



## State of Louisiana

Louisiana Department of Health  
Office of the Secretary

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

FROM: Drew Maranto  
LDH Undersecretary

A blue ink signature of Drew Maranto, written in a cursive style.

RE: FY 2025 Annual Management and Program Analysis Report (AMPAR)

DATE: December 4, 2025

In accordance with Louisiana Revised Statutes 36:8, the Louisiana Department of Health is submitting its Annual Management and Program Analysis Report (AMPAR) for the 2025 fiscal year. These reports summarize the activities of each LDH agency as it relates to management and program analysis, outstanding accomplishments, areas where we are making significant progress, and any specific management or operational issues that may exist.

If there are questions regarding these reports, you may contact Kevin Suire at 225.342.4305 ([Kevin.Suire2@la.gov](mailto:Kevin.Suire2@la.gov)).

**FY 2024-2025 AMPAR  
Agency Listing**

---

09-300 Jefferson Parish Human Services Authority

09-301 Florida Parishes Human Services Authority

09-302 Capital Area Human Services District

09-303 Developmental Disabilities Council

09-304 Metropolitan Human Services District

09-305 & 306 Medical Vendor Administration & Medical Vendor Payments

09-307 Office of the Secretary

09-309 South Central Louisiana Human Services Authority

09-310 Northeast Delta Human Services Authority

09-320 Office of Aging & Adult Services (OAAS)

09-324 Louisiana Emergency Response Network Board (LERN)

09-325 Acadiana Area Human Services District

09-326 Office of Public Health (OPH)

09-330 Office of Behavioral Health (OBH)

09-340 Office for Citizens with Developmental Disabilities (OCDD)

09-350 Office of Women's Health & Community Health

09-375 Imperial Calcasieu Human Services Authority

09-376 Central Louisiana Human Services District

09-377 Northwest Louisiana Human Services District

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-300 Jefferson Parish Human Services Authority

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Rosanna Dichiro

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

For each accomplishment, please discuss and explain each item below.

#### Accomplishment #1: Homeless Services Center/Homeless Continuum of Services.

- A. What was achieved?  
In May 2025, JPHSA, in partnership with a stakeholder, the Parish President's Office, and Council District 2 opened the Homeless Services Center. This Center provides a continuum of services for unhoused individuals from case management to housing placement. Other services include skills building (meal preparation), a clothing donation shop, and soon to have availability of showers/laundry (which will assist with job placement opportunities). JPHSA's Homeless Outreach staff and other potential stakeholders identify individuals that can benefit from the Center.
- B. Why is this success significant?  
It allows for a variety of services in Jefferson Parish to address the growing unhoused population, while also addressing the community concerns regarding this issue.
- C. Who benefits and how? All Jefferson Parish residents, both housed and unhoused, benefit.
- D. How was the accomplishment achieved? The accomplishment was achieved through collaboration with Jefferson Parish government, Jefferson Parish Council, local partners (both municipal government and social service agencies), and law enforcement. This

collaboration involved a year-long planning process to determine needs in the community, community readiness for the project, review of best practices across the country, and funding opportunities for sustainability.

- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, JPHSA's collaboration and partnership with our stakeholders in providing services in the community furthers our mission to help residents living in Jefferson Parish lead full, healthy, independent, and productive lives; thereby advancing the support of the sustainability of resources through the implementation of evidence-based and promising practices, which is the first goal of our strategic plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes, this model is a Best Practice.

### Accomplishment #2: Multi-disciplinary treatment team planning for individuals with complex behavioral health/primary care needs

- A. What was achieved?

A multi-disciplinary team responsible for identifying individuals with complex needs, and proactively developing a treatment strategy to address service recipient triggers and decrease exacerbating behaviors. The team consists of a lead from each team:

Administrative, behavioral health clinical and psychiatry, primary care, and nursing.

The plan includes instructions to schedule individual with all providers on the same day to assist with transportation issues; schedule appropriately to minimize wait times, also being mindful of barriers to attending appointments and assisting in real time; quickly checking-in and triaging to prevent triggers in our lobby, staff are continuously monitoring elevated behaviors so they can address quickly; and, keeping in constant communication while individual is present in the health center.

- B. Why is this success significant? Improves patient care and outcomes.
- C. Who benefits and how? Individuals served by having their needs fully and appropriately addressed without crisis or need for hospitalization. Crises for complex individuals can be traumatizing. Reducing need for hospitalization helps manage resources.
- D. How was the accomplishment achieved? Through review of existing processes, and proactive development of a new strategy to address an identified issue.
- G. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, this initiative furthers our mission to help residents living in Jefferson Parish lead full, healthy, independent, and productive lives; thereby advancing the support of the sustainability of resources through the implementation of evidence-based and promising practices, which is the first goal of our strategic plan.
- E. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes, multi-disciplinary teams that plan and organize care for patients with complex needs is a common practice.

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

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

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

Throughout Fiscal Year 2024-2025 JPHSA remained on target for its stated Strategic Plan Goals and Objectives. Strategies outlined in the Strategic Plan continued to be effective and were strengthened by a strong commitment to continuous Performance and Quality Improvement throughout every division and program within the agency.

- ◆ **Where are you making significant progress?** If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
  1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department’s contribution to the joint success?
    - Other? Please specify.
  2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

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

JPHSA made progress toward reaching this goal in Fiscal Year 2024- 2025. As discussed

above, JPHSA initiated a multi-disciplinary team process in its health centers to ensure prompt, effective, and continued care and services for individuals in need; and, a best practice to better serve the needs of the community in its Behavioral Health Community Services Division. JPHSA was able to maintain resources and utilized external resources to extend its reach.

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

JPHSA made progress toward reaching this goal in Fiscal Year 2024-2025.

Please note in particular:

- Throughout Fiscal Year 2024-2025, JPHSA used brand management as a recruitment tool.
  - JPHSA also used existing staff to talk about the Mission and their role in filling that Mission at various community stakeholder and outreach events throughout the year.
  - Throughout Fiscal Year 2024-2025, JPHSA continued to use online job postings for certain hard-to-fill positions beyond the State Civil Service website and its own website by recruiting on external websites including Indeed, LinkedIn, Facebook, and Handshake. Other recruitment efforts included advertising with professional networks, such as the local Behavioral Health Taskforce, outreach events, and collaborating with local colleges and universities.
  - Throughout Fiscal Year 2024-2025, JPHSA's Executive Management Team monitored staff member retention rates and ensured all staff members received appropriate monitoring, supervision, and development by continuing leadership development efforts using leadership concept focused discussions with key staff.
- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:
1. To what do you attribute this lack of progress? For example:
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
    - Is the lack of progress due to budget or other constraint?
    - Is the lack of progress related to an internal or external problem or issue? If

so, please describe the problem and any recommended corrective actions in Section III below.

- Other? Please specify.

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

None

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

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

No. If not, why not? JPHSA did not submit a revised Strategic Plan for 2018-2025 this Fiscal Year and continues to make strides to reach its current goals.

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

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

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

Each service area Division Director is required to develop and implement an annual plan in support of the JPHSA Strategic Plan. Directors provide written reports on progress to the Executive Director throughout the year.

Additionally, JPHSA implements PQI initiatives and provides on-going PQI training to key staff. Any JPHSA staff member can be designated as a Full or Ad-Hoc subject matter expert.

JPHSA uses its staff member electronic newsletter – *Have You Heard* – as a key tool for communicating with staff members about Strategic Plan Goals, Objectives, and Performance Indicators; policies and procedures; employee recognition; and organization operations. *Have You Heard* is published a minimum of once each week via the JPHSA email system with occasional special editions.

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

Regularly scheduled Executive Management Team meetings are used as group supervision, as forums for discussion of progress on meeting/exceeding goals, and for collaborative development of corrective action and/or Performance and Quality Improvement plans. The Executive Director holds the Executive Management Team accountable on both an individual and group basis for successful implementation of the JPHSA Strategic Plan, Annual Division Plans, and any Performance and Quality Improvement Initiatives. The Executive Director focuses a significant portion of the Executive Management Team members' performance reviews on their contributions to the Strategic Plan, PQI Initiatives, in accomplishing their Annual Plan objectives, and in their ability to lead and develop their divisions toward a culture of accountability, growth and development.

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

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

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

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

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

A. Problem/Issue Description

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

There are no department management problems that exist. JPHSA's culture of continuous Performance and Quality Improvement allows leadership to proactively identify and address problems in real time as they arise. Using data, JPHSA makes calculated changes to ensure ongoing seamless operations that best serve Jefferson Parish residents and the rest of the community.

B. Corrective Actions

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

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

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
  - a. If so:
    - What is the expected time frame for corrective actions to be implemented and improvements to occur?
    - How much progress has been made and how much additional progress is needed?
  - b. If not:
    - Why has no action been taken regarding this recommendation?

- What are the obstacles preventing or delaying corrective actions?
- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

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

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

A. Check all that apply.

**Internal audit**

JPHSA's Compliance & Performance Support (CPS) Division provides ongoing monitoring of service delivery, business, and administrative functions as well as staff development and supervision activities. Audit tools with identified criteria and standards are utilized; results are reported; and appropriate Performance and Quality Improvement and/or corrective actions are implemented. Further, the Executive Management Team (EMT), the Executive Director and key staff monitor JPHSA's performance using benchmarks set forth in Council on Accreditation standards and in adherence to federal, state, and local laws and regulations. Improvement and/or corrective action plans are developed and executed as needed. The Division monitors progress on plan implementation as well.

