is one strategy in moving toward comprehensive wellness. OBH identifies with the SAMHSA eight dimensions of wellness, described as emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual. OBH will lead efforts to address these elements in designing and implementing wellness activities.

Agency Goals:

Goal I

To serve children and adults with extensive behavioral health needs including mental health and/or addictive disorders by providing oversight and guidance of behavioral health services in the Medicaid Healthy Louisiana plans.

Goal II

To assure that all Louisiana citizens with serious behavioral health challenges have access to needed forensic, residential, and other “safety net” services and promote use of contemporary, evidence-informed treatment, support, and prevention services.

Goal III

To support the refinement and enhancement of a comprehensive system and associated service array for children, youth and families that appropriately addresses their behavioral health needs that is based on contemporary, best practice principles of care.

Program A: Behavioral Health Administration and Community Oversight

Program Description: The Office of Behavioral Health Administration and Community Oversight Program consists of results-oriented managerial, fiscal and supportive functions, including business intelligence, quality management, and evaluation and research, which are necessary to advance state behavioral health care goals, adhere to state and federal funding requirements, monitor the operations of Medicaid-related specialized behavioral health services (SBHS) and support the provision of behavioral health services for uninsured adults and children.

Program A Mission

The mission of the Behavioral Health Administration and Community Oversight Program is to monitor and manage a comprehensive system of contemporary, innovative, and evidence-based prevention, treatment and recovery support services for Louisiana citizens with serious behavioral health challenges, as well as external monitoring of specialized behavioral health services through clinical analysis and behavioral health subject matter expertise. Additional functions include quality strategy and compliance, planning, monitoring, and providing accountability in the delivery of mental health and addictive disorders services by statewide partners.

Program A Goals:

Goal 1

The Behavioral Health Administration and Community Oversight Program will ensure that Louisiana citizens receive appropriate public behavioral health services through fiscal and programmatic oversight and monitoring activities, including the assurance that critical functions of specialized behavioral health services administered in a Medicaid managed care environment are being performed within expected standards.

Objective I: Through FY 2028, 90% of clean claims will be paid within 15 days, and 99% of clean claims will be paid within 30 days.

Strategies:

- 1.1 Review and analyze required fiscal reporting
- 1.2 Track billing and revenue experience for SBHS providers
- 1.3 Target areas of concern or deficiencies through recommending corrective action planning
- 1.4 Identify and recommend penalties on Managed Care Organizations (MCOs) or Coordinated System of Care (CSoC) Contractor, as contractually provided, in instances where the MCO or CSOC Contractor has failed to meet behavioral health standards or to comply with corrective action plans

Performance Indicators:

- Percentage of clean claims processed within 15 days of receipt
- Percentage of clean claims processed within 30 days of receipt

Objective II: By FY 2028, network access and sufficiency will achieve an annual positive outcome of 90% in accessibility standards.

Strategies:

- 2.1 Review and analyze required provider network reporting inclusive of Geo Access mapping, density and penetration data
- 2.2 Review network development and management plans
- 2.3 Review member and provider grievance reports
- 2.4 Perform administrative desk reviews and on-site audits of providers and the health plans
- 2.5 Review member and provider satisfaction surveys

Performance Indicators:

- Percentage of providers who meet urban/rural access standards for specialized behavioral health services
- Percentage of providers who meet emergent, urgent and routine appointment availability standards
- Percentage of members' and providers' satisfaction related to network access

Objective III: Through FY 2028, 100% of Local Governing Entities (LGEs) will report to the OBH Data Warehouse in order to provide for accurate state and federal reporting.

Strategies:

- 3.1 Work to ensure 100% of LGEs are reporting to the OBH Data Warehouse with completion of pre-integration activities
- 3.2 Conduct and report monthly post-validation activities within the OBH data warehouse
- 3.3 Develop processes to improve monitoring data input into systems under the span of control of OBH

Performance Indicator:

- Percentage of LGEs reporting to the OBH Data Warehouse

General Performance Indicators:

- Percentage of LGEs reporting to the OBH Data Warehouse
- Percent of federally-established reporting timelines met by utilizing LGE data in the OBH Data Warehouse

Objective IV: Through FY 2028, quality of care for managed care members with specialized behavioral health needs will be improved through care delivery, as measured by the health plans meeting the target rates on key performance metrics.

Strategies:

- 4.1 Monitor Medicaid managed care performance indicators and compliance with federal managed care standards and waiver assurances
- 4.2 Analyze member survey data
- 4.3 Work with the Bureau of Health Services Financing (Medicaid) to address areas of concern or deficiencies concerning Medicaid managed care

Performance Indicators:

- Percent of CMS waiver assurances satisfactorily met
- Percent of surveyed behavioral health providers adequately meeting quality standards and requirements

General Performance Indicators:

- Percent of CSoC Contractor's compliance with federal Medicaid managed care standards
- Rate of CSoC members reporting satisfaction with services
- Rate of Healthy Louisiana members reporting satisfaction with services

Goal 2

OBH will ensure accessibility of needed behavioral health services for Louisiana citizens which will include expansion of Recovery Support Services to support the behavioral health population throughout the state.

Objective I: By FY 2028, expand Peer Provider Types eligible to practice in Medicaid service delivery system.

Strategies:

- 1.4 Research and analyze how other states have established Peer Provider Types. Consultation and technical assistance with national subject matter experts to help guide the plan for development.
- 1.5 Identify and collaborate with other necessary partners to identify the development of this provider type, which would likely include Health Standards Section, Medicaid, current agencies providing peer services, peer support specialists, Centers for Medicaid and Medicare Services (CMS); and other identified stakeholders.
- 1.6 Successfully completing process to develop new provider type, to include establishing necessary rules and obtaining necessary approvals at federal and state levels.
- 1.4 Outreach, engagement and assistance to identified provider agencies with obtaining newly established Peer Provider type.

Performance Indicators:

- Establishment of Peer Provider Type
- Number of agencies successfully obtaining Peer Provider Type status and providing Medicaid reimbursable services

Objective II: Workforce Development – Through FY 2028, OBH will increase the number of Peers Trained per year by a minimum of 30% per year.

Strategies:

- 1.1 Research peer training programs utilized in other states throughout the country. Obtain consultation and technical assistance with national subject matter experts to support the identification and/or development of additional training programs to allow for additional training curriculums for Peers seeking to be Recognized Peer Support Specialists in Louisiana.
- 1.2 Obtain necessary contracts and/or procurements to successfully obtain and/or develop additional training models for utilization throughout the state.
- 1.3 Modify and obtain necessary approvals to modify the any rules, state plan amendments, policies, and/or service definitions to allow for the utilization of additional training models.
- 1.4 Successful implementation of various training models to ensure access to training for Peers who are seeking to obtain recognition as Peer Support Specialist.

Performance Indicators:

- Successful development and/or identification of additional Peer Provider Trainings

- Number of Peers successfully completing the initial Peer Support Specialist training and obtaining designation and Recognized Peer Support Specialist.

Objective III: By FY 2028, the number of individuals enrolled in Medication Assisted Treatment (MAT) will be increased by 5%, from a baseline of 3,976.

Strategies:

- 2.1 Seek alternative funding sources for Medication Assisted Treatment (MAT), including for individuals with addictive disorders.
- 2.2 Provide educational seminars and training on opioid overdose in collaboration with community stakeholders.
- 2.3 Promote legislation that facilitates enhanced treatment opportunities in the community.
- 2.4 Pursue Medicaid reimbursement of methadone.

Performance Indicator:

- Percent increase in number of individuals enrolled in MAT, including those with Substance Use Disorders

Objective IV: By FY 2028, the number of individuals served for problem gambling will be increased by 5%, from a baseline of 440, and gambling treatment completion rates will be maintained at 65%.

Strategies:

- 3.1 Enhance and heighten awareness of gambling treatment services in Louisiana.
- 3.2 Improve surveillance and evaluation of gambling population.

Performance Indicators:

- Percent increase in the number of individuals served for problem gambling
- Percent of individuals discharged from gambling treatment reporting a decrease in the frequency of gambling activities

General Performance Indicators:

- Number of individuals screened for gambling within LGEs and Healthy Louisiana plans
- Number of individuals with positive problem gambling screenings within LGEs and Healthy Louisiana plans
- Number of individuals admitted for gambling treatment
- Total number of intake calls to the Gamblers Helpline

Goal 3

OBH will ensure that effective and efficient prevention services are provided statewide to promote overall wellness and to delay the initiation and progression of behavioral health disorders by increasing knowledge, awareness, and healthy behaviors.

Objective I: Through FY 2028, OBH will continue to provide evidence-based prevention programs in school based settings.

Strategies:

- 1.1 Implement evidence-based prevention programs in school-based settings through a partnership with the Department of Education
- 1.2 Promote behavioral health wellness through implementation of public health models

Performance Indicators:

- Number of individuals served by evidence-based prevention programs
- Percentage of individuals served, ages 12 – 17, who reported that they used alcohol, tobacco and marijuana during the last 30 days

Objective II: Through FY 2028, OBH will continue to provide Suicide Prevention education and awareness activities and resources.

Strategies:

- 3.1 Provide suicide prevention training and awareness activities.

Performance Indicators:

- Number of suicide prevention trainings
- Number of individuals who participated in suicide prevention trainings
- Obtain an in-state answer rate of 80% for calls routed to the local crisis contact centers as reported by the National Suicide Prevention Lifeline

Program B: Hospital-Based Treatment

Program Description: Hospital Based Treatment Services refer to the State Psychiatric Hospital Program, which provides an array of services to persons in need of acute, intermediate or long-term psychiatric inpatient care, including special treatment populations, such as those persons who are forensically involved. The state psychiatric hospitals are coordinated with community emergency services, treatments, and supports, and provide inpatient evaluation, diagnosis, treatment, and rehabilitation. Treatment services include individual, family, and group psychotherapy, recreational and occupational therapy, art and music therapy, work therapy, speech and hearing therapy, nutritional counseling, dental services, pastoral care services, and limited diagnostic medical services. The Hospital Based Treatment Program operates two hospitals: Central Louisiana State Hospital (CLSH) and Eastern Louisiana Mental Health System (ELMHS).

Program B Mission

The mission of the Hospital-Based Treatment Program is to provide comprehensive, integrated, evidence-informed treatment and support services enabling persons to function at their optimal level thus promoting recovery.

Program B Goals

Goal 1

The Hospital-Based Treatment Program will promote recovery through the efficient use of evidence-informed care and successful transition to community-based services.

Objective I: Through FY 2028, OBH will improve behavioral health outcomes of inpatient care by maintaining an annual 30 days readmission rate within the national norm.