Each JPHSA Division establishes an annual plan containing measurable outcomes in support of the Strategic Plan. JPHSA's Finance Operations division

provides ongoing monitoring of JPHSA resources using standard accounting practices. Further, a fiscal monitor is assigned to each Division for ongoing monitoring of both budgets as well as grants and contracts, using standard accounting practices, and in the case of grants and contracts, the scope of work and deliverables as well as budgets. On-site monitoring of contractors is standard operating procedure with improvement or corrective action initiated as a need is identified.

**External audits (Example: audits by the Office of the Legislative Auditor)**

JPHSA goes through an annual audit through the Office of the Legislative Auditor. The Fiscal Year 2024-2025 audit is underway as of the time of this writing. The FY 23-24 audit had no findings.

The Louisiana Department of Health's Office of Behavioral Health (OBH) and Office for Citizens with Developmental Disabilities (OCDD) audit JPHSA as set forth in the Accountability Plan, i.e. ongoing data reporting, annual peer review, and annual on-site audit. The OCDD and OBH Fiscal Year 2024-2025 audits were conducted during the Fiscal Year, with JPHSA receiving no findings with minimal recommendations that were promptly addressed.

JPHSA underwent re-accreditation in FY 24 through Council on Accreditation. We received an expedited re-accreditation, with no findings or recommendations. We are fully re-accredited through February 2028.

- Policy, research, planning, and/or quality assurance functions in-house  
EMT has overall accountability for policy development and management, as well as for JPHSA's quality assurance functions. With regard to policy development and update, the JPHSA's policy workgroup has overall responsibility for ensuring legal and regulatory compliance. EMT, under the direction of the Executive Director, is also responsible for short- and long-term planning. The Executive Director informs and seeks consultation from the JPHSA Board of Directors as appropriate and according to Board policy and the Policy Governance Model. The Executive Director provides the Board with monitoring reports as specified in Board policy. The PQI Plan is reviewed annually, adjustments made as needed. All staff members complete annual PQI training. Accreditation standards are reviewed on an on-going basis for any updates/changes to standards and to ensure continued compliance. Further, in compliance with Council on Accreditation standards, JPHSA has a variety of time-limited work groups in place at all times.

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

Program performance is monitored on an ongoing basis utilizing the JPHSA

Strategic Plan, Operational Plan, Division-Specific Annual Plans, PQI Initiatives, Staff Development & Supervision Guidelines, and position-specific expectations. All have clearly stated goals/objectives and performance targets and/or outcome measures. Additionally, the annual Maintenance of Accreditation report required by the Council on Accreditation helps ensure adherence to accreditation program and service standards through ongoing monitoring on the division level. JPHSA also provides a variety of Evidence-based Practices (EBP) that are monitored closely throughout the year to ensure model fidelity.

- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)**  
JPHSA collects data, performs analysis, and reports outcomes/outputs into LaPAS on a quarterly basis. Notes of explanation are provided for positive and negative variances of 5% or more from quarterly Performance Indicator targets. Each note outlines any needed corrective action or process improvement activities. JPHSA also provides data or makes data available to the Louisiana Department of Health (LDH), Office for Citizens with Developmental Disabilities (OCDD), and the Office of Behavioral Health (OBH) on an ongoing basis and as required by contractual agreement. JPHSA is compliant with the LDH Human Services Accountability Plan, which contains an extensive array of outcome/output measures, many of which OCDD and OBH utilize in compiling data for their own LaPAS reports.
- In-house performance accountability system or process**  
JPHSA utilizes the following to model its performance accountability process: Council on Accreditation Standards and Rating System; JPHSA Staff Development & Supervision Guidelines in conjunction with the Louisiana Department of State Civil Service Performance Evaluation System; JPHSA's PQI Plan in conjunction with PQI Initiatives; JPHSA's legal and regulatory compliance in conjunction with applicable federal and state laws and regulations; ongoing internal monitoring with appropriate follow-up activity inclusive of the Evidenced-Based Program fidelity monitoring; and, ongoing data collection, mining, and analysis for decision support.
- Benchmarking for Best Management Practices**  
Developmental Disabilities services data is obtained through the Office for Citizens with Developmental Disabilities software. Comparative studies are enabled through other Local Governing Entities reporting into the LaPAS system as well as through benchmarking against national standards for evidence-based and best practices (Multi-Systemic Treatment, Functional Family Therapy, First Episode Psychosis Navigate Model, various Prevention

programming, Assertive Community Treatment, Supported Employment, Housing Programs etc). Research on Best Practice programs occurs prior to programmatic decision making. JPHSA's Financial System, Microsoft Dynamics GP, is a highly sophisticated system that allows detailed budget reporting, enabling the measurement of performance against quarterly targets and annual goals as well as identification of trends.

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

The CPS division reviews all contract statements of work and monitoring plans for legal and regulatory compliance prior to the contracts being approved for final signature, and the Executive Director has final approval on all contracts.

- Peer review
- Accreditation review  
JPHSA is fully accredited by the Council on Accreditation (COA). In Fiscal Year 2023-2024, JPHSA was awarded a four-year reaccreditation, the longest COA grants, without any findings or recommendations. JPHSA must also complete Maintenance of Accreditation on key standards yearly. JPHSA's next reaccreditation cycle will begin in Fiscal Year 2025-2026 with a reaccreditation deadline of February 29, 2028.
- Customer/stakeholder feedback  
JPHSA completes the Telesage Quality of Care Survey within its Health Centers on an ongoing basis. JPHSA also participates in the C'est Bon survey yearly with the Office of Behavioral Health. JPHSA invites confidential feedback in a variety of ways (in person, in writing, via email) and offers service recipients and their families the means of expressing their view of services received and/or other interactions with JPHSA. This feedback is received and processed by JPHSA's Quality Improvement Specialist, who ensures a response is provided to the individual who gave the feedback (if desired) within prescribed timelines, and tracks data for use in developing internal Performance and Quality Improvement initiatives. JPHSA requires contractors delivering community-based behavioral health services to field satisfaction surveys with their service recipients and to share results with

JPHSA. Staff members also have access to this same feedback process. The members of the Board of Directors, per the Policy Governance Model, actively engage in “community linkages” and report the outcomes of these community stakeholder interactions during each Board meeting. Additional feedback is obtained through active participation in the monthly Jefferson Parish Behavioral Health Task Force meetings, Children and Youth Planning Board, attendance by Executive Director and EMT in various local and state workgroups/committees, and in the quarterly Regional Advisory Committee meetings for Behavioral Health and Developmental Disabilities. JPHSA also participates on the Jefferson Parish Criminal Justice Collaborative.

Other (please specify):

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

Yes. Proceed to Section C below.

No Skip Section C below.

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

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

E-mail:

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-301 Florida Parishes Human Services Authority

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Richard Kramer

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

For each accomplishment, please discuss and explain each item below.

#### Accomplishment #1: Implementation of new Electronic Health Record

- A. What was achieved? A new electronic health record was implemented for the behavioral health services section of FPHSA
- B. Why is this success significant? Although, the implementation is still being completed and the system is not quite at it's final phase just yet, the new record will allow for better documentation, more efficient workflows, increased availability of data for decision making, and is optimized for Certified Community Based Health Centers (CCBHC)
- C. Who benefits and how? Clients will benefit through improved documentation and treatment planning, providers will benefit through improved workflows as documentation tools, management will benefit through improved availability of reports and data upon which to base decisions. All of these improvements will benefit the state and its citizens, in general, by improving efficiency and outcomes.
- D. How was the accomplishment achieved? The team evaluated EHR options and developed an internal implementation plan. Funds were used from a federal grant for implementation.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, it will help the organization in achieving all of the objectives related to

behavioral health services.

- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes, to the extent that finding the right technologies to support strategies makes the agency more efficient and effective.

### Accomplishment #2: Implementation of Capable Communities

- A. What was achieved? FPHSA sought to partner with employers in the region in order to provide employment opportunities for those affected by developmental disabilities.
- B. Why is this success significant? There are many individuals with disabilities in our state who are not given the opportunity to work in the community while employers often complain about a lack of qualified applicants.
- C. Who benefits and how? Individuals with developmental disabilities who can find gainful and rewarding employment. Employers who may identify a new pool of employees, some who may be uniquely qualified for certain roles.
- D. How was the accomplishment achieved? This is being accomplished by forming a task force with local employers willing to sign on to the project. The project is still early in its development but expected to grow and add employers.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, in that it helps improve community integration including opportunities to gain employment.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? It may be too early to say as this is a new project but it is hoped that the results will indicate so in the future.

## **II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- ◆ **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized? Yes, the strategic plan was updated within the past year and reflects the priorities of the organization.
- ◆ **Where are you making significant progress?** If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each: Implementation of CCBHC requirements and future accreditation represent a best practice model to provide community based behavioral health services.

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

The leadership team identified the CCBHC model as a preferred option for providing behavioral health services. We worked with a consultant to write a grant application and received the grant for CCBHC implementation.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? The implementation grant is a four year grant meant to support implementation of CCBHC requirements. It is expected that, during this period, both the organization and the state will be taking efforts to build a sustainable CCBHC model following the completion of the grant period.
- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:
    1. To what do you attribute this lack of progress? For example:
      - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
      - Is the lack of progress due to budget or other constraint?
      - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
      - Other? Please specify.
    2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?
  - ♦ **Has your department revised its strategic plan to build on your successes and address shortfalls?**

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

No. If not, why not?

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

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

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

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

#### A. Problem/Issue Description

1. What is the nature of the problem or issue? *The biggest problem continues to be a lack of resources ad related to staffing.*
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) *To the extent that we cannot serve as many people as we otherwise could, yes, but the overall goals are still appropriate but just at a reduced capacity.*
3. What organizational unit in the department is experiencing the problem or issue? *Primarily in outpatient behavioral health clinics.*
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) *People seeking services from us may see longer wait times before appointments.*
5. How long has the problem or issue existed? *The problem has existed for many years but was exacerbated by the trouble across all sectors following Covid. It has improved some in the past year but is still problematic.*
6. What are the causes of the problem or issue? How do you know? *There is an overall shortage in the state for the types of licensed providers we need and our*

*rate of pay is not as competitive as we'd like in order to be able to attract more applicants.*

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? *Numbers of people served is reduced and access to services may be delayed.*

#### B. Corrective Actions

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

No. If not, skip questions 2-5 below.

Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue? *Our human resources department is currently pursuing special entrance rate adjustments through the department of Civil Service*

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? *Not specifically*

4. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur? *We intend to have our proposal to Civil Service this fiscal year.*
- How much progress has been made and how much additional progress is needed? *The Department of Civil Service has made some pay scale changes already which provide some relief but do not go far enough for all positions.*

b. If not:

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

5. Do corrective actions carry a cost?

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs. *Unknown as of yet. This is being explored as a part of the process to request new rates.*

- b. How much has been expended so far? *N/A*
- c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts? *Possibly, but this can't be answered until further work has been done.*
- d. Will additional personnel or funds be required to implement the recommended actions? If so:
  - Provide specific figures, including proposed means of financing for any additional funds.
  - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

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

A. Check all that apply.

**Internal audit**

FPHSA's Behavioral Health and Development Disabilities Services conduct quarterly quality enhancement reviews and audits. Audit findings affords FPHSA the opportunity to monitor for trends and evaluate program efficacy as well as implement corrective actions, as indicated.

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

State of LA Civil Service, Office of Risk Management, LDH, Office of the Legislative Auditor, and the Healthy Louisiana Medicaid Plans are among those who conduct audits and reviews of FPHSA's processes, procedures and services. Corrective actions are devised and implemented in response to deficiencies. External audits may also be performed by other cohorts with whom FPHSA contracts for service delivery, such as Functional Family Therapy and the Courts. (See some examples captured below.)

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

- Performance Progress Reports (Louisiana Performance Accountability System)**  
 FPHSA participates in all required Louisiana Performance Accountability monitoring. This includes the compilation of reports of performance data such as data used by LDH's Division of Planning and Budget, which coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
- In-house performance accountability system or process**  
 FPHSA conducts in-house performance based monitoring activities that align with LDH's performance based accountability monitoring activities. Internal monitoring includes, but is not limited to strategic planning, operational planning, and self-monitoring using the same monitoring tools that the State uses to conduct its monitoring.
- Benchmarking for Best Management Practices**  
 The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary if modifications or additions are needed. FPHSA uses these benchmarks to set performance goals and objectives.
- Performance-based contracting (including contract monitoring)**  
 LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan. Subsequently, FPHSA uses these descriptions to structure any sub-contractors in order to support LDH's goals and objectives.
- Peer review (SCLHSA)  
 Accreditation review (CARF)  
 Customer/stakeholder feedback  
 Other (please specify):

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

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

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

1. Title of Report or Program Evaluation: ORM Full Risk Management Audit
2. Date completed: 3/6/2025
3. Subject or purpose and reason for initiation of the analysis or evaluation:  
Ensure client, staff, and all other stakeholders safety by providing a risk free environment. Minimize exposure for the State of Louisiana and Florida Parishes Human Services Authority.
4. Methodology used for analysis or evaluation: On-site completion of a 9 page tool that examines general safety (written policies and procedures) required inspections (OPH, ORM, OSFM), incident and investigation reporting (internal and related to employee injuries and facility physical plant issues), HR policies and procedures, Blood Borne Pathogens and First Aid training, Emergency Preparedness training, maintenance of State vehicles, security of records, key control, overall security of offices and equipment maintenance.
5. Cost (allocation of in-house resources or purchase price): NA
6. Major Findings and Conclusions:
  1. 1.1.3.1 Have these rules been: 1). Distributed ANNUALLY (via printed copy and/or electronically) to ALL EMPLOYEES with such action documented, and 2). posted in the facility for review by ALL EMPLOYEES? **NO**
  2. 1.4.3.2 Are all completed DA2000/DA3000 or equivalent form(s) from the prior fiscal year for all incidents/accidents available for review by the Loss Prevention Officer? **NO**
  7. Major Recommendations:
    1. Distribute safety rules ANNUALLY (via printed copy and/or electronically) to ALL EMPLOYEES with such action documented, and 2). post in the facility for review by ALL EMPLOYEES.
    2. Retain for review by the Loss Prevention Officer the completed DA2000/DA3000 or equivalent form(s) for all incidents/accidents.
    8. Action taken in response to the report or evaluation:  
Although FPHSA did not agree with the findings, FPHSA has put action in place to meet the rule in such a way that there is no doubt that we are in compliance.
    9. Availability (hard copy, electronic file, website):  
Results and all supporting documentation available from the RM coordinator in e-file or paper.
    10. Contact person for more information  
Name & Title: Richard Kramer, Executive Director  
Agency & Program: FPHSA  
Telephone: (985) 543-4333  
E-mail: [Richard.Kramer@fphsa.org](mailto:Richard.Kramer@fphsa.org)

1. Title of Report or Program Evaluation: Accountability Plan (AP) Behavioral Health

2.Date completed: 8/5/2024 – 8/8/2024 and 1/27/2025 – 1/29/2025

3.Subject or purpose and reason for initiation of the analysis or evaluation:

The Human Services Accountability Plan (AP) was developed in accordance with the provisions of LA. R.S. 28:918 in conjunction with the Human Services Interagency Council and the Louisiana Department of Health, to guide the delivery of substance use disorder, mental health, and developmental disability services funded by appropriations from State, gambling, and block grant dollars. As part of the AP, the Local Governing Entity (LGE), and service subject to monitoring.

4.Methodology used for analysis or evaluation:

5. Review conducted by OBH and guided by the LGE Monitoring Workbook Tool.

6.Cost (allocation of in-house resources or purchase price): NA

7.Major Findings and Conclusions:

**August 2024 Review:**

**Findings across all sites:**

- Collection of "Improved Functioning/Reduction in Symptoms Severity" outcomes could not be found.
- Collection of "Social Connectedness" outcomes could not be found.
- No MH Outpatient Consumer Satisfaction Surveys were found for these two indicators at this facility.

**January 2025 Review**

**Findings across sites:**

- Client was notified that the LGE shall comply with federal law and regulations regarding provisions of the confidentiality of Alcohol and Drug Abuse Patient Records codified as 42 U.S.C. 290dd-2 and 42 CFR Part 2 and shall establish appropriate safeguards that protect the confidentiality of patient records could not be found

8.Major Recommendations: Take the necessary steps to come into compliance.

9.Action taken in response to the report or evaluation:

**August 2024**

The results of FPHSA's investigation into the failure to collect this information provided guidance on next steps. Consults with Shamim Akhter (OBH data team) and James Brock (Telesage) concluded that the cause of the deficiency was two-fold. 1. Staff was not completing as the completion schedule requires, and 2. the Telesage system was malfunctioning. Both issues have been addressed, and deficiencies should be fully resolved resulting in positive outcomes at the next survey.

**January 2025**

Charts were flagged with a notification that at the next visit, staff needed to secure signatures document the completion of the outpatient Acknowledgments and Authorizations document. This document attests that the clients are in receipt of the FPHSA Privacy Handbook with all information listed in the findings.

10. Availability (hard copy, electronic file, website):

11. Contact person for more information:

Name & Title: Richard Kramer, Executive Director

Agency & Program: FPHSA

Telephone: (985) 543-4333

E-mail: [Richard.Kramer@fphsa.org](mailto:Richard.Kramer@fphsa.org)

1. Title of Report or Program Evaluation: **LaPAS Quarters 1-4 (DDS)**

2. Date completed: Q1 – 10/17/24, Q2 – 1/29/25, Q3 – 4/24/25, Q4 – 8/7/25

3. Subject or purpose and reason for initiation of the analysis or evaluation: Developmental Disabilities Services (DDS) will provide services that emphasize person-centered individual and family supports to people with developmental disabilities. Delivery of services will result in an increased percentage of people within the FPHSA catchment area that remain in the community rather than being institutionalized.

4. Methodology used for analysis or evaluation: LaPAS calculation methodology

5. Cost (allocation of in-house resources or purchase price): None

## 6. Major Findings and Conclusions:

Q1 – The fourth quarter total Individual and Family Support Services target and the total unduplicated number of individuals receiving community-based services was decreased below the Fiscal Year Standard to capture the decrease in individual and family support disposable undergarment requests due to funding in the Home and Community Based waivers for adults and the increase in fully funding other individual and family support requests.

The fourth quarter total unduplicated number of individuals receiving Individual and Family Support Crisis Services target was increased to above the Fiscal Year Standard to capture the increase in the number of fully funded rent requests, the increased cost of rent to remain in community and the increased family support requests submitted through Entry and Act 421

Q2 – The cost of requested Individual and Family Support services has increased; therefore, agreements were funded at higher amounts. More agreements were fully funded. More individuals than anticipated were provided diversion services to help them remain in the community. There was a decrease in individuals referred for the PASRR nursing home service process than anticipated.