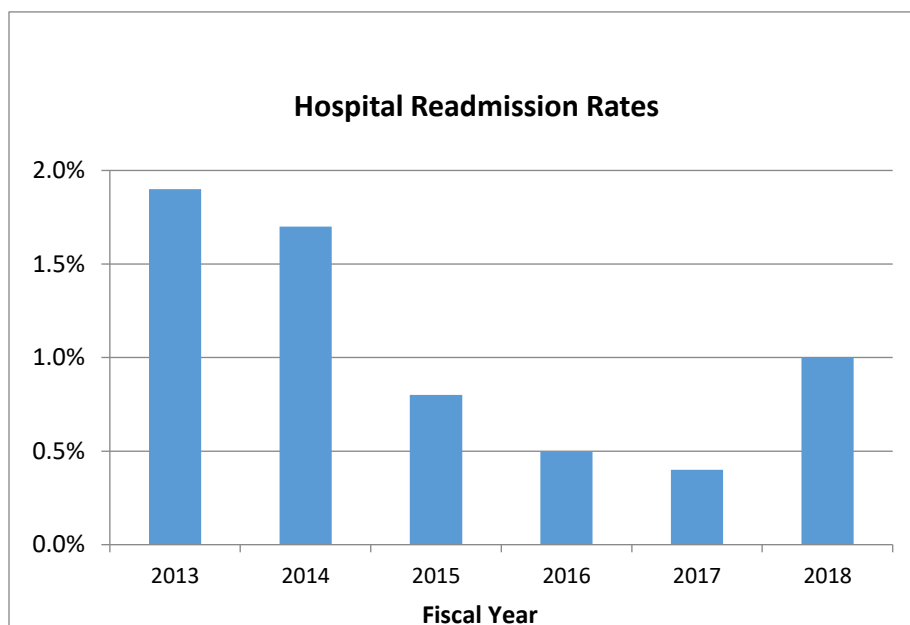
Strategies:

- 1.1 Begin discharge planning at time of admission.
- 1.2 Consult the client, family, community, and hospital team for input on discharge planning, when possible.

Performance Indicators:

- Percentage of adults discharged from a state hospital and readmitted within 30 days of discharge (Statewide)

***Liz is waiting on most recent data, if any?**



This chart represents the percentage of consumers discharged from state psychiatric hospitals and re-admitted to an OBH inpatient program within 30 days of discharge. This is NOMS indicator number 2.

Objective II: During FY 2028, the rate of the use of physical restraints will be below national norm, as reported by The Joint Commission ORYX report.

Strategies:

- 2.1 Limit use of restraints as a last resort only in cases where an immediate safety risk to the client or others is present.

Performance Indicator:

- Ratio of hours patients spent in restraint for every 1,000 inpatient hours

Goal 2

Through the Hospital-Based Treatment Program, OBH will provide services to individuals involved with the court system in compliance with the Forensic consent decree ruling.

Objective I: Through FY 2028, OBH will maintain substantial compliance with the forensic consent decree.

Strategies:

- 1.1 Maintain processes put in place following the consent decree to assure that clients involved with the court system are provided services within required timeframes.

Performance Indicator:

- Percentage of compliance with forensic consent decree factors

General Performance Indicators:

- Inpatient Care - Total adults served (ELMHS-Civil License)
- Inpatient Care - Average daily census (ELMHS-Civil License)
- Inpatient Care - Average length of stay in days (ELMHS-Civil License)
- Inpatient Care - Average daily occupancy rate (ELMHS-Civil License)
- Inpatient Care - Total adults served (ELMHS-Forensic License)
- Inpatient Care - Average daily census (ELMHS-Forensic License)
- Inpatient Care - Average length of stay in days (ELMHS-Forensic License)
- Inpatient Care - Average daily occupancy rate (ELMHS-Forensic License)
- Inpatient Care - Total adults served (ELMHS-Civil & Forensic License)

- Inpatient Care - Average daily census (ELMHS-Civil & Forensic License)
- Inpatient Care - Average length of stay in days (ELMHS-Civil & Forensic License)
- Inpatient Care - Average daily occupancy rate (ELMHS-Civil & Forensic License)
- Inpatient Care - Total adults served (CLSH Civil Intermediate)
- Inpatient Care - Average daily census (CLSH Civil Intermediate)
- Inpatient Care - Average length of stay in days (CLSH Civil Intermediate)
- Inpatient Care - Average daily occupancy rate (CLSH Civil Intermediate)



09-340 Office for Citizens with Developmental Disabilities

Vision

A society that promotes partnerships and relationships which empower people with developmental disabilities to live fully integrated and valued lives.

Mission

The Office for Citizens with Developmental Disabilities (OCDD) is committed to ensuring quality services and supports, offering information and opportunities that provide choices to people of Louisiana with developmental disabilities and their families.

Philosophy/Values

Essential to the achievement of the Office's vision and mission are the following core values that guide the Developmental Disabilities Services System:

- Accountability – People set goals, plan what needs to be done, do the work, monitor progress, report results, evaluate, exchange feedback and take responsibility for their actions.
- Choice – People have the opportunity to learn about options and use this information to make their decisions.
- Clarity – Openness, honesty and accountability are fundamental in all services, supports and information. All information is known and understood by everyone.
- Cultural Sensitivity – People regardless of cultural differences are to be treated with respect and dignity to meet their needs in a fair manner.
- Dignity – People are valued, and the system supports their sense of pride and self-respect.
- Empowerment – People act on issues they define as important.
- Inclusion – People take part in their communities of choice including taking part in policies and program planning.
- Partnership – People work together in shared decision making to achieve common values and goals.
- Person/Family Driven Services System – People are at the center of the system and their needs and preferences determine how services are provided.
- Quality – People achieve desired outcomes.

These values are at the center of the OCDD's philosophy and form the foundation for the following guiding principles, which provide our Office direction and are the basis from which all decisions are made:

- Developmental disabilities are a natural part of the human experience that does not diminish the rights of people to have control and choice over their own lives and fully participate in their communities or locations of choice.
- The OCDD values all people and protects their rights and privileges as citizens of Louisiana

and the United States of America.

- People have the power to make decisions about services and supports, how they are delivered and by whom. The necessary services, supports and information are received promptly.
- Services and supports are designed to allow people to remain in their most integrated communities or locations of choice, support people to achieve valued outcomes, develop meaningful relationships and attain quality of life as defined by the person.
- Services are flexible, and personal outcomes and goals are considered in the development of individualized supports for each person.
- Family supports enable people to live in stable environments with lasting relationships while existing natural supports and community resources are promoted and utilized.
- The needs of the entire family and the natural support system are considered in the development of services and supports.
- The OCDD system values and respects services agencies and workers who provide supports.
- The OCDD system is easy to navigate, user friendly and culturally sensitive. People are able to access services, supports and information through a single point of entry that is person-centered. The services system is a seamless, flexible and responsive system of various services and supports through various stages of life.
- The OCDD promotes cost-effective delivery of services.
- The OCDD is always seeking continuous improvement by which there is meaningful and consistent involvement by people supported and their families in policy development, agenda and priority setting.

Executive Summary

Following its vision and mission, the Office for Citizens with Developmental Disabilities (OCDD) has taken steps to align its services system with national evidence-based best practices. Initiatives have focused on offering choice, managing cost, and improving quality of services. Developing partnerships with and soliciting input from people with developmental disabilities, their families, service providers, and other stakeholders have been critical to the success of the Office's system change.

Initiatives have resulted in a more efficient and comprehensive network of supports and services for people with developmental disabilities and their families. There is a more cohesive stakeholder contingency; service delivery is coordinated in a more unified manner; public sector expertise has been utilized to strengthen community capacity; fewer people are served in large facilities; and more people are living and working in integrated and appropriate settings of their choice.

Our strategic planning for the next five years will utilize this foundation to build the system envisioned by OCDD's philosophy and guiding principles. We will build on our system access to assure fair, equitable and timely delivery of services based on need as well as the development and funding of community living and work opportunities. We will build on a planning process that identifies and balances needs and preferences and provides a mechanism for provision of the identified supports through individualized, cost-effective allocation of resources. Lastly, we will continue implementation of a quality management system in a manner that measures quality based on outcomes and provides an ongoing cycle of improvement that responds quickly to the changing needs of people and our society.

Office Goals:

Goal I

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.

Goal II

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.

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.

Program A: Administration (1000)

Program A Mission

The mission of Administration is to provide effective and responsive leadership in the administration and enhancement of the Developmental Disabilities Services System in order for people with developmental disabilities and their families to receive information, opportunities for choice, and quality supports and services. The mission of the OCDD Resource Center is to collaborate with private providers to assist with identification of support needs, as well as develop activities / interventions / products that improve their ability to achieve positive outcomes for persons with developmental disabilities.

Program A Goal

To provide system design, policy direction, and operational oversight to the Developmental Disabilities Services System in a manner which promotes person-centeredness, evidence-based practices, accountability, cost effectiveness, and system responsiveness.

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.

Objective I:

To provide programmatic leadership and direction to Louisiana's Developmental Disabilities Services System in a manner that is responsive to citizens' needs and results in effective/efficient service delivery during FY 2023-2024 through FY 2027-2028.

Strategies:

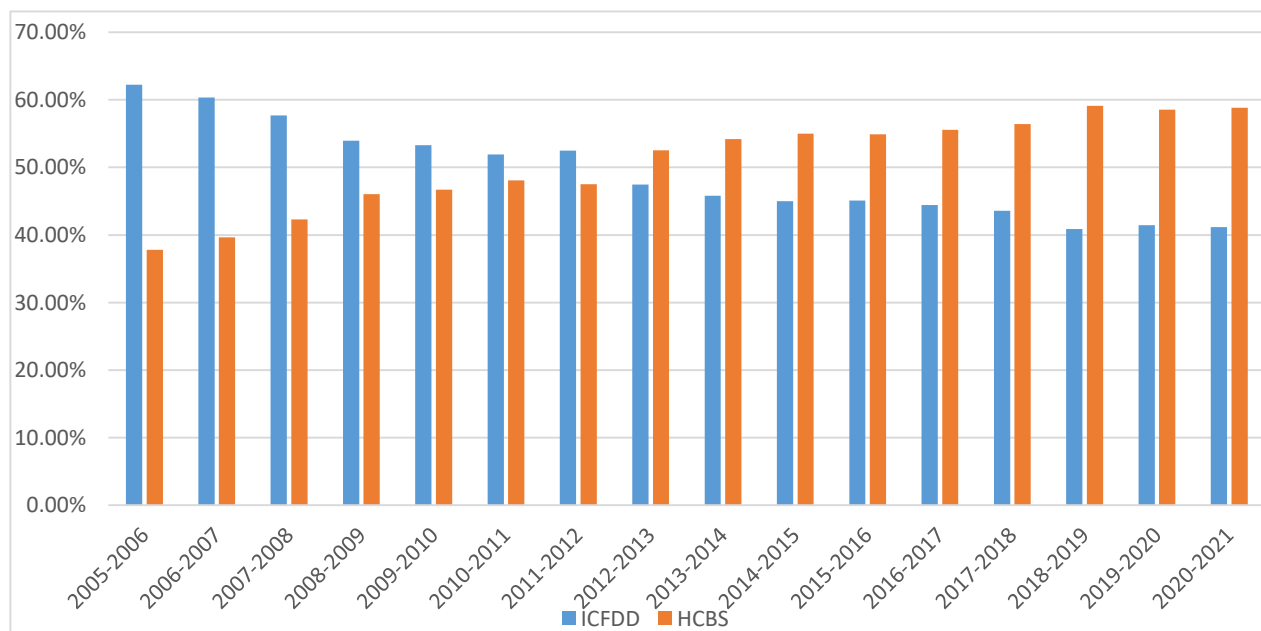
- 1.1 Build partnerships with community organizations to expand the capacity for supporting individuals with complex medical and behavioral needs in community living situations.
- 1.2 Provide effective management of community service and waiver programs through OCDD Central Office oversight of regional delivery of developmental disability services in order to optimize the use of community-based services while decreasing reliance on institutional services.
- 1.3 Develop and implement a variety of innovative rebalancing/restructuring activities that focus existing funding toward achievement of quality outcomes targeted to individual needs.
- 1.4 Provide advocacy, one-on-one assistance, and collaboration with other agencies to overcome barriers for persons with developmental disabilities to obtain accessible, affordable and safe housing.