Q3 – The costs associated with the requested Individual and Family Support services have risen, resulting in agreements being allocated higher funding amounts. Consequently, a greater number of agreements received full funding. Additionally, there has been a reduction in the requests for individual and family support undergarments, alongside an increase in fully funded individual and family support requests. This resulted in fewer individuals being served.

The methodology used to establish the PASRR targets for Quarters 1 through 3 was flawed, leading to an underestimated target and incorrect data for Q1 and Q2.

Q4 – Although a high volume of requests was received in Quarters 1 through 3, it was anticipated that this trend would continue into Quarter 4. However, fewer requests were submitted in Q4 than expected, leading to a lower total number of individuals served than originally projected. This shortfall in Q4 demand, combined with higher per-agreement funding and expanded access to other supports, contributed to the program not meeting its overall service target. More individuals were referred for the PASRR nursing home service process than anticipated. Fourteen (14) waiver participants out of 2,323 admitted to a more restrictive setting; this is a positive outcome.

An Individual and Family Support Q3 data entry error was corrected in Q4. Q3 participants were marked as non-diversion and changed to diversion in Q4. This impacted the data in Q3 and Q4.

## 7. Major Recommendations

Q1 – Change the Total Unduplicated Number of Individuals Receiving Community Based Services, the Total unduplicated number of individuals receiving Individual and Family Support service and Total unduplicated number of individuals receiving Individual and Family Support Crisis services Quarter 4 target.

Q2 – N/A

Q3 – Increase the PASRR target for Quarter 4. Calculate Q1 and Q2 PASRR data using the correct calculation methodology. Recalculate the Total Unduplicated Number of Individuals Receiving Community-based services.

Q4 – Recalculate the Individual and Family Support data and the Individual and Family Support

Diversion data.

8. Action taken in response to the report or evaluation:

Q1 – The Total Unduplicated Number of Individuals Receiving Community Based Services and the Total unduplicated number of individuals receiving Individual and Family Support service were decreased. The Total unduplicated number of individuals receiving Individual and Family Support Crisis services Quarter 4 target was increased.

Q2 – N/A

Q3 – The PASRR target for Quarter 4 was raised. The Q1 and Q2 PASRR data was recalculated using the correct calculation methodology. The Total Unduplicated Number of Individuals Receiving Community-based Services was recalculated using the corrected PASRR data for Q1 and Q2.

Q4 – Individual and Family Support data and the Individual and Family Support Diversion data were recalculated. The Total Unduplicated Number of Individuals Receiving Community-based Services was not impacted.

9. Availability (hard copy, electronic file, website) Available in hard copy and electronic file.

10. Contact person for more information, including

Name: Richard Kramer

Title: Executive Director

Agency & Program: FPHSA

Telephone: (985) 543-4333

E-mail: [Richard.Kramer@fphsa.org](mailto:Richard.Kramer@fphsa.org)

1. Title of Report or Program Evaluation: **Accountability Plan (AP) Quarters 1-4 (DDS)**

2. Date completed: Q1 – 10/25/24, Q2 – 1/30/2025, Q3 – 5/1/2025, Q4 – 7/25/2025

3. Subject or purpose and reason for initiation of the analysis or evaluation: The purpose of Section II of the AP Annual On-site Monitoring Preliminary Report is to provide results from validating the accuracy of performance indicator data reviewed on-site according to the operational instruction #F-7 Quality Partnership: Reporting and Verification of Performance Measures and Quality Management Initiatives for Developmental Disabilities Services.

4. Methodology used for analysis or evaluation: The monitoring goal is verification of Performance Measures and Quality Management Initiatives for Developmental Disabilities Services through records reviews. Monitoring occurs on an annual basis for performance indicators shown in the outcome measures in Section II: D of the Human Services Accountability Plan (AP) as agreed by the Office for Citizens with Developmental Disabilities (OCDD) and the Human Service Interagency Council (HSIC). Records are also reviewed for your Systems Entry Program, Individual and Family Support Program, Flexible Family Fund (FFF) Program, Preadmission Screening and Resident Review (PASRR) Program, New Opportunities Waiver (NOW), Children's Choice (CC) Waiver, Supports Waiver (SW) and Residential Options Waiver (ROW) to determine compliance with program policies and guidelines. Each LGE is expected to review its performance indicator data results, develop, and implement a Corrective Action Plan (CAP) when a performance standard is not met. OCDD Central Office is responsible for reviewing CAP(s) and providing technical assistance based on the best and promising practices and services provided that are consistent with statewide strategies and evidence-based principles.

5. Cost (allocation of in-house resources or purchase price): No costs reported.

6. Major Findings and Conclusions:

Q1-4 - PI# 9 The calculation methodology for the percentage of waiver persons aged 18-59 receiving NOW, ROW or SW services employed in the community changed. The performance indicator was

consistently met all quarters.

Q4 - PI #21, The percentage of applications for ICF/DD admissions that were completed within five (5) working days was not met in Quarter 4. The recent transition of a staff member into the role responsible for completing community home placement referrals contributed to this occurrence.

7. Major Recommendations

Q1-3 – NA

Q4 - PI#21, The timely completion of applications for ICF/DD will be monitored closely during fiscal year 2026. A corrective action plan was not warranted.

8. Action taken in response to the report or evaluation:

Q1-3 – N/A

Q4 - PI #21, The staff member was instructed on the timeline for completing ICF/DD admission applications.

9. Availability (hard copy, electronic file, website) electronic file: Hard copy and electronic file are available.

10. Contact person for more information, including

Name: Richard Kramer

Title: Executive Director

Agency & Program: FPHSA

Telephone: (985) 543-4333

E-mail: [Richard.Kramer@fphsa.org](mailto:Richard.Kramer@fphsa.org)

1. Title of Report or Program Evaluation: **Flexible Family Fund Quarters 1-4**

2. Date completed: Q1 – 10/10/24, Q2 – 1/24/25, Q3 – 4/23/25, Q4 – 7/21/25

3. Subject or purpose and reason for initiation of the analysis or evaluation: An internal performance review of administration of the Flexible Family Fund (FFF) program for compliance with criteria established in the promulgated rule and published in the Louisiana Register (LAC 48:I Chapter 161) and the FFF manual. The question, “Was all the documentation present to make the eligibility determination present?”, is used for the Accountability Plan question #3.

4. Methodology used for analysis or evaluation: See FFF Manual Appendix B Forms 9.a, 9.b and 9.c

The internal performance review will consist of a quarterly review of the following:

- a. no less than 10% of the total number of currently active Flexible Family Fund records (an annual total of 40% of active records) with representation of every practitioner;
- b. a random sampling of at least one record for each year of the LGE’s Service Request List; and
- c. a random sampling of one of the records closed per quarter by that LGE.

5. Cost (allocation of in-house resources or purchase price): None

6. Major Findings and Conclusions: Q1 – Q4 In compliance

7. Major Recommendations: Q1 – Q4 N/A

8. Action taken in response to the report or evaluation: Q1 – Q4 N/A

9. Availability (hard copy, electronic file, website) electronic file: Report in hard copy or electronic file

10. Contact person for more information, including

Name: Kasey Hill  
Title: Community Service Manager  
Agency & Program: FPHSA – Pride Drive, Developmental Disabilities Services  
Telephone: 985-543-4730, ext. 1105  
E-mail: kasey.hill@fphsa.org

1. Title of Report or Program Evaluation: **Individual and Family Support Quarters 1-4**

2. Date completed: Q1 – 10/10/24, Q2 – 1/24/25, Q3 – 4/23/25, Q4 – 7/21/25

3. Subject or purpose and reason for initiation of the analysis or evaluation: An internal performance review of active Plans of Support to ensure compliance with program guidelines and quality of service delivery to persons requesting and receiving Individual and Family Supports. The following questions from the monitoring form are used for the Accountability Plan: Does the record contain a prioritization instrument? Reflect the participant’s personal outcome goals to adequately justify the need for a service? Have appropriate billing forms, instructions and documents necessary to complete expenditure been provided to the individual/family?

4. Methodology used for analysis or evaluation: See IFS Manual Appendix A, Form 6

The internal performance review will consist of a quarterly review of at least 10% of the total number of active IFS Plans of Support.

5. Cost (allocation of in-house resources or purchase price): None

6. Major Findings and Conclusions: Q1 – Q4 In compliance

7. Major Recommendations: Q1 – Q4 N/A

8. Action taken in response to the report or evaluation: Q1 – Q4 N/A

9. Availability (hard copy, electronic file, website) electronic file: Report in hard copy or electronic file

10. Contact person for more information, including

Name: Kasey Hill  
Title: Community Service Manager  
Agency & Program: FPHSA – Pride Drive, Developmental Disabilities Services  
Telephone: 985-543-4730, ext. 1105  
E-mail: kasey.hill@fphsa.org

1. Title of Report or Program Evaluation: **LOC POC Quarters 1-4**

2. Date completed: Q1 – 9/30/24, Q2 – 12/27/24, Q3 – 3/31/2025 , Q4 – 6/30/2025

3. Subject or purpose and reason for initiation of the analysis or evaluation: The Level of Care Plan of

Care (LOC POC) Quality Review is a method of obtaining information for CMIS related to the waiver assurance requirements. LOC POC reviews the percentage of waiver plans, initials and annuals, that were approved in the previous quarter. A random sample of names is selected by the OCDD Data System LOC POC Application.