Performance Indicators:

- Percentage of New Opportunities Waiver (NOW) participants making progress toward or achieving personal goals (from quarterly quality review tool)
- Total number of HCBS and ICF/IID recipients
- Total HCBS and ICF/IID expenditures
- Percentage of recipients of HCBS
- Percentage of recipients of ICF/IID services

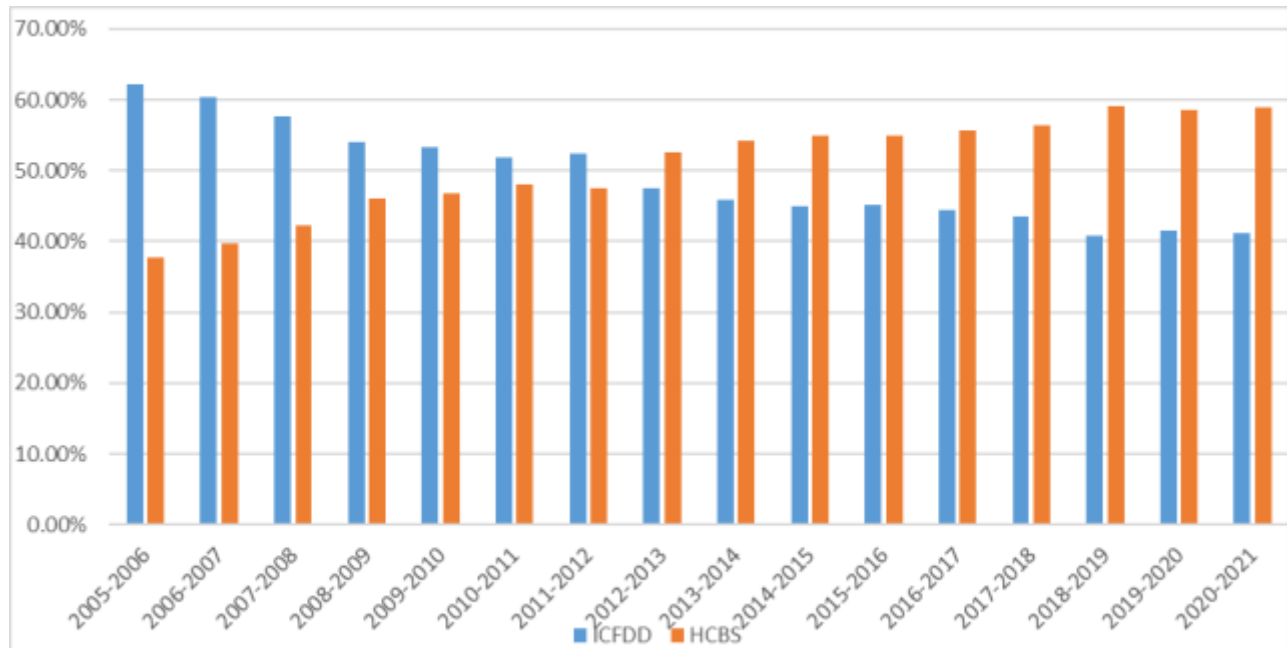
- Percentage of expenditures for HCBS
- Percentage of expenditures for ICF/IID services
- Percentage of budgeted community funding expended
- Number of re-admissions to an institutional setting (public or private ICF/IID, nursing facility, acute care hospital, psychiatric hospital) for more than 30 days within one year of transition as My Place Louisiana participant
- Percentage of individuals transitioned as a My Place Louisiana participant who do not return to an institutional setting (public or private ICF/IID, nursing facility, acute care hospital, psychiatric hospital) for more than 30 days within one year of transition
- Percentage of progress toward My Place Louisiana transitions annual benchmark of number of persons transitioned

Louisiana - ICF/IID Expenditures vs DD HCBS Expenditures (FY 2006-2021)



*Data Source: Medicaid MARS Data Warehouse

Louisiana - ICF/IID Recipients vs DD HCBS Recipients (FY 2006-2021)



*Data Source: Medicaid MARS Data Warehouse

Objective II:

To provide administrative and support functions to Louisiana's Developmental Disabilities Services System in a manner that is responsive to citizens' needs and results in effective/efficient service delivery during FY 2023-2024 through FY 2027-2028.

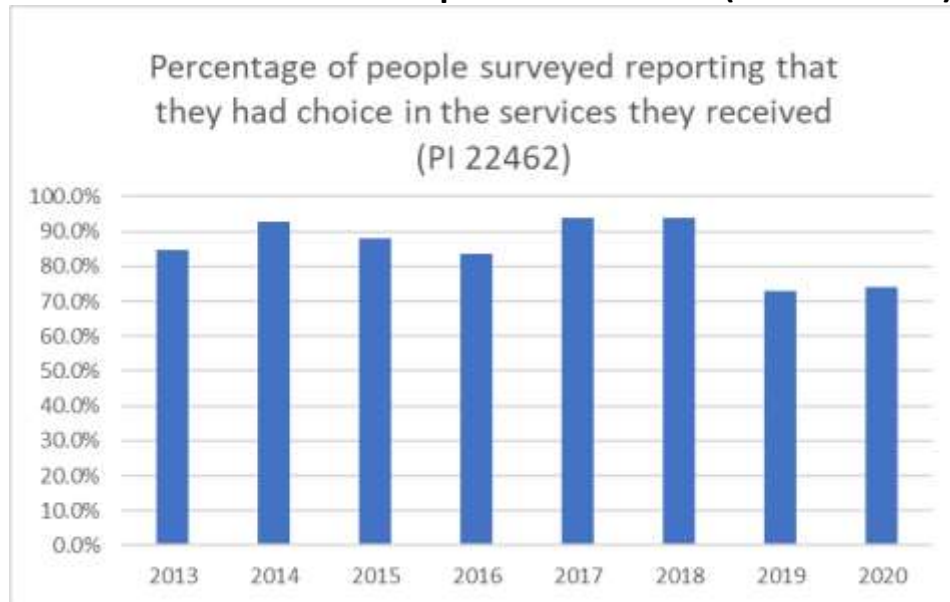
Strategies:

- 2.1 Produce an accurate and timely monthly expenditure report beginning September of each fiscal year through June reflecting the current budgetary position and proposing any necessary actions to the Assistant Secretary for remaining within the appropriations for the fiscal year.
- 2.2 Participate in the National Core Indicators (NCI) Project for individuals, families, and providers and develop quality improvement strategies for prioritized areas of concern by comparison of Louisiana results with national average of participating states.
- 2.3 Conduct annual survey of Local Governing Entities utilizing Human Services Accountability Plan (AP) performance indicators and data.
- 2.4 Produce monthly contract reports to include the current status and expenditures for each OCDD contract for the current fiscal year.
- 2.5 Implement an integrated, full-scale data-driven quality enhancement system.
- 2.6 Coordinate *Partners in Quality* (PIQ) process (transition and technical assistance) for all individuals transitioning from Supports and Services Center.
- 2.7 Provide ongoing review and oversight for all Cooperative Endeavor Agreements

Performance Indicators:

- Percentage of months in the designated period that monthly expenditure reports were delivered accurately and timely
- Percentage of months in the fiscal year that a monthly contract report was produced reflecting status of Office contracts
- Percentage of people surveyed reporting they had overall satisfaction with services received
- Percentage of people surveyed reporting that they had choice in the services they received
- Percentage of Local Governing Entities (LGEs) receiving an annual validation visit (from review of reports of validation visits)
- Percentage of individuals reporting satisfaction across the *Partners in Quality* (PIQ) assessed living situations
- Percentage of individuals reporting satisfaction across the *Partners in Quality* (PIQ) assessed work/day areas

Louisiana – DD Service Recipients and Choice (FY 2011-2018)



*Data Source: Annual National Core Indicators (NCI) Survey

Objective III (Statewide Resource Center):

To increase capacity-building activities for private community providers, creating private sector community infrastructure to meet the complex needs and support diversion of individuals from public residential services during FY 2023-2024 through FY 2027-2028.

Strategies:

- 1.1 Provide professional support/consultation to individuals with complex medical/behavioral needs residing in the community.
- 1.2 Provide capacity-building activities for private community providers to enhance their ability to support individuals with complex medical/behavioral needs.

- 1.3 Partner with community stakeholders to improve crisis response and oversight of individuals with life-threatening conditions and who pose a risk to public safety.

Performance Indicator:

- Percentage of individuals served by the resource center’s medical/nursing, allied health, and behavioral health professionals who remain in their most integrated setting
- Number of providers receiving Resource Center services
- Number of resource center training events
- Number of resource center technical assistance sessions
- Number of resource center consultations
- Percentage of customers that report satisfaction with resource center services

Program B: Community Support (2000)

Program B Mission

The mission of Community Supports is to effectively and efficiently implement the Office's community-based programs in a manner that is responsive to people with developmental disabilities and their families and that promotes independence, participation, inclusion, and productivity at home and in the community through an array of services and supports that include utilization of natural supports.

Program B Goals

Goal I

To develop and manage in a fiscally responsible way 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.

Goal II

To increase community capacity and competence in a manner consistent with evidence-based practice and national standards of care in order to meet the identified needs of people with developmental disabilities, including the capacity of families, government agencies, and community organizations and businesses, as well as the capacity of those providing specialized disability supports and services.

Objective I:

To provide effective and efficient management, delivery, and expansion of waiver and state-funded community programs and to optimize the use of natural and typical community resources in order to promote and maximize home and community life and prevent and reduce institutional care during FY 2023-2024 through FY 2027-2028.

Strategies:

- 1.1 Combine OCDD’s four current HCBS waivers (NOW, ROW, CC, and SW)

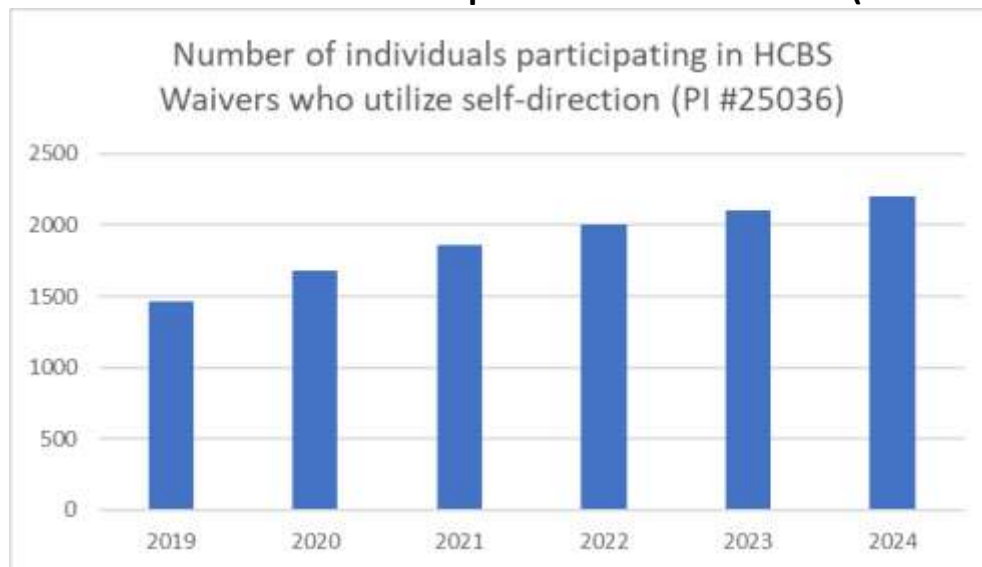
into one single waiver.