4. Methodology used for analysis or evaluation: See LOC POC quality review form and appendix B interpretive guidelines. The data is entered in the OCDD Data System LOC POC Application.
5. Cost (allocation of in-house resources or purchase price): None
6. Major Findings and Conclusions: Q1 – Q4 In compliance
7. Major Recommendations: Q1 – Q4 N/A
8. Action taken in response to the report or evaluation: Q1 – Q4 N/A
9. Availability (hard copy, electronic file, website) electronic file: Report in hard copy or electronic file
10. Contact person for more information, including

Name: Andrea Albert  
 Title: Program Monitor  
 Agency & Program: FPHSA – Pride Drive, Developmental Disabilities Services  
 Telephone: 985-543-4730, ext. 1126  
 E-mail: andrea.albert@fphsa.org

1. Title of Report or Program Evaluation: **Preadmission Screening and Resident Review (PASRR) Supervisory Review Checklist Quarters 1-4**

2. Date completed: Q1 – 10/24/24, Q2 – 1/24/25, Q3 – 4/23/25, Q4 – 7/21/25
3. Subject or purpose and reason for initiation of the analysis or evaluation: An internal performance review of PASRR adult nursing home admissions to ensure compliance with the Operational Instruction and appropriate placement. All Case Record Review questions from the monitoring form are used for the Accountability Plan.
4. Methodology used for analysis or evaluation: See PASRR O.I. #D-10, Appendix C-3  
 The internal performance review will consist of a quarterly review of 50% of PASRR referrals who were new admissions to the nursing home.
5. Cost (allocation of in-house resources or purchase price): None
6. Major Findings and Conclusions: Q1 – Q4 In compliance
7. Major Recommendations: Q1 – Q4 N/A
8. Action taken in response to the report or evaluation: Q1 – Q4 N/A
9. Availability (hard copy, electronic file, website) electronic file: Report in hard copy or electronic file
10. Contact person for more information, including

Name: Kasey Hill  
Title: Community Service Manager  
Agency & Program: FPHSA – Pride Drive, Developmental Disabilities Services  
Telephone: 985-543-4730, ext. 1105  
E-mail: [kasey.hill@fphsa.org](mailto:kasey.hill@fphsa.org)

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-302 Capital Area Human Services District

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Executive Director:** Janzlean Laughinghouse, Ph.D., LCSW-  
BACS, LAC

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

For each accomplishment, please discuss and explain each item below.

#### **Accomplishment #1: CCBHC Grant Update – Opening of Total Health and Wellness Clinic**

A. What was achieved?

CAHSD opened its Total Health and Wellness Clinic, which is conveniently located downstairs from CAHSD's Baton Rouge Behavioral Health/Addiction Recovery Services outpatient clinic and next door to our contracted pharmacy. The CAHSD Total Health and Wellness Clinic provides primary health care that includes preventive care, first point of contact sick visits, identification and treatment of common medical conditions, comprehensive care, full physical exams, gynecological exams, STI/STD testing, onsite lab services, referrals to specialists, and continuing care.

B. Why is this success significant?

CAHSD's Total Health and Wellness Clinic offers a "one stop shop" to serve the physical health needs of our adult clients with mental illness and/or substance use disorders, especially those who are low income and lack dependable transportation which are barriers to healthcare access.

C. Who benefits and how?

CAHSD's adult clients (ages 18+) with mental illness and/or substance use disorders can be referred to the CAHSD Total Health and Wellness Clinic for primary health care if they do not already have a primary care provider. No one is denied access to services due to inability to pay, and there is a discounted/sliding fee schedule available based on family size and income. CAHSD's medical and behavioral health physicians, nurse practitioners, nurses, therapists, case managers, and peer support specialists work together to manage the care of CAHSD clients in one place and within one set of health records for whole health care coordination.

D. How was the accomplishment achieved?

CAHSD was able to use existing office space and medical equipment to set up the Total Health and Wellness Clinic. CAHSD also repurposed existing staff positions funded by self-generated revenue and assigned them to the clinic. SAMHSA Certified Community Behavioral Health Clinic-Planning, Development, & Implementation (CCBHC-PDI) grant funding awarded to CAHSD was utilized to fund the clinic nurse position that is responsible for conducting outpatient primary care screening and monitoring of key health indicators and health risk for the population of focus, which is one of the core services provided by CCBHCs.

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

Yes.

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

Yes.

Accomplishment #2: Community Narcan Trainings and Kit Distributions & Community Health Fair in previous year

A. What was achieved?

18 Narcan trainings with a total of 308 attendees was completed during FY2024-2025.

A total of 439 Narcan kits were distributed.

**Naloxone Training Dates/Locations:**

08/14/2024: Rubicon Chemical Plant (Medical Department), Geismar, LA

09/19/2024: MAT Clinic, Baton Rouge, LA

09/19/2024: Aetna, Baton Rouge, LA

10/15/2024: Hope Resuscitated, Baton Rouge, LA  
 10/10/2024: Pointe Coupee Homebound Hospice, New Roads, LA  
 10/23/2024: West Feliciana Hospital, St. Francisville, LA  
 10/30/2024: Array of Hope, Baton Rouge, LA  
 12/09/2025: The Reach Center, Baton Rouge  
 02/04/2025: Life House University, Gonzales, LA  
 02/24/2025: Life House University (male facility #2), Gonzales, La  
 03/06/2025: Ascension Sheriff Officers, Gonzales, LA - Session #1  
 03/25/2025: Ascension Sheriff Officers, Gonzales, LA - Session #2  
 03/27/2025: Ascension Sheriff Officers, Gonzales, LA - Session #3  
 04/02/2025: Women's Recovery, CAHSD Wooddale office, Baton Rouge, LA  
 04/11/2025: East Baton Rouge Juvenile Court Staff, Baton Rouge, LA  
 05/15/2025: US Probation/Federal Court, Baton Rouge, LA  
 05/31/2025: Love Impact Health Event, Baton Rouge, LA  
 06/25/2025: AmeriHealth Caritas of Louisiana, Baton Rouge, LA

In the previous fiscal year, CAHSD held a Community Health Fair on November 4, 2023, from 9 a.m. to noon, at its Baton Rouge Behavioral Health location on Wooddale Blvd. in Baton Rouge.

B. Why is this success significant?

Narcan training and distribution is significant because it saves lives, empowers communities, and strengthens public health. Narcan trainings allow CAHSD to educate and train first responders and individuals who work with or have contact with any individual who may be at risk of opioid overdose. Training includes how to administer Narcan in cases of suspected overdose.

The CAHSD Community Health Fair was an interactive event that offered medical screenings, alcohol, tobacco and other drug prevention, and education to the community.

C. Who benefits and how?

Narcan training and distribution benefits everyone, from individuals, and families to whole communities, by saving lives, building confidence, and reducing harm. During Narcan trainings and distribution, participants learned how to recognize the signs of opioid overdose, properly administer Narcan, and each were provided with free doses to take with them while equipping the community with life-saving knowledge and tools.

The community benefits. The health fair provided a central location for people to get useful information and interact with more than 23 vendors and sponsors to receive blood pressure and glucose checks, COVID-19 and flu vaccinations and screening and brief interventions for anxiety, depression, and problem gambling by licensed mental health professionals.

D. How was the accomplishment achieved?

The accomplishment was achieved by delivering comprehensive education on recognizing and responding to opioid overdose and by distributing free Narcan kits to the community, made possible through support from the LaSOR 4.0 grant.

The CAHS Health Fair was achieved by organizing, promoting and partnering with sponsors including Priority Care, Smoothie King, Coca Cola, WellCare, the City of Baton Rouge and the Office of Mayor-President Sharon Weston Broome.

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

Yes.

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

Yes.

Accomplishment #3: Prevention/ARS (Community outreach & faith-based initiatives)  
Driving Into Recovery/Recovery Sundays

A. What was achieved?

By hosting Driving Into Recovery and Recovery Sundays events, the community achieved greater awareness of recovery resources, reduced stigma around substance use, and created supportive spaces that connected individuals and families to hope, healing, and local services.

CAHS conducted 7 Driving into Recovery events and 6 Recovery Sundays events during FY2024-2025.

B. Why is this success significant?

This success is significant because Driving Into Recovery and Recovery Sundays events brought the community together to celebrate recovery, reduce stigma, and connect individuals and families with vital prevention, treatment, and support resources, showing that recovery is possible and that no one has to walk the journey alone.

C. Who benefits and how?

By attending the Driving into Recovery events, the community had an opportunity to receive an abundance of resources from CAHSD and partnering sponsors including food boxes, children's diapers, health insurance resources, and information about mental and physical health, substance misuse, prevention, and addiction recovery while remaining in the comfort of their vehicles.

By attending Recovery Sundays, community residents benefited by being informed of the harms of substance misuse and how to get help if they or someone they know has a substance misuse problem.

D. How was the accomplishment achieved?

These initiatives were accomplished by partnering with communities of faith and social services vendors in Region 2.