- 1.2 Implement an electronic plan of care format that encompasses person-centered practices.
- 1.3 Provide processes, training and support to providers, individuals with disabilities, and their families to access and utilize natural, community and generic supports and resources that best meet their needs and lead to people being a part of, not separate from, their communities.
- 1.4 Develop processes that enhance pathways to community employment for people with developmental disabilities.

Performance Indicators:

- Percentage of available I/DD Waiver opportunities utilized
- Percentage of waiver participants who have remained in the community and do not require admission to a more restrictive setting
- Number of individuals participating in HCBS Waivers who utilize self-direction
- Number of persons in individual integrated employment
- Number of years on DD Request for Services Register (RFSR) for individuals with unmet "urgent/emergent" needs based on Screening for Urgency of Need (SUN) score
- Number of individuals with developmental disabilities supported through a HCBS waiver
- Number of available I/DD Waiver opportunities

Louisiana – DD HCBS Waiver Participants and Self-Direction (FY 2019-2024)



*Data Source: Statistical Resources Inc. (SRI)

Objective II:

To provide supports to infants and toddlers with disabilities and their families in order to increase participation in family and community activities, to minimize the potential for developmental

delay, to reduce educational costs by minimizing the need for special education/related services after reaching school age, and to improve child outcomes to the level of current national standards during FY 2023-2024 through FY 2027-2028.

Strategies:

- 2.1 Identify eligible infants and toddlers through community early childhood network outreach activities.
- 2.2 Assure that eligible infants and toddlers and their families are supported by qualified, trained providers.
- 2.3 Continue the implementation of the EarlySteps state systemic improvement plan focused on improving child outcomes through supports that are focused on family concerns, priorities and resources and provided through a team-based approach.
- 2.4 Conduct quality assurance reviews to assure that Individualized Family Service Plans are developed within 45 days of referral.
- 2.5 Conduct quality assurance reviews to assure that Individualized Family Service Plans are implemented within 30 days of parent consent of the plan.
- 2.6 Provide team-based service delivery which supports families in meeting their children's needs in family and community settings across the state's early care and education network.
- 2.7 Assure that training is easily accessible within the system.
- 2.8 Assure that families are referred to Families Helping Families and other appropriate community resources for information and support based on their identified priorities.

Performance Indicators:

- Percentage of infants and toddlers in the state who are identified as eligible for EarlySteps
- Percentage of Individual Family Services Plan developed within 45 days of referral for eligible infants and family
- Percentage of Individual Family Services Plans implemented within 30 days of parental consent on the Individual Family Services Plan
- Percentage of families referred for entry to developmental disability services whose applications are processed by Local Governing Entities
- The percentage of children exiting EarlySteps at the level of their typical peers.
- Percentage of families reporting that early intervention improved their ability to help their child develop and learn

Program F: Pinecrest Supports and Services Center (6000)

Program F Mission

The mission of Pinecrest Supports and Services Center is to support people with intellectual and developmental disabilities to reach treatment goals and to return to more integrated community living settings. Pinecrest Supports and Services Center specializes in the treatment of people with comorbid intellectual and developmental disabilities and complex medical, behavioral, and psychiatric support needs.

Program F Goals

Goal I:

To provide specialized residential services to individuals with developmental disabilities and comorbid complex medical/behavioral/psychiatric needs in a manner that supports the goal of returning or transitioning individuals to community-based options.

Goal II:

To provide services in a manner that is efficient, effective and supports choice, dignity and quality of life.

Objective I:

To further decrease reliance on public residential supports and services during FY 2023-2024 through FY 2027-2028.

Strategies:

- 1.1 Conduct person-centered planning, including a needs-based assessment, for all individuals residing in the center to determine if community living is indicated by needs and wishes.
- 1.2 Transition individuals to private-provider options where applicable and appropriate.
- 1.3 Inform individuals and their families of community options, services and supports that are available to them.

Performance Indicators:

- Number of people transitioned to private provider community options according to assessment/support team recommendations
- Number of re-admissions to center within one year of transition
- Percentage of Conditions of Participation in compliance during Health Standards Reviews

Objective II:

To increase successful re-entry into traditional community settings for individuals with developmental disabilities who require specialized therapeutic, psychiatric and behavioral supports/stabilization during FY 2023-2024 through FY 2027-2028.

Strategies

- 2.1 Focus on specialized, therapeutic psychiatric and behavioral supports/

stabilization initiatives to increase the rate of successful re-entry into traditional community settings for individuals with developmental disabilities who have comorbid complex medical/behavioral/psychiatric needs.

Performance Indicators:

- Percentage of individuals discharged who do not return to the facility (Pinecrest Supports and Services Center) within one year of discharge
- Average length of stay (years) in the facility (Pinecrest Supports and Services Center) for individuals admitted within the last five years

Program G: Central LA Supports and Services Center

Program F: Mission

The mission of Central Louisiana Supports and Services Center is to support people with intellectual and developmental disabilities to reach their maximum capacity in life.

Program F Goals

Goal I:

To provide high quality medical services and achieve excellent resident outcomes in a cost effective manner through fiscal year 27/28.

Goal II:

To provide services in a manner that is efficient, effective and supports choice, dignity and quality of life.

Objective I:

To increase the potential of each resident through active treatment (residential services, therapeutic services, medical services, social services, transitional services and nutritional services).

Strategies:

- 1.1 Conduct person-centered planning, including a variety of inter-disciplinary assessments to devise and Individualized Program Plan.
- 1.2 Meet the residents where they are in all areas and to use the IPP to focus on growth of quality of life.
- 1.3 Support the resident and family to create a life that is full of quality.

Performance Indicators:

- Number of people participating in daily active treatment.
- Number of residents that show improvement in at least one of the six listed domains (residential services, therapeutic services, medical services, social services, transitional services and nutritional services).

Objective II:

To increase the quality of life for each resident through the participation in active treatment.

Strategies

- 2.1 Focus on specialized, therapeutic initiatives to increase the rate of successful

daily active treatment.

Performance Indicators:

- Percentage of Conditions of Participation in compliance during Health Standards Reviews

Program H: Auxiliary Administration (A1000)

Program G Mission

The mission is to support people with developmental disabilities with quality of life and the attainment of personal goals.

Program G Goal

To provide individually determined supports and services to residents of the supports and services center through a growing and diverse range of community options and resources operated and/or provided by the center.

Objective I:

To provide residents of the supports and services center with opportunities for paid work and/or therapeutic activities, as recommended by their support teams during FY 2023-2024 through FY 2027-2028.

Strategies:

- 1.1 Develop/secure paid work opportunities.

Performance Indicator:

- Percentage of individuals of the LDH-operated supports and services center who have paid work and/or therapeutic activities as recommended

Imperial Calcasieu Human Services Authority



Vision

Imperial Calcasieu Human Services Authority (ImCal HSA) strives to provide the highest quality care and supports available to ensure an improved quality of life for those we serve.

Mission

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.

Philosophy/Values

The Imperial Calcasieu Human Services Authority shall adhere to the principles of effectiveness, efficiency, and egalitarianism. The ImCal HSA shall maintain objective data derived from evidence-based practices and implementation efforts that rationally explain its efforts to maximize all resources within its control. Individuals receiving services will have access to evidence based services that are responsive to their needs and cost effective so that:

- a) Individuals with acute illnesses are able to rapidly resume optimal functioning;
- b) Individuals with chronic illness may live in a safe environment that encourages personal growth;
- c) Youth and Families' strengths and resilience are enhanced;
- d) The voice of and collaboration with Individuals in the community is enhanced;

ImCal HSA will make 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.

Executive Summary

The Louisiana Legislature, the Louisiana Department of Health (LDH) and its program offices have created a statewide integrated human services delivery system with local accountability and management to provide behavioral health and developmental disabilities services. The Imperial Calcasieu Human Services Authority was established in 2008 under the provisions of the Louisiana revised statutes (LSA-RS): RS. 373 to provide administration, management, and operation of mental health, addictive disorders, and developmental disabilities services to the residents of Allen, Beauregard, Calcasieu, Cameron and Jefferson Davis Parishes. Direct oversight of these services was previously provided through the Louisiana Department of Health (LDH) Offices of Behavioral Health and Citizens with Developmental Disabilities.

Governance of Imperial Calcasieu HSA is by an eight (8) member Board of Directors. The Board is comprised of one resident from each parish as appointed by their parish governing authority, and three residents from the southwest Louisiana area as appointed by the Governor. Each board member must possess personal or professional experience in the area(s) of behavioral health or developmental disabilities and represent parents, family members, consumers, advocacy groups, or serve as a professional in one of the areas. All board members serve without compensation (reimbursement for travel mileage is allowed, as funds are available).

Administration of the ImCal HSA is headed by an Executive Director, who is selected by the Board of Directors and is supported in administration and day-to-day operations by the Executive Management Team. It is the policy of ImCal HSA to administer, monitor, and continually improve community-based quality care using strengths-based, person-centered approaches consistent with a recovery and resiliency model of care. Success is defined by positive individual and programmatic outcomes, consumer satisfaction, and increased efficiencies and cost-effectiveness in the provision of services. Leadership shall continually review its mission and vision, seeking input from the persons served and other stakeholders, in order to ensure the needs of the community guide the direction of ImCal HSA.

ImCal HSA serves a five parish area including Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis and has service sites in Lake Charles, Oberlin, DeRidder, Jennings and Sulphur. This area has a population of approximately 300,000 persons (from 2012 US Census estimates). Of this population, Imperial Calcasieu HSA has the responsibility to care for those who are indigent within ImCal HSA service sites.

Agency Goals:

- I. To 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.

Activity: Administration

Program Description:

The Louisiana Department of Health (LDH), its program offices and the Louisiana Legislature have created a statewide integrated human services delivery system with local accountability and management to provide behavioral health and developmental disabilities services. These local human service systems are referred to as local governmental entities (LGEs). LGEs feature practices such as a framework anchored in clear policy objectives, well-defined local roles and responsibilities, and measures to assure accountability of delivering quality services to individuals that assist in determining the relative efficiency and effectiveness of public systems. The Imperial Calcasieu Human Services

Authority was created by Act 373 in the 2008 Legislative Session for the parishes of Allen, Beauregard, Calcasieu, Cameron and Jefferson Davis.

Mission:

Through its administrative activity, Imperial Calcasieu Human Services Authority will provide for the management and operational activities of services for addictive disorders, mental health and developmental disabilities.

Goal:

Administration shall ensure that services are provided in accordance with applicable licensure requirements, law, rules, and regulations and that the highest level of ethical standards are adhered to in all functions of operations.

Objective I:

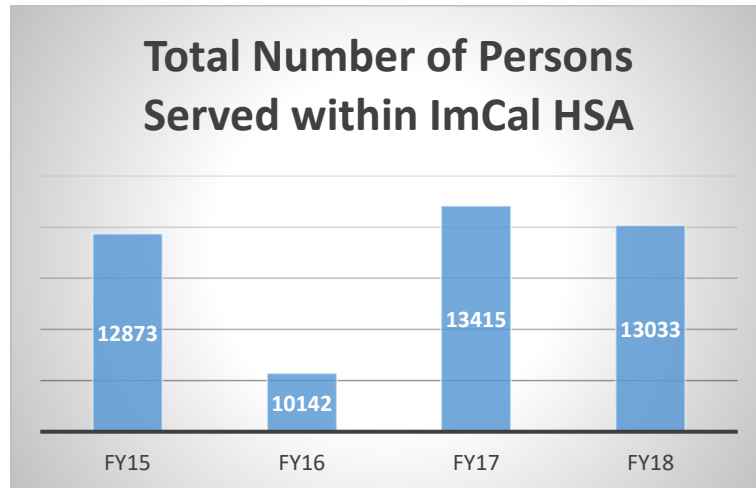
To develop policies and procedures that govern the provision of services, to ensure accountability of those quality services to individuals served throughout the ImCal HSA catchment area each year through June 30, 2028.