- Greater Baton Rouge Food bank
- Priority Care
- AETNA
- Coca-Cola Bottling Company
- WellCare
- Healthy Blue
- Humana
- Set Free
- Clear Minds Behavioral Health
- Crossroad Recovery Center of Louisiana
- Provost Memorial Hospital
- Grandparents Raising Grandchildren
- The Bridge Center of Hope
- Nurse Family Partnership
- Tobacco Free Living
- Discovery Renew Family Resource Project
- Louisiana Department of Health and Hospital
- Families Helping Families
- East Baton Rouge Parish Library
- Pennington Biomedical Research
- Love Me on Purpose
- Christian Outreach
- Open Health
- Metro Health
- Ascension Parish Library
- NAMI Louisiana
- Elks Lodge
- AmBetter
- Care South Health System
- Department of Public Health
- LifeShare Blood Bank
- Louisiana Spirit
- START Corporation
- East Baton Rouge Sheriff Department
- Family Services of Greater Baton Rouge

## Driving into Recovery 2024-2025 Dates/Locations:

03/17/2024 in Plaquemine, LA  
 06/08/2024 in Port Allen, LA  
 09/28/2024 in New Roads, LA  
 12/14/2024 in St. Francisville, LA  
 04/26/2025 in Clinton, LA  
 05/24/2025 in Baton Rouge, LA  
 09/27/2025 in Gonzales, LA

## Recovery Sundays 2024-2025 Dates/Locations:

04/28/2024: Donaldson Chapel Baptist Church, Baton Rouge, LA  
 07/01/2024: The Church of God, Baton Rouge, LA  
 08/11/2024: Elevate Church, Baton Rouge, LA  
 09/08/2024: Beacon Light of Baton Rouge, Baton Rouge, LA  
 04/13/2025: New Canaan Baptist Church, Baton Rouge, LA  
 05/11/2025: Sweet Home Baptist Church, Baton Rouge, LA

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

Yes.

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

Yes.

Accomplishment #4: School Based Summer Enrichment & Services provided during the year:

- A. What was achieved?

One hundred seventy-three (173) children attended CAHSD's School Based Summer Enrichment Camps at eight area schools in five parishes. Additionally, during the 24-25 school year, 9,250 clinical services were provided by the 23 Masters level clinicians. Finally, one of our school based behavioral health clinicians was recognized by the East Feliciana School Board as the School Health Provider of the Year for East Feliciana Parish for her excellent work over many years. Our program was also requested to expand into additional schools demonstrating the excellence support for our program by the school systems in which we work.

- B. Why is this success significant?

The camps are significant because CAHSD is able to provide continuity of care and summer services close to the clients' homes.

C. Who benefits and how?

The beneficiaries are school-aged children, with behavioral health challenges, and their families who are served via the CAHSD school-based behavioral health program during the school year. Through adventure-based indoor and outdoor activities, children are taught important life skills, such as showing kindness, problem-solving, effective communications, and coping. Students also learned about impulse control, bullying, mindfulness, and positive self-esteem.

D. How was the accomplishment achieved?

CAHSD School Based Behavioral Health Program therapists staffed the Summer Enrichment Programs, facilitating indoor and outdoor activities.

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

Yes

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

Yes, this accomplishment is an innovative way to engage clients during the summer months and youth get the opportunity to practice the skills learned in a fun and exciting manner.

Accomplishment #5: Community Education/Prevention: (trainings/events to spread awareness of services) including Crisis Intervention Team (CIT) training with law enforcement officers, workshops with local schools and employers, and other community events including "Hope to Heal" Behavioral Health Symposium.

A. What was achieved?

Secured professional continuing education credits for all workshops (social workers/counselors), Standardization of CAHSD Operations, aligned Carelogic workflow with CCBHC requirements & developed tracking methods for quality measures.

**Community Education/Workshops:**

03/2025: BRPD Academy 40-hr CIT Training (7 trainees)

11/2024: Louisiana Probation & Parole POST Academy 8-hr CIT Training (25 trainees)

08/2024: Intermediate Motivational Interviewing CEU (60 registrants)

11/2024: Motivational Interviewing for Medical Case Management (11 registrants)

01/2025: Turning the Tide-Reducing Overdose Deaths through Treatment & Recovery (53 registrants)

04/2025: Build Trust Doing Motivational Interviewing & Dialectical Behavior Therapy (91 registrants)

CAHS representatives participated in the 4<sup>th</sup> Annual Senior Black American Health Fair, held April 12, 2025, at the C.B. Pennington Biomedical Research Center in Baton Rouge. The event attracted more than 400 attendees.

B. Why is this success significant?

All CAHSD mental health professionals and persons in the community had an opportunity to obtain CE hours to renew licensure. Improved client intake experience by quicker/stream-lined process, increased access to care & submission of required reports towards gaining CCBHC certification.

Annual Senior Black American Health Fair, held April 12, 2025, at the C.B. Pennington Biomedical Research Center in Baton Rouge attracted more than 400 attendees.

C. Who benefits and how?

Clients, MHPs and the agency benefits because CAHSD is contributing to the continued competence of providers thus improving care quality.

The community benefits. Attendees who participated in a healthy-aging panel discussion, received various health screenings, visited with vendors, and engaged in fun activities that included line dancing, bingo, virtual reality, exercising and stretching, and lawn games.

D. How was the accomplishment achieved?

Gathering/submitting applications to respective boards, securing qualified presenters, and developing trainings on relevant practice topics. Had several ongoing meetings to understand current processes and develop revised process. Meeting with Data Analyst and CCBHC Program Manager.

CAHS Program Monitor Supervisor Yolanda Yancy, RPP, and Program Monitor Tamara Jones, PSIT, educated attendees about CAHS' various services, the dangers of vaping, binge drinking and other drugs. They also distributed promotional items and treated attendees to "spin the wheel" for prizes. Other vendors included Our Lady of the Lake Health, Louisiana Blue, CareSouth, AT&T, Humana, Ochsner Health, NAMI Louisiana, Ageless Healthcare, and the LSU AgCenter.

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

Yes. B.1.c

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

### Accomplishment #6: Youth Mental Health Awareness Campaign

- A. What was achieved?

In March 2025, in an effort to raise awareness about mental health, CAHS partnered with Youth City Lab to launch a youth Mental Health awareness campaign.

- B. Why is this success significant?

According to the National Alliance on Mental Illness (NAMI), about 17% of youth, ages 6 to 17, experience a mental health disorder, and suicide is the second-leading cause of death among youth between the ages of 10 and 14.

- C. Who benefits and how?

Youth, ages 6 to 17.

- D. How was the accomplishment achieved?

A video entitled “Nobody Knows” was created to illustrate the real concerns of youth and their struggles with anxiety, depression and self-doubt. Posters expressing positive messages about self-acceptance, self-love and support were distributed to public and private area schools within Region 2.

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

Yes.

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

## **II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- ◆ **Please provide a brief analysis of the overall status of your strategic progress.** What

is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

Capital Area Human Services District (CAHSD) operates under two separate plans, a strategic plan with the state, and an internal operational plan. We, as a political subdivision of the state of the Louisiana, participate in the state-wide LaPAS Performance Based Budgeting and Planning process which establishes common goals and objectives with pre-set performance standards used to establish funding needs and efficient use of allocated resources. The District is on target with the expected accomplishments set forth in this plan.

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

- ♦ **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
  1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
    - Other? Please specify.

CAHSD has made significant progress with our integrated care model. In October 2024, the agency opened its onsite primary care clinic to provide medical services for CAHSD clients who receive services for behavioral health conditions. CAHSD leveraged funds from the Promoting the Integration of Primary and Behavioral Health Care and the Certified Community Behavioral Health Clinic grants to procure equipment and qualified personnel for the clinic. Other staffing is provided by reallocation of staff in existing areas. By January of 2025, the clinic had 400 regular patients who accessed care for their chronic health conditions such as obesity,

hypertension, and diabetes. They also received preventative care such as annual exams.

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

CAHSD estimates that this progress is a one-time gain because of the new service line; however, we do expect to continue adding individuals to the patient load over time.

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

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

None

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

N/A

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

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

N/A

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

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

The CAHSD Executive Board requires semi-annual and year end progress reports to ensure progress is made for selected services and initiatives.

**III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?** (“Problems or issues” may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. “Problems or issues” may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. “Problems or issues” may or may not be related directly to strategic plan lack of progress.)

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

**A. Problem/Issue Description**

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

A potential issue that could cause issues with operations and service delivery is ACT 351, the 2025 law require state agencies that provide public assistance to collect and report information of ineligible applicants to U.S. Immigration and Customs Enforcement (ICE). While CAHSD can and will comply with the requirement to prove U.S. citizenship for any individual requesting services, compliance with the reporting requirement could pose potential issues due to confidentiality regulations such as the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2. CAHSD will obtain a resolution from its governing board requesting that the Attorney General issue a legal opinion on the matter.

## B. Corrective Actions

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

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

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

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

4. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur?
- How much progress has been made and how much additional progress is needed?

b. If not:

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

5. Do corrective actions carry a cost?

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

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

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

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

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

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

**Performance Progress Reports (Louisiana Performance Accountability System)**

The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to

the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

- In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.
- Benchmarking for Best Management Practices**  
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.
- Performance-based contracting (including contract monitoring)**  
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

1. Title of Report or Program Evaluation: The Commission on Accreditation of Rehabilitation Facilities (CARF International)

CARF completed an onsite survey and issued the fifth three-year re-accreditation to Capital Area Human Services District (CAHSD) through November 30, 2027 for the following programs and services: Outpatient Treatment: Mental Health (Adults); Outpatient Treatment: Mental Health (Children and Adolescents); Outpatient Treatment: Substance Use Disorders/ Addictions (Adults); Outpatient Treatment: Substance Use Disorders/ Addictions (Children and Adolescents); and Residential Treatment: Substance Use Disorders/ Addictions (Adults).