Strategies:

- 1.1. Develop and implement long-range, strategic and operational plans, service design, resource allocation, and organizational policies in keeping with the mission and vision of the agency.
- 1.2. Ensure that services are provided in accordance with applicable licensure requirements, law, rules, and regulations and that the highest level of ethical standards are adhered to in all functions of operations and assure that changes in regulations and requirements are addressed appropriately in ImCal policy on an ongoing basis.
- 1.3. Produce accurate and timely expenditure reports reflecting the current budgetary position and proposing any necessary adjustments, in addition produce monthly reports to include the current status and expenditures for each program and contract.
- 1.4. Develop and implement an outcomes driven performance improvement plan to facilitate growth and enhancement of ImCal HSA's governance, management, clinical, and support functions.
- 1.5. Plan and implement a safety management program within the framework of Office of Risk Management guidelines, to assure the safety of all clients, staff, and visitors of ImCal HSA facilities and offices.
- 1.6. Establish and maintain a cultural sensitivity plan that is responsive to the diversity of its stakeholders with respect to culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status and language.
- 1.7. Maintain a workforce development program to ensure staff has the educational resources and training needed to provide the highest quality level of service.

Performance Indicators:

- Total number of individuals served in the Imperial Calcasieu Human Services Authority.
- Percentage of Imperial Calcasieu Human Services Authority clients who state they would continue to receive services at our clinics if given the choice to go elsewhere.
- Percentage of Imperial Calcasieu Human Services Authority clients who state they would recommend the clinics to family and friends.



This performance indicator measures the number of people reached by all ImCal services within its BH and DD Divisions.

Activity: Behavioral Health

Program Description

ImCal HSA provides a comprehensive system of services addressing the ongoing Behavioral Health needs of individuals with mental, substance use or emotional/behavioral disorders in the community via direct program operation or provision of funding for services thru contractual agreements. ImCal HSA operates outpatient and intensive outpatient behavioral health programs which provide mental health and substance use services for children, adolescents and adults. The scope of core services provided within these programs include screening, triage, and referral; psychosocial assessment and psychiatric evaluation; person-centered treatment planning; individual and group counseling; psycho-education; medication management; peer support groups, comprehensive transition and discharge planning. Lake Charles Behavioral Health Clinic, the largest of the clinics within ImCal HSA also provides primary care services through SAMHSA Primary Care and Behavioral Health Integration Grant funding. Contracted services include substance abuse prevention, intensive and non-intensive residential addiction services, medically supported detoxification, case management, housing, crisis intervention and referral, community based treatment and support services, outreach and referral for homeless or other underserved populations, and consumer care resources to provide financial support.

All Behavioral Health clinics in the Imperial Calcasieu Human Services Authority participate as Medicaid Application Centers for persons requesting services.

Mission:

To provide a comprehensive system of services addressing the ongoing behavioral health needs of the community which are assured within the oversight of ImCal HSA via direct operation or provision of funding for services thru contractual agreements.

Goals:

- A. Enhance the quality of life of the persons served and their families.
- B. Successfully engage clients in services and support their active engagement with behavioral interventions that encourage and reward positive behaviors.
- C. Build positive relationships with clients and demonstrate unconditional positive regard in all interactions with persons served.
- D. Motivate clients to make positive behavioral changes in order to reduce symptoms and build resilience.
- E. Empower clients to successfully manage their own symptoms and behavior to increase personal independence and integration into the community.

Objective II:

To extend quality mental health and addictive disorders prevention and treatment services to children/adolescents and adults within the Authority target population, including inpatient services, with client satisfaction feedback that meets threshold each year through June 30, 2028.

Strategies:

- 2.1 Assume administrative, fiscal, and programmatic responsibilities for all community-based behavioral health services within its five-parish area, as agreed upon through a contract with LDH.
- 2.2 Implement an effective fiscal and programmatic monitoring system that ensures the quality, quantity, and appropriateness of services delivered by all contract providers.
- 2.3 Assess current access procedures comparative to national models to determine best practices based upon procedures, staffing patterns, and technical support.
- 2.4 Implement standardized screening, registration, admission, and intake procedures along with relevant documentation.
- 2.5 Actively seek input from stakeholders and consumers to identify service gaps and to initiate program development or modification as appropriate. Input will be gathered on an ongoing basis in a variety of means, to include at least an annual community forum.

- 2.6 Maintain close working relationship with and support the work of the ImCal HSA BH Regional Advisory Council in their efforts to advocate for consumers and families.

Performance Indicators:

- Number of adults served with mental health (MH) services in Imperial Calcasieu Human Services Authority Behavioral Health clinics.
- Number of children/adolescents served with MH services in Imperial Calcasieu Human Services Authority Behavioral Health clinics.
- Number of adults served with addictive disorders (AD) services in Imperial Calcasieu Human Services Authority Behavioral Health clinics.
- Number of children/adolescents served with AD services in Imperial Calcasieu Human Services Authority Behavioral Health clinics.
- Number of individuals served by residential AD services within Imperial Calcasieu Human Services Authority.
- Percentage of MH cash subsidy slots utilized.
- Number of enrollees in prevention programs.
- Number of individuals enrolled in primary care services provided through the ImHealthy Program.

Activity: Developmental Disabilities

Program Description:

ImCal HSA provides core services for individuals with Developmental Disabilities which consist of serving as the Single Point of Entry (SPOE) into the Developmental Disabilities (DD) Services System and providing support coordination services to individuals and their families through DD and other available community resources. DD services include the assessment of needs for support and services, development of individual plans of support, making applicable referrals, and providing ongoing coordination for the individual's support plans. Targeted services are centered on Home and Community-Based Services Waiver programs and Federal criteria which allow services to be provided in a home or community-based setting for the recipient who would otherwise require institutional care. The Family Support Program is designed to assist individuals whose needs exceed those normally used resources in the community, and other natural resources available. Individual and Family Supports include but are not limited to: respite care, personal assistance services, specialized clothing, such as adult briefs, dental and medical services not covered by other sources, equipment and supplies, communication services, crisis intervention, specialized utility costs, specialized nutrition, and family education. The Flexible Family Fund Program is intended to assist families with children with severe or profound disabilities to offset the extraordinary costs of maintaining their child in their own home. The program provides a monthly stipend to families of children who have qualifying exceptionalities identified through their local educational authority.

Mission

To provide developmental disability resources for participants to live as independently as possible in their home and community by supporting a wide-range of direct/indirect services within ImCal HSA catchment area.

Goals

- A. Enhance the quality of life of the persons served and their families.
- B. Build positive relationships with clients and demonstrate unconditional positive regard in all interactions with persons served.
- C. Empower clients to successfully manage their own activities of daily living to increase personal independence and integration into the community.
- D. Provide quality home-based, person-centered services to enable participants to remain in the community.
- E. Serve as the Single Point of Entry into the developmental disability services system.

Objective III:

Provide core services for individuals with Developmental Disabilities which consist of serving as the Single Point of Entry (SPOE) into the Developmental Disabilities (DD) Services System and providing support coordination services to individuals and their families through DD and other available community resources each year through June 30, 2028.

Strategies:

- 3.1 Serve as the Single Point of Entry (SPOE) into the Developmental Disabilities Services System providing support coordination services to individuals and their families through community resources.
- 3.2 Identify State agencies and community organization resources in order to better support people with developmental disabilities to live full community lives and support partnerships with and referrals to these agencies and/or organizations.
- 3.3 Monitor program utilization, effectiveness, and collect performance indicator data.
- 3.4 Develop and implement policies and procedures for adult waiver participants to have paths to community employment.
- 3.5 Meet quarterly with service providers and families to discuss goals and services and to resolve barriers to achieving goals.
- 3.6 Maintain a close working relationship with and support the work of the ImCal HSA DD Regional Advisory Council, to include public input into the regional planning process and comment on regulations proposed by OCDD.

- 3.7 Collaborate with the ImCal DD Regional Advisory Committee to develop outreach plans. Such outreach plans shall provide for public dissemination of information regarding developmental disabilities and the services available through ImCal HSA.

Performance Indicators:

- Number of persons receiving DD services per year.
- Number of people receiving individual and family support services.
- Number of people receiving flexible family fund services.
- Percentage of eligibility determinations determined valid according to the Flexible Family Fund promulgation.

09-376

Central Louisiana Human Services District



Vision

The vision of the Central Louisiana Human Services District (CLHSD) is to provide access to care to all people in its catchment area (Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon and Winn parishes) who are in need of behavioral (mental health and addiction) and developmental disabilities programs and services.

Mission

CLHSD's mission is to increase public awareness of behavioral health disorders 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.

Philosophy

CLHSD believes the people served by the District have the right to comprehensive and integrated health care of their choice that meets their individual needs and achieves the best possible outcome in terms of their recovery. CLHSD delivers and or contracts for services that take into account the cultural and social diversity of its consumers and meets their needs and those of their family and community.

We profess that helping young children and their parents manage difficulties early in life may prevent/curtail the development of disorders and that early intervention and prevention strategies minimize risk of illness and curtails the cost of treatment. Our preferred treatment milieu is community based.

Organizational Goals

- I. To 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 abiding by District, Departmental, 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.

Executive Summary

Our Business

House Bill 930 of the 2008 Legislative Session, signed into law as Act 373, mandates that the administration of the Louisiana mental health, addictive disorders, and developmental disability health care systems change from a centrally controlled set of Regions by the Louisiana Department of Health (LDH), to a system of independent healthcare districts or locally controlled authorities.

These districts and authorities are referred to as Local Governing Entities (LGEs). This law expands and creates standards for Human Services Districts to be locally governed and operated and to become the primary providers of behavioral health and developmental disability services on a LGE-by-LGE platform.

Each LGE is governed by a board and managed with input from the community. The Board is comprised of one resident from each parish as appointed by their parish governing authority, and three residents from the area as appointed by the Governor. Each board member must possess experience in the area(s) of behavioral health or developmental disabilities and represent parents, family members, consumers, advocacy groups, or serve as a professional in one of the areas. The human services district is headed by an Executive Director, who is selected by the Board.

LDH oversight of the LGEs is managed through a contract between LDH and each LGE. LDH through its program offices, the Office of Behavioral Health (OBH) and the Office for Citizens with Developmental Disabilities (OCDD) monitors performance through a statewide Accountability Plan (AP). According to existing guidelines, success is defined by positive individual and programmatic outcomes, consumer satisfaction, increased efficiencies and cost-effectiveness in the provision of services.

LDH's Office of Behavioral Health (OBH) retains as one of its responsibilities to be the single recipient of Federal Block Grant funds for these areas. As part of their oversight role LDH ensures compliance with federal guidelines and requirements for all LGEs that receive Block Grant funding. The LGEs must maintain Behavioral Health Regional Advisory Councils, officially linked to the State Planning and Advisory Council, in order to qualify for Block Grant funding.

Per Act 373 of the 2008 Legislative Session, all regions that convert to an LGE must successfully complete a readiness process that demonstrates their capability to assume the responsibility for high quality service delivery and governance. CLHSD successfully completed the process May 15, 2014.