2. Date completed: The three-day survey was conducted December 16-18, 2024.
3. Subject or purpose and reason for initiation of the analysis or evaluation: Persons served benefit by receiving quality services that meet international accreditation standards and state licensing standards. Founded in 1966, CARF International is an independent, nonprofit organization focused on advancing the quality of health and human services to meet the needs of persons served for the best possible outcomes. In addition, CARF accreditation is necessary for the purposes of self-generated revenue through billing and reimbursement. Third party payers and managed care organizations (MCOs) require CARF accreditation to reduce risk and raise the accountability of service providers. As CARF-accredited, state-licensed behavioral health service providers, CAHSD's mental health and substance use treatment facilities are able to produce self-generated revenues that help sustain the availability of services for uninsured and underinsured persons within CAHSD's legislatively designated seven-parish area.
4. Methodology used for analysis or evaluation: Three CARF surveyors from out of state conducted the intensive three-day onsite survey by reviewing policies, procedures, and documentation as well as interviewing persons served, staff, and stakeholders.
5. Cost (allocation of in-house resources or purchase price): \$18,360.00
6. Major Findings and Conclusions: There were no major findings.
7. Major Recommendations: The surveyors recommended a few edits to program policies in order to reflect the standards more clearly.
8. Action taken in response to the report or evaluation: Staff completed the policy edits.
9. Availability (hard copy, electronic file, website): Report is available as an electronic file.
10. Contact person for more information:

Name: Janzlean Laughinghouse, Ph.D., LCSW-BACS, LAC  
Title: Executive Director  
Agency & Program: Capital Area Human Services District  
Telephone: (225) 922-2700  
E-mail: [janzlean.laughinghouse@la.gov](mailto:janzlean.laughinghouse@la.gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-303 Developmental Disabilities Council

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Ebony Haven

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

For each accomplishment, please discuss and explain each item below.

#### Accomplishment #1: Leadership in Advocacy, Capacity Building and Systemic Change Activities:

**A. What was achieved?**

The Council provided leadership in advocacy, capacity building, and systemic change activities that contributed to increased awareness of the need for improved community-based supports and services for people with intellectual and developmental disabilities (I/DD). Through the Council's trainings and technical assistance provided to the grassroots Louisiana Council's Advocacy Network (LaCAN), policies were changed to improve and/or increase community services including within the education system. Significant policy and practice changes influenced by LaCAN and Council advocacy related to community-based services included: 1) successfully advocating for an additional \$500,000 for Families Helping Families Resource Centers for the 5<sup>th</sup> year; 2) successfully advocating to protect disability services from cuts in the State budget and; 3) successfully creating new legislation to make sure seclusion and restraint in schools are used safely and only when needed.

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

Families Helping Families Regional Resource Centers provide information and referrals,

educational programs and training and peer-to-peer support to families of persons with disabilities. The Council and LaCAN have successfully advocated for this increased funding from the legislature since FY21, which basically doubles their State General Fund. Prior to that, the funding to the Centers hadn't been increased since the early 2000 so we're talking about a couple of decades with stagnant funding for our Centers. This success is significant for the thousands of families across our state that reach out to the FHF Centers to get the resources and supports they need to navigate a very challenging service delivery system.

Protecting disability services from cuts was significant because earlier this year the disability community was being told if Amendment 2 failed to pass then cuts would happen, government efficiencies would amount to cuts in services and the Reconciliation Bill would have major impacts on services. Additionally, during previous Administrations (state level), disability services suffered massive cuts to home-and-community-based supports and services because the services are categorized as optional. Therefore, this success is significant because the legislature saw the importance of disability and recognizes that these services are most definitely not optional.

Lastly, improving policies around seclusion and restraint is a significant success because it helped to address concerns found in a recent special education audit which showed how the lack of monitoring and oversight of special education services has left students with disabilities vulnerable to abuse and neglect. With the passage of Act 479 of the 2025 legislative session, new policies were put in place including, but not limited to, schools must put cameras in special education classrooms, even if parents don't ask and teachers will be trained to handle tough situations and behaviors (crisis intervention) as part of becoming a teacher.

C. Who benefits and how?

People with intellectual and developmental disabilities and their family members benefit the most, but also professionals who care for the individuals. Increasing funding to the FHF Centers continues to ensure they will be able to provide services to assist families with navigating the very confusing developmental disabilities and special education systems here in Louisiana. Additionally, people with I/DD and their families benefit from no cuts to disability services because they can remain in their homes and communities with the supports and services they need and not in more costly institutional care. These services include waiver services (NOW, ROW, Children's Choice, etc.), Flexible Family Fund, Early Steps and Support Coordination. Finally, Act 479 ensures seclusion and restraint in schools will only be used when needed and the new policies make it possible to watch video footage to make sure rules were followed properly. There are also new policies around reporting when seclusion and restraint are used which ensures parents are notified the same day.

D. How was the accomplishment achieved?

The legislative accomplishments were achieved through technical assistance, training, information and support provided to members of the Louisiana Council's Advocacy Network (LaCAN) and policy makers, and through collaboration with advocates,

Disability Rights Louisiana, and providers, including the Arc of Louisiana.

- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)  
Yes. The accomplishments directly contribute to the success of the Council's five-year goals and annual objectives/activities.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?  
Some of the strategies used represent Best Management Practices including gathering stakeholder input to create a consumer-directed, consumer-driven service delivery system. These strategies have been shared to build the capacity of other agencies to improve services.

### Accomplishment #2: Capacity Building through Training and Technical Assistance:

- A. What was achieved?

The Council provided support to multiple capacity building initiatives that will continue in their new FY2026 Action plan. These initiatives include trainings to people with I/DD and their families on how to navigate the Developmental Disability, Behavioral Health, and Medicaid/Managed Care Organization systems for individuals with a dual DD and behavioral health diagnosis. The Council also has an initiative collaborating with the Office for Citizens with Developmental Disabilities to educate and train on people and families on abuse, neglect and exploitation. These trainings have had great participation and the Council has received a lot of positive feedback.

Additionally, the Council continued to fund Partners in Policymaking (PIP), a national leadership training program for people with I/DD and parents of young children with DD. During the six-month long training program, PIP builds the capacity of these individuals to be leaders in systems change advocacy. The Class of 2025 had a total of 18 graduates. Additionally, PIP held a reunion for all graduates from the first class of graduates (1991) to present. There were a total of 75 graduates that attended the reunion to see old friends, celebrate the good work done in advocacy and reignite the passion for advocacy to keep making a difference in Louisiana for people with disabilities.

Finally, the Council continues to fund and support the Louisiana Youth Leadership Forum (LAYLF). LAYLF is an educational and motivational summer camp for 10th-12th graders with disabilities, focused on empowerment, self-determination, and disability pride. LAYLF is hosted on a college campus so delegates can experience what it might be like to live away from home, and 100% of the guest speakers are successful adults with disabilities, providing immediate peer mentorship. LAYLF is also accredited through the American Camp Association, which means that it adheres to national best standards of camp safety and quality. There were fourteen campers that participated in and completed the LAYLF in FY2024-25, and it was held on the LSU Eunice (LSUE) campus.

B. Why is this success significant?

The success of building the capacity of individuals with I/DD, providers, and community members improves the quality of services delivered, improves the ability to successfully advocate or speak for one's self, increases opportunities for inclusive education/employment/living, and results in overall better outcomes for individuals with developmental disabilities.

C. Who benefits and how?

First and foremost, people with dual diagnoses of developmental disabilities and behavioral health will benefit from the knowledge of how to navigate Louisiana's complex systems including OCDD, OBH and Medicaid. A detailed Guide developed for Individuals and their families and professionals is given to participants on each of the systems one must navigate and information on services available in each and to easily modify and make accommodations to improve access and health outcomes for individuals with a Dual Diagnosis. The Council's training on abuse and neglect is helping to empower individuals with I/DD with knowledge of the aspects of abuse prevention and response to lead safer, more secure lives with confidence and support.

Additionally, campers that participate in LAYLF work to identify resources that can help them achieve their goals while building lifelong friendships. It is critical students with disabilities identify themselves with pride, as individuals and as members of their community. YLF offers students with common experiences the opportunity to learn from each other in a framework of history and an atmosphere of encouragement. Likewise, the goal of PIP is to achieve productive partnerships between people needing and using services and those who make public policy. It is designed to provide knowledge and skill building so that participants may work to obtain state of the art services for themselves and others.

D. How was the accomplishment achieved?

These accomplishments were achieved mostly through partnerships with other state agencies to develop and offer training opportunities. Some of the training initiatives were through identification of nationally respected organizations and presenters.

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

Yes. The accomplishments directly contribute to the success of the Council's five-year goals and annual objectives/activities.

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

Some of the methods to accomplish these results represent best practices. Other agencies have been heavily involved with implementation of these capacity-building initiatives.

## II. Is your department Five-Year Strategic Plan on time and on target for

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

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

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

The Council is confident that the investments that have been made in leadership and capacity building trainings and systems change activities have resulted in significant returns. Individuals especially those with I/DD are becoming more engaged and empowered to advocate for the services and supports they need in order to live in the community.

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

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

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

While many of the successes in policy and practice changes were a result of collaborations with other agencies, the successes realized are a direct result of targeted educational campaigns to policy makers, advocates and the general public conducted by the Council. The vast majority, if not all, of these changes

would not have occurred without the specific actions taken by the Council. The Council has expanded its repertoire of strategies and tools to connect with the public and policy makers and has successfully increased its capacity to utilize social media networks and tools to conduct educational campaigns and provide timely information to constituents.

This progress is due to the Council having developed and supported large grassroots advocacy networks and family support agencies over the past thirty years. It is also the result of engaging with stakeholders and carrying out initiatives that will address the needs and benefit the disability community.