Areas Served

- CLHSD serves Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon and Winn parishes. This service area covers approximately 71,000 square miles (approximately 17% of State total) and has a population of approximately 297,000 persons (from 2020 US Census estimates).
- All eight (8) parishes in the CLHSD service area are designated as Medically Underserved Areas. Medically Underserved Areas/Populations are areas or populations designated by the Department of Health Resources & Services Administration/Bureau of Primary Care and Rural Health (HRSA) in 2021 as having: too few primary care providers to population ratios, increased homelessness, migrant farm workers, Native Americans, or Medicaid-eligible. Avoyelles, Catahoula, Concordia, Grant, Rapides, LaSalle, Vernon, and Winn parishes are designated by the U.S. Department of Health and Human Services as a Health Professional Shortage Area (HPSA). CLHSD service area is also designated as a mental health shortage area. Mental Health HPSAs are based on a psychiatrist to population ratio of 1:30,000.

Persons Served

- CLHSD ensures the provision of behavioral health and developmental disability services for the residents of Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon and Winn parishes.
- CLHSD admissions age profile, according to the District Electronic Health Records (E.H.R.) demographics reporting from December 2021, the following percentages of the total persons served by age are as follows: Ages 0-17 is 12%, ages 18-40 is 38%, ages 41-65 is 42%, and ages 66 or older is less than 8%.
- During FY 2021 the Developmental Disabilities activities yielded 1167 clients served by CLHSD. The Individual Family Support Services (FSS) demographics show a total of 191 clients. The Flexible Family Fund Services (FFF) Participant Data Base profile shows 113 adults. A manual count of the Waiver Services program for FY 2021 yielded 924 people served district wide.

CLHSD Model

- Priorities are client centered
- Resources target people served and those in need of services.

- Restoration of community life is achieved through heightened awareness of natural supports-family, school and church- and community resources.
- Resilience skills are fostered through prevention resources, early intervention strategies relapse prevention and education.

Priorities

Under the leadership of the Executive Director, CLHSD pledges to invest its resources in addressing the following priorities:

1. Individuals and families in CLHSD affected by Mental Illness, Addictive Disorders or Developmental Disabilities shall live full, independent and productive lives to the greatest extent possible within available resources.
2. Persons and families in crisis related to mental illness, addictive disorders or developmental disabilities shall have their crisis resolved and a safe environment restored (*People We Serve*).

People in Crisis

- ✚ Assessment of person needing urgent assistance
- ✚ Assist OBH in developing the Coordinated Crisis System of Care in our area

3. Persons not yet identified with specific serious or moderate mental illness, addictive disorders, or developmental disabilities who are at significant risk of such disorders due to the presence of proven risk factors or the absence of proven protective factors (*People We Need to Serve*).

People at Risk

- ✚ Evidenced Based Prevention Services for Children and Adults
 - ✚ Healthy Initiatives Coalitions and other Educational Events
 - ✚ Mental Health and Drug Courts
 - ✚ Mobile Outreach
4. Persons with serious and disabling mental illness, addictive disorders or developmental disabilities shall be made aware and have access to the use of natural supports and community resources and shall participate in the community (*Building Community Coalitions*).

Awareness and Access

- ✚ Identify all current community providers (District, contracts, others)
- ✚ Increase knowledge of available services (Clients, community, leaders)
- ✚ Make connections to expand services
- ✚ Improve transportation options

- ✚ Public Forums
- ✚ Attendance on community board, coalitions, councils
- ✚ Use of media to promote missions and services

5. Persons with mild to moderate needs related to mental illness, addictive disorders or developmental disabilities shall be made aware and have access to the use of natural supports and community resources and shall participate in the community (*Strengthening Protective Factors*).

Awareness and Access

- ✚ Continuously Identify active community providers (District, contracts, others)
- ✚ Increase knowledge of available services (Clients, community, leaders)
- ✚ Make connections to expand services
- ✚ Improve transportation options
- ✚ Public Forums
- ✚ Attendance on community board, coalitions, councils
- ✚ Use of media to promote missions and services

ACTIVITY A: ADMINISTRATION

Mission

The mission of the Administration Activity is to ensure the functioning of the organization at an optimum level of performance in administrative and programmatic quality, while meeting federal, state and other regulatory authorities' guidelines.

Goal 1 The Goal of the Administration activity is to oversee and direct the provision of behavioral health and developmental disabilities services in the District.

Objective 1 Through the Administration activity, Central Louisiana Human Services District (CLHSD) will oversee and direct the management and operational activities of Behavioral Health (Mental Health and Addictive Disorders) and Developmental Disabilities.

Strategies:

Strategy 1.1: Provide programmatic leadership and direction to CLHSD behavioral health (addictive disorders and mental health) and developmental disabilities

program/services, to ensure compliance with state and federal licensing and grant requirements, standards of care, accreditation of programs when applicable, and the accountability plan (AP) agreement with the Louisiana Department of Health (LDH).

Strategy 1.2: Conduct routine and periodic monitoring/assessments and provide feedback, technical assistance and consultation geared toward maintaining compliance with Federal and State regulations governing behavioral health and developmental disabilities programs; to include financial monitoring/reporting.

Strategy 1.3: Conduct quarterly client satisfaction surveys to identify potential need for intervention.

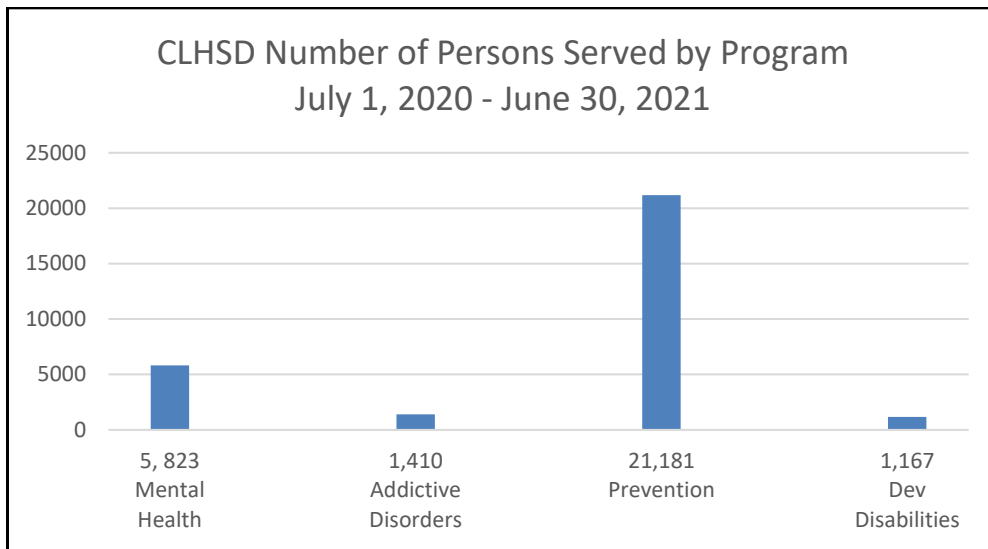
Strategy 1.4: Improve treatment outcomes and client satisfaction.

Strategy 1.5: Actively seek input from stakeholders and consumers to identify service gaps and to initiate program development or modification as appropriate.

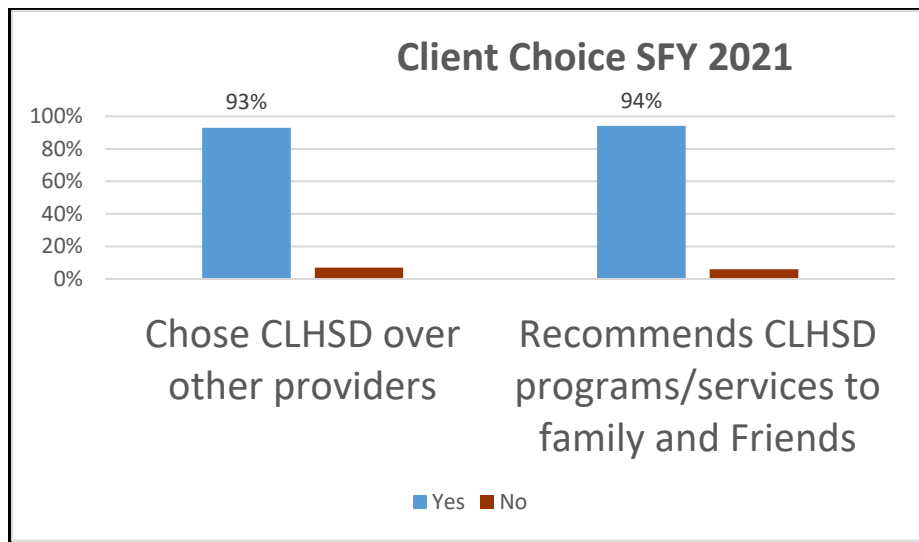
Strategy 1.6: Provide ongoing staff development activities to enhance service delivery quality and improve the outcome of treatment services.

Performance Indicators:

- Percentage of Central Louisiana Human Services District (CLHSD) clients who state they would continue to receive services through CLHSD, contracts and clinics, if given the choice to go elsewhere.
- Percentage of Central Louisiana Human Services District (CLHSD) clients who state they would recommend CLHSD programs to family and friends.
- Total number of individuals served in the Central Louisiana Human Services District (CLHSD).
- Annual increase in staff productivity measured by the volume of services provided.



Source: Contracts, DD Participant Database, Clinics' Manual Count



Source: C'EST BON Consumer Survey for CLHSD (Clinics)

Objective 2 To utilize technology to maintain and advance efficiency of program services, administrative functions and fiscal operations of the district by using performance improvement strategies that include performance analysis, measurement and reporting.

Strategies:

Strategy 2: Use Tele-health technology to maximize existing prescriber and Licensed Mental Health Provider resources.

Strategic 2.1: Use data collection and analysis to support performance improvement activities and to make decisions based on outcome measurements.

Strategy 2.2 Use electronic health records information to provide a standard format for assessment, diagnosis and treatment planning for persons served.

Strategy 2.3 Use electronic health records technology to ensure compliance with the requirements needed to support effective treatment planning and outcomes.

Strategy 2.4 Utilize information collected by technology based systems to analyze performance, and use information as a tool for Executive Team decisions or as warranted.

Strategy 2.5 Use on-line technology to conduct quarterly client satisfaction surveys to identify potential needs for intervention.

Strategy 2.6: Use on-line technology/web-based applications to ensure ease of access and monitoring of payroll and attendance records.

Strategy 2.7: Use an electronic billing system to facilitate staff efficiency, timeliness of billing, and to promote billing's accuracy.

Performance Indicators:

- Percentage of District programs using an Electronic Health Record (EHR) to manage/improve programmatic outcomes, scheduling clinical appointments, and facilitate billing timeliness and accuracy.
- Percentage of district clinics using the TOMS' website to manage satisfaction surveys and programmatic outcomes.
- Number of Tele- health sites Districtwide.

ACTIVITY B: BEHAVIORAL HEALTH

Mission

The mission of the Behavioral Health Activity is to provide the people we serve with access to comprehensive, integrated, person-family centered system of prevention and treatment services that promote recovery and resilience, have a positive impact on the individual and its community and are culturally and clinically competent and are delivered in partnership with all stakeholders.

Goal 1 The Behavioral Health Activity's goal is to provide behavioral health (Mental Health and Substance Abuse) treatment services as part of the State's continuum of care (per the Human Services Accountability and Implementation Plan) in Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon and Winn parishes.

Objective 1 Through the Behavioral Health activity, Central Louisiana Human Services District (CLHSD) will provide quality behavioral health services to children, adolescents, adults and their families in the District (including prevention and flexible family funds). Also, the CLHSD will monitor behavioral health services (outpatient and inpatient) including contract providers, to insure quality standards are met throughout the continuum of care. Customer feedback will be used as one of the measuring tools.

Strategies

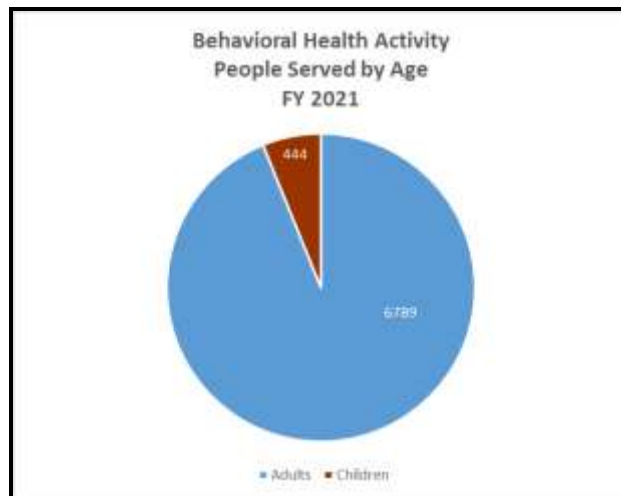
- Strategy 1.1: Assume administrative, fiscal, and programmatic responsibilities community-based behavioral health services and Prevention programs/activities within its eight-parish area, as agreed upon through a contract with LDH
- Strategy 1.2: Implement an effective fiscal and programmatic monitoring system that ensures the quality, quantity, and appropriateness of services delivered by all contract providers.
- Strategy 1.3: Provide standardized screening, registration, and admission procedures (along with relevant documentation).
- Strategy 1.4: Actively seek input from stakeholders and consumers to identify service gaps and to initiate program development or modification as appropriate. Input will be gathered on an ongoing basis in a variety of means, to include at least an annual 'community forum'.

Strategy 1.5: Maintain close working relationship with and support the work of the ‘regional advisory council’ in their efforts to advocate for consumers and families.

Strategy 1.6: Implement Mobile Outreach Service to rural communities within the CLHSD.

Performance Indicators:

- Number of adults receiving Mental Health services in all CLHSD Behavioral Health Clinics.
- Number of children/adolescents receiving Mental Health services in all CLHSD Behavioral Health programs.
- Number of adults served in outpatient Addictive Disorders programs in the CLHSD.
- Percentage of adults receiving Mental Health services who report that they would choose to continue to receive services from CLHSD if given a choice to receive services elsewhere.
- Percentage of Mental Health clients who would recommend CLHSD services to others.
- Percentage of MH cash subsidy slots utilized.
- Total number of individuals served by outpatient Addictive Disorders in Central Louisiana Human Services District.
- Total number of individuals served in Central Louisiana Human Services District clinics and programs.
- Total number of enrollees in prevention programs in CLHSD geographic area.



Data Source: LaPAS FY 2021

ACTIVITY C: DEVELOPMENTAL DISABILITIES

Mission

The mission of the Office for Citizens with Developmental Disabilities (OCDD) activity is to assess the need for support and services of developmentally disabled clients and to develop individual plans that will meet those needs, including referrals and coordination of appropriate services.

Goal 1 OCDD goal is to provide access to appropriate, comprehensive community based supports through waivers, family support and flexible family fund programs for individuals with disabilities, their families and/or support system(s) such that they will be able to be maintained within their communities.

Objective 1 Through the Developmental Disabilities activity the CLHSD will promote and facilitate independence for citizens with disabilities via the availability of home and community based services.

Strategies:

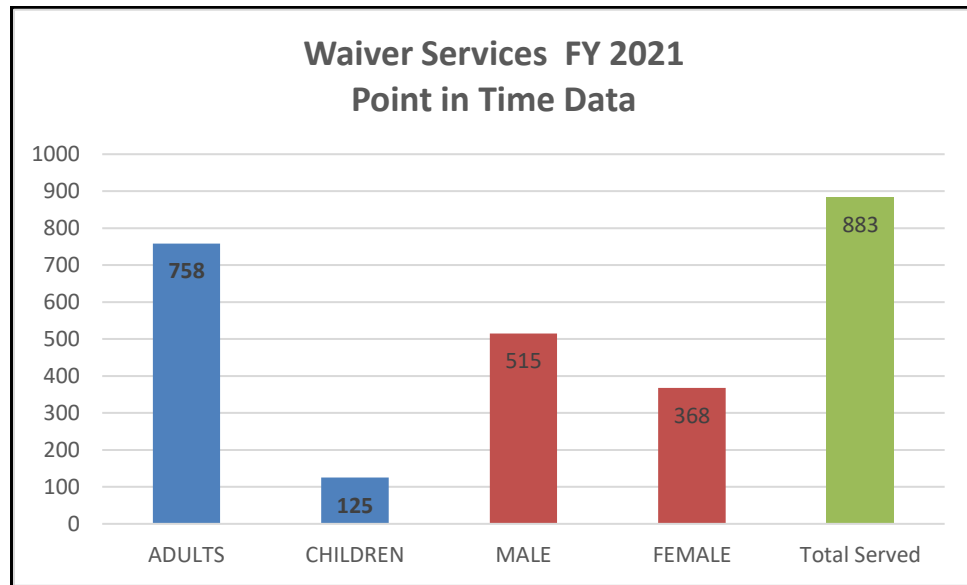
Strategy 1.1: Serve as the Single Point of Entry (SPOE) into the Developmental Disabilities Services System providing support coordination services to individuals and their families through community resources.

- Strategy 1.2: Identify State agencies and community organization resources in order to better support people with developmental disabilities to live full community lives and support partnerships with and referrals to these agencies and/or organizations.
- Strategy 1.3: Monitor program utilization, effectiveness, and collect performance indicator data.
- Strategy 1.4: Develop and implement policies and procedures for adult waiver participants to have paths to community employment.
- Strategy 1.5: Meet quarterly with service providers and families to discuss goals and services and to resolve barriers to achieving goals.
- Strategy 1.6: Maintain communication with the Regional Advisory Committee, to include public input into the regional planning process and comment on regulations proposed by OCDD.
- Strategy 1.7: As per stated regulations, OCDD will provide the Advisory Committee timely information on the budget, in addition to information on implementation of all services and quality assurance reports.
- Strategy 1.8: Collaborate with the Regional Advisory Committee to develop outreach plans. Such outreach plans shall provide for public dissemination of information regarding developmental disabilities and the services available through CLHSD. The state advisory committee shall coordinate with all regional advisory committees and shall use data provided by the regional advisory committees in the deliberations of the committee.
- Strategy 1.9: To conduct Community Education and Awareness events sponsored by CLHSD to educate individuals, family member, community organizations, school systems and the medical community regarding service access.
- Strategy 1.10: To actively seek input from stakeholders and consumers to identify service gaps and to initiate program development or modification as appropriate. Input will be gathered on an ongoing basis in a variety of means, to include at least an annual ‘community forum’.

Performance Indicators:

- Number of persons receiving individual and family support services.

- Number of persons receiving Flexible Family Fund (FFF) services.
- Percentage of eligibility determinations determined to be valid according to the Flexible Family Fund provisions.
- Number of individuals certified for Waiver services.
- Number of persons receiving developmental disabilities services in CLHSD.



Source: Developmental Disabilities Staff Manual Count

Northwest Louisiana Human Services District**Vision (ENDs)**

The Northwest Louisiana Human Service District exists so that individuals with mental health, addictive disorders, and developmental disabilities residing in the parishes of Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster are empowered, and self-determination is valued such that individuals live a satisfying, hopeful, and contributing life.

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.

Philosophy/Values

The Northwest Louisiana Human Services District was formed to provide local governance and direction for behavioral health and developmental disability services for nine Louisiana parishes. The Board of Directors consists of representatives from each of the parishes making up the district and three representatives appointed by the Governor of Louisiana. The Executive Director, hired by the Board of Directors, is responsible for achieving the ENDs as defined by the Board. The Carver Policy Governance Model is used to define the role and relationship of the Board, and the Executive Director through the use of Policy Governance. The Board-defined ENDs are implemented by the Executive Director with policy-driven input and monitoring by the Board of Directors.

The Board of Directors governs with an emphasis on:

- 1) Outward vision rather than internal preoccupation
- 2) Encouragement of diversity in viewpoints
- 3) Strategic leadership rather than administrative detail
- 4) Clear distinction of board and executive director roles
- 5) Collective rather than individual decisions
- 6) Future rather than past or present
- 7) Proactively rather than reactively.

The Northwest Louisiana Human Services District will make use of best practices in implementing, evaluating, monitoring, modifying existing services so that quality is assured,

services meet the needs of those served, the variety of services available adequately address the range of health issues identified, and/or that services are further developed to address service gaps and sustainability of programs.

Executive Summary

Northwest Louisiana Human Services District provides a mechanism for the provision of services through a local governing board focused on directing the resources available in a more cost-effective way. The Board maximizes available resources by participation in the State Budgeting/Grant allocation process, legislative advocacy, collection of self-generating funds, and developing new resources when possible.

Participation in the state's Medicaid managed care model, Healthy Louisiana, helps integrate services and self-generate funds needed to offset underfunding concerns. Healthy Louisiana is designed to increase access to community-based services, improve quality of care and health outcomes, and reduce utilization of more restrictive and crisis driven services such as emergency departments, hospitalizations, out-of-home placements and institutionalizations. As efficiencies are created through integrated care, District clinics are able to provide appropriate levels of care as determined by the parameters set forth in the managed care plan, and are able to self-generate additional funds by billing insurance companies for many of the services provided by the District.

The state's Medicaid managed care plan and the expansion of Louisiana Medicaid through the Affordable Care Act in 2016 has moved a significant percentage of clients from an uninsured status to full Medicaid coverage. This has given a significant number of individuals more access to services but, with Medicaid reimbursement being well below the cost of providing those services, our District remains the only safety net service provider in our service area focused on meeting the needs of both the uninsured and the underinsured Behavioral Health populations.

Agency Goals

Goal I: Align the activities and services of the District with other state agencies and organizations so that the impact of services provided within the service area of the District is maximized.

Goal II: Assure compliance with the contract between LDH and the District.

Goal III: Provide core services in a cost-effective and efficient manner.

Goal IV: Identify and implement services that meet the unique needs of the District and achieve the ENDS established by the NLHSD Board of Directors.

Program A: Administration

The Northwest Louisiana Human Services District was created by Act 373 in the 2008 Legislative Session to serve the parishes of Caddo, Bossier, Webster, Claiborne, Bienville, Red River, Desoto, Sabine and Natchitoches. The Northwest Louisiana Human Services District began operations as a District on July 1, 2014. The district is one of ten human service delivery systems with local accountability and management to provide behavioral health and developmental disabilities

services. Together, they make up a group of statewide, integrated, local human service delivery systems that are frequently referred to as local governmental entities, or LGEs. The District's administrative program is responsible for all governance, management and operational activities of the District so that behavioral health and developmental disability services are efficiently and effectively provided in the nine-parish service area.

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.

Goals

Goal 1: To assure the services of the NLHSD are being performed within the expectations set forth in the NLHSD Board Governance Policy Manual. This includes assuring individuals have access to evidence-based, cost-effective services that are responsive to their needs so that:

- a. Individuals with acute illnesses may rapidly resume optimal functioning.
- b. Individuals with chronic illness may focus on hope, empowerment, and personal growth so that self-determination leads to safe choices and positive lifestyle decisions.
- c. Youth, adults and family strengths are emphasized and recovery and resilience are enhanced.

Goal 2: Maintain a trained and effective leadership team at the Board and District level

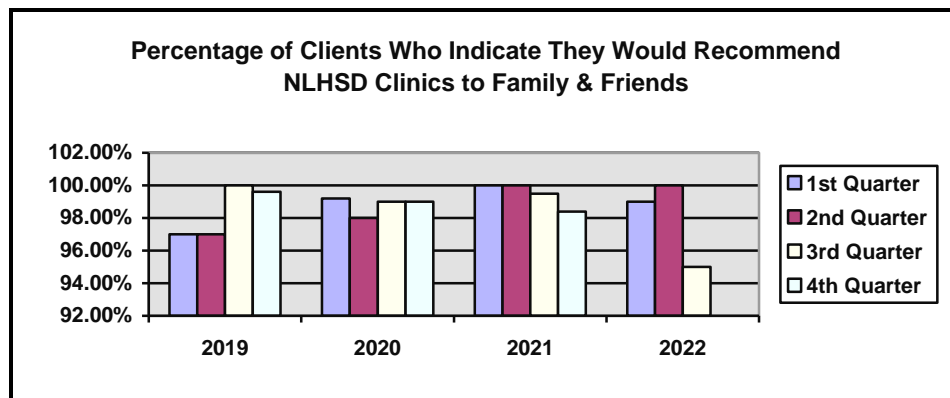
Objective I: Through administrative activity, Northwest Louisiana Human Services District will provide for the management and operational activities of services for addictive disorders, developmental disabilities and behavioral health.

Strategies:

- 1.1.1 Ensure communication with and support to the Board with regard to its work regarding governance policies.
- 1.1.2 Develop District operational policies and procedures, which support and build upon Board Governance Policies.
- 1.1.3 Provide programmatic leadership and direction to the programs of behavioral health (addictive disorders and mental health) and developmental disabilities services.
- 1.1.4 Educate staff on how services support the Board ENDs.
- 1.1.5 Modify services and develop metrics for measuring success in meeting END's expectations.
- 1.1.6 Conduct client satisfaction surveys to identify potential need for intervention.

Performance Indicators:

- Percentage of clients who indicate they would continue to receive services at NLHSD clinics if given the choice to go elsewhere (25303)
- Percentage of clients who indicate they would recommend NLHSD clinics to family and friends (25304)
- Total number of individuals served in the Northwest Louisiana Human Services District (25317)



Data obtained from the Louisiana Performance Accountability System (LaPAS)

Program B: Behavioral Health

Mental Health: Northwest Louisiana Human Services District catchment area provides for mental health outpatient clinic services for children, adolescents, adults and those with co-occurring disorders. Clinic based services include Information/Referral, Screening/Assessment/Evaluation, Community Psychiatric Supports and Treatment (CPST), Individual, Family and Group Counseling, Medication Management, Nursing Services, Peer Support and Wellness Recovery Action Plan (Wrap) Services, Pharmacy Services and Interagency Service Coordination. Contracted services include evidence-based practice Assertive Community Treatment Services, Case Management Services, Homeless Outreach, Mobile Crisis Services, Consumer Care Resources, Transportation and Supported Housing. Service delivery includes full participation in the specialized behavioral health services through the Healthy Louisiana Plans. All Behavioral Health clinics in the Northwest Louisiana Human Services District participate as Medicaid Application Centers for persons requesting services.

Addictive Disorders (AD): Alcohol and drug abuse continues to be a major health problem in our state as well as in the Northwest Louisiana Human Services District catchment area. The resources available are not sufficient to meet the growing need for treatment and prevention services. Northwest Louisiana Human Services District falls into this category when considering the vast geography covered in the service area, which limits inpatient service options. The same is true for outpatient services. The program has made significant strides to prioritize services to meet these crucial needs by encouraging and supporting the awareness and understanding of alcoholism and drug addiction amongst the citizens of our state. The basic premise of addictive disorder services is to develop ideas and programs that can help increase public

awareness, treat adults and youth who need AD services and prevent the abuse of alcohol and drug addiction as well as compulsive gambling. The largest barrier to success for addictive disorder programs is the ability to maintain patient gains made in outpatient and inpatient treatment. Sometimes the impulse to abuse substance and/or to participate in dysfunctional behavior is too great and the gains from treatment can be wiped out in an instant. The need to provide education on prevention at an early age is key to deterring abuse and the subsequent need for treatment. AD and prevention service providers focus their attention on providing comprehensive, fully integrated prevention and treatment services. We actively seek the assistance of partnerships and collaborations to fully meet the needs of individuals, families and communities. The needs of the individuals, families and communities requiring addictive disorder services and the consequences they suffer are the impetus to incorporate addictive disorders practices in the health care debate. The goal remains to seamlessly integrate these practices into the comprehensive health care system without losing attention to the special needs of individuals, families, communities requiring substance abuse intervention. Clinic based services provided include Information/Referral, Screening/Assessment, Nursing Services, Individual, Group and Intensive Outpatient Treatment. Contract services include Primary Prevention, Medical Detox, Residential Adult Treatment, Inpatient Adolescent Treatment and Gambling Treatment (Outpatient, Intensive Outpatient and Inpatient).

Mission

To increase public awareness of and to provide access to care and support to improve the quality of life of individuals with mental illness and addictive disorders through a broad range of programmatic and community based wellness and recovery promoting services.

Goals

Goal 1: Maintain Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation to ensure quality outcomes for the persons we serve, maintain ability to receive Medicaid reimbursement and utilize techniques that are efficient, cost-effective, and based on outcomes and consumer satisfaction.

Goal 2: Maximize financial viability so that the District is less dependent on State General Funds (SGF) and Block Grant Funds for the provision of services.

Objective I: To ensure access to quality wellness and recovery oriented mental health, substance use and prevention services for children, adolescents and adults in the NLHSD service area through use of strong partnership with providers, use of best practices and use of utilization management data such that access to care and client satisfaction thresholds are achieved.

Strategies:

- 1.1.1 Stay current on CARF accreditation standards through training and updated policies/procedures that support current accreditation standards.
- 1.1.2 Utilize ICANotes reporting systems to assess business activities and modify processes as needed to improve efficiencies.
- 1.1.3 Implement and expand billable services when feasible.

- 1.1.4 Enhance client engagement to improve client outcomes, reduce no-show rates and increase productivity through the use of evidence based practices, an automated telephone/email/text system for reminder calls and re-engagement sessions with clients.

Performance Indicators:

- Number of adults receiving mental health services in all NLHSD behavioral health clinics (25305)
- Number of children/adolescents receiving mental health services in all NLHSD behavioral health clinics (25306)
- Percentage of adults receiving mental health services who report that they would choose to continue to receive services from NLHSD if given a choice to receive services elsewhere (25307)
- Percentage of mental health clients who would recommend NLHSD services to others (25308)
- Percentage of mental health Flexible Family Fund slots utilized (25309)
- Percentage of individuals successfully completing the 24-hour residential addictive disorders treatment program (25310)
- Percentage of individuals successfully completing the Primary Inpatient Adolescent addictive disorders treatment program (25312)
- Total number of individuals served by outpatient mental health in Northwest Louisiana Human Services District (25318)
- Total number of individuals served by inpatient Addictive Disorders in Northwest Louisiana Human Services District (25319)
- Total number of individuals served by outpatient Addictive Disorders in Northwest Louisiana Human Services District (25320)
- Total number of enrollees in prevention programs (25321)

Program C: Developmental Disabilities

Developmental Disabilities core services consist of serving as the Single Point of Entry (SPOE) into the Developmental Disabilities (DD) Services System and providing support coordination services to individuals and their families through DD and other available community resources. Staff members assess the needs for support and services, develop individual plans of support, make applicable referrals, and

provide ongoing coordination for individual support plans. Targeted services are centered on Home and Community-Based Services Waiver programs and Federal criteria which allow services to be provided in a home or community-based setting for the recipient who would otherwise require institutional care.

The Family Support Program is designed to assist individuals whose needs exceed those normally met by use of existing resources in the community, and other natural resources available.

Individual and Family Supports services include but are not limited to: respite care, personal care assistance, specialized clothing, such as adult briefs, dental and medical services, equipment and supplies, communication devices, crisis intervention, specialized utility costs, specialized nutrition, and family education.

The Flexible Family Fund Program is designed to enable families to keep their children with severe disabilities in the home. It is designed to offset the extraordinary costs of maintaining their child in their own home. The program provides a monthly stipend to families of children who have qualifying exceptionalities identified through their local educational authority.

Mission

Provide access for individuals with developmental disabilities to integrated community based services while supporting individuals to achieve their personal outcomes, meet their needs and promote their independence through a broad range of programmatic and community resources in Northwest Louisiana.

Goals

Goal 1: Ensure the health and safety of individuals receiving home and community based waiver services.

Goal 2: Ensure state general fund dollars are used in an efficient and effective manner to best serve individuals with developmental disabilities.

Objective I: Through the Developmental Disabilities activity, to foster and facilitate independence for citizens with disabilities through the availability of home and community based services.

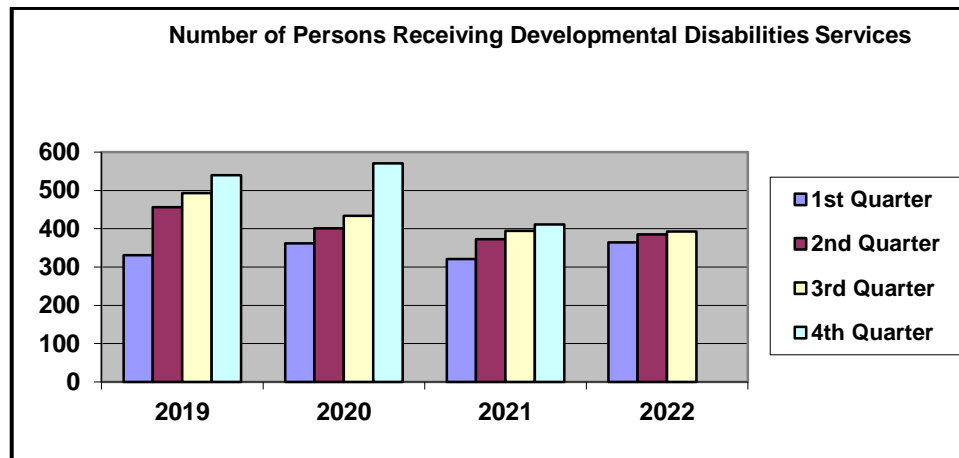
Strategies:

- 1.1.1 Serve as the Single Point of Entry (SPOE) into the Developmental Disabilities Services System providing support and coordination services to individuals and their families through community resources.
- 1.1.2 Family Support Committee will meet monthly to review requests for state general funding.
- 1.1.3 Ensure critical incidents are addressed in a timely manner in accordance with policy.
- 1.1.4 Ensure waiver cases are maintained properly in accordance with policy.

- 1.1.5 Monitor current recipients each quarter to ensure current eligibility for Flexible Family Funds.
- 1.1.6 Identify agencies, community organizations, and other available resources that can assist in supporting people with developmental disabilities to live full and productive lives in the community.

Performance Indicators:

- Number of persons receiving individual and family support services (25313)
- Number of persons receiving Flexible Family Fund services (25314)
- Percentage of eligibility determinations determined valid according to the Flexible Family Fund Provisions (25315)
- Number of persons receiving developmental disability services (25316)



Data obtained from the Louisiana Performance Accountability System (LaPAS)