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

It is expected that there will continue to be an increase in the influence the Council, self-advocates and family members of individuals with developmental disabilities have on decisions by policy makers. The Council's capacity to educate the general public and policy makers about needed changes to existing policies and/or the impact of pending decisions is well established.

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

1. To what do you attribute this lack of progress? For example:

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

*The Council is not experiencing a significant lack of progress in the current 5 year plan.*

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

*The Council is not experiencing a significant lack of progress in the current 5 year plan.*

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

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

The Council just completed the fourth year of its Five-year plan (2022 - 2026). Each activity is reviewed for performance outcomes and adjustments are made in response to feedback and outcome data. Every year, a planning committee convenes to modify the next year's plans to add, or sometimes remove activities based on performance and stakeholder feedback.

No. If not, why not?

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

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

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

- III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?** (“Problems or issues” may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. “Problems or issues” may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. “Problems or issues” may or may not be related directly to strategic plan lack of progress.)

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

reports and evaluations at the end of this form.

#### A. Problem/Issue Description

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

Unlike larger offices that can redistribute responsibilities through promotions, transfers, or temporary support, our agency is very small—only six program staff and two administrative staff. Therefore if there are staff turnover, unfortunately, the administrative staff cannot take on the programmatic duties required, leaving our other programmatic staff with no choice but to absorb these tasks themselves.

Compounding this challenge, the hiring freeze and new LDH hiring processes have left our agency short-staffed and delayed in filling vacancies. These added hurdles have further increased the burden on programmatic staff. We lost an employee in March, but due to the hiring freeze would could not hire between April and June.

Additionally, since the state's return-to-work schedule began, we have lost another program monitor, and both managers are exploring other employment opportunities with more flexibility. We deeply value their expertise, and we know how essential they are to achieving the goals laid out in our plan. Additionally, all Council activities are dependent on federal and state appropriations. The Council consistently takes all actions possible to ensure continuation of allocations. One significant issue is the economy in general and Louisiana's capacity to maintain the contributions to supporting necessary programs in the future.

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

Yes, the Council requires full staff in order to carry out its Five-Year Plan effectively and efficiently. When we are not fully staffed, Council work suffers because others are trying to fill in the gaps and continue to operate effectively in their hired roles.

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

All units within LDH are experiencing additional processes to hire and the entire State Civil Service system was affected by the hiring freeze.

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

When the Council is not able to fully carry out its plan due to lack of staff, stakeholders in the disability community are affected.

5. How long has the problem or issue existed?

The hiring freeze was implemented on April 11<sup>th</sup> and lasted until June 30<sup>th</sup>. Additionally, LDH has now placed new hiring processes in place for advertising and filling positions which started on July 24<sup>th</sup>.

6. What are the causes of the problem or issue? How do you know?  
The cause is unknown.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?  
Due to increased workload, the consequences could result in decreased retention of experienced staff leaders, increased staff turnover including turnover costs, and a decrease in meeting the needs of the families who rely on our work.

#### B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?
  - No. If not, skip questions 2-5 below.
  - Yes. If so, complete questions 2-5 below.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
  - a. If so:
    - What is the expected time frame for corrective actions to be implemented and improvements to occur?
    - How much progress has been made and how much additional progress is needed?
  - b. If not:
    - Why has no action been taken regarding this recommendation?
    - What are the obstacles preventing or delaying corrective actions?
    - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?
5. Do corrective actions carry a cost?
  - No. If not, please explain.
  - Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)  
Please discuss the following:
    - a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
    - b. How much has been expended so far?

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

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

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

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

- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
  
- Performance Progress Reports (Louisiana Performance Accountability System)**  
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
  
- In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.
  
- Benchmarking for Best Management Practices**  
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.
  
- Performance-based contracting (including contract monitoring)**  
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.
  
- Peer review
- Accreditation review
- Customer/stakeholder feedback

Other (please specify):

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

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

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

The Council completes a federal program performance report (PPR) and an annual report that summarizes the progress of the Council's work and successes each year.

1. Title of Report or Program Evaluation: *Program Performance Report*
2. Date completed: *3/31/2025*
3. Subject or purpose and reason for initiation of the analysis or evaluation:

The purpose of the PPR is to document DD Council results, outcomes, and impacts of Council work that occurred during the previous federal fiscal year.

4. Methodology used for analysis or evaluation: The Council uses data collected from contractors on demographics and general information about participation in the activity or event.
5. Cost (allocation of in-house resources or purchase price): **No cost**
6. Major Findings and Conclusions: See [Annual Report](#)
7. Major Recommendations:
8. Action taken in response to the report or evaluation: *N/A*
9. Availability (hard copy, electronic file, website): The report is available on the Council's website, the Council was given a hard copy at the July 2025 quarterly meeting and a newsletter was shared with the public July 10<sup>th</sup>.
10. Contact person for more information:  
Name & Title: Stephanie Carmona, Program Manager  
Agency & Program: Developmental Disabilities Council  
Telephone: 225-342-6804

E-mail: [Stephanie.Carmona@la.gov](mailto:Stephanie.Carmona@la.gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-304 Metropolitan Human Services  
District

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Rochelle Head-Dunham

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

For each accomplishment, please discuss and explain each item below.

#### Accomplishment #1: Mental Health First Aid (MHFA) Expansion

##### A. What was achieved?

The New Orleans MHFA Collective was established prior to the COVID pandemic to strengthen the local crisis response system by increasing community readiness to identify and respond to mental health crises. The Collective stemmed from earlier efforts occurring at Metropolitan Human Service District (MHSD). Supported by a 4-year, \$100,000/year grant from the Behavioral Health Council (BHC)—a coalition of healthcare providers, nonprofits, government agencies, and businesses—the initiative promotes community resilience and behavioral health.

Training partners include the Louisiana Public Health Institute (LPHI), the National Alliance on Mental Illness (NAMI) New Orleans, and Metropolitan Human Services District (MHSD). These organizations offer culturally responsive, skills-based MHFA training to help individuals recognize and respond to mental health and substance use

challenges.

Historically, training has been predominately adults. MHSD has collaborated with LCMC Health to train nursing, administrative, and frontline staff, enhancing their ability to support patients in crisis. Expansion now encompasses training of our community youth.

Most recently, MHSD partnered with New Orleans Public Schools to train school staff and case managers and expanded in FY24–25 to include teen MHFA (tMHFA) for students, starting with Belle Chasse High School’s sophomore class in response to rising crises and suicide rates. Notably to date, MHSD is the first and only agency to train teenagers in MHFA in the state of Louisiana.

Since inception participation has grown annually. Through the MHFA Collective, MHSD has trained over one thousand community members, with trainees representing schools, communities, private organizations, and MHSD staff.

B. Why is this success significant?

This is significant because mental stability is an ever-growing struggle for populations in general that may have never experienced a diagnosed mental health condition. Diagnosed persons continue to struggle daily with the challenges of mental and substance use disorders in the setting of a finite number of clinical resources available for stabilization.

C. Who benefits and how?

Benefits individual with behavioral health conditions, but it also benefits the broader community by focusing on prevention and early intervention and promoting health and wellness for all.

D. How was the accomplishment achieved?

Continuous community outreach efforts and the support of MHSD Executive Leadership.

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

Yes.

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

Yes.

**Accomplishment #2: Imani Breakthrough NOLA Faith Partners Project**

A. What was achieved?

The Imani Breakthrough Recovery Program is a faith-based recovery initiative designed to be culturally, spiritually, and trauma-informed, assisting individuals recovering from opioid use/abuse and other drug or alcohol problems. This program

takes place in churches and involves two parts:

- **Group Component:** 12 weeks of classes and mutual support focused on wellness enhancement and the 5 Rs—Roles, Resources, Responsibilities, Relationships, and Rights—and their importance to recovery and community connection.
- **Wellness Coaching Component:** During the 12 weeks and up to one month after, coaches provide weekly check-ins to support participants in achieving their recovery goals.

Developed out of Yale University, the project model was implemented by MHSD in collaboration with Yale in 2022. In 2023, program implementation began in two churches located in New Orleans (Central City neighborhood). Participants in the program were between the ages of 22 and 64, with 96% being African American males. To date, three cohorts with a total of 63 participants have successfully completed the 24-week program and have been referred to MHSD and other resources for long-term recovery support. The program has been implemented in a third church in St. Bernard parish, with a total of 11 participants.

B. Why is this success significant?

Improves the standard and quality of care of the addiction program.

C. Who benefits and how?

Persons served and their families and MHSD program staff.

D. How was the accomplishment achieved?

By Executive Leadership prioritizing addiction services and supports.

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

Yes.

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

Yes.

### Accomplishment #3: Community Integration of Services for the Homeless

A. What was achieved?

Metropolitan Human Services District (MHSD) has laid the groundwork for a coordinated service delivery model that will provide mental health, substance use, and social services to individuals experiencing homelessness. The MHSD Homeless/Unhoused Outreach program consists of four multi-partner components of care: 1. Collaboration with a homeless shelter (Ozanam Inn), Tulane and LSU Graduate Medical Education Programs and Health Care for the Homeless for telehealth and

integrated mental and physical health services ; 2. Collaboration with Tulane and LSU Graduate Medical Education Programs and the Orleans School System for child. adolescent and parental homeless services; 3.) Collaboration with a Case Management Service Provider for continuity of clinic based Behavioral health care to support permanent supported housing services. Ultimately, all persons served are encouraged to seek continuity of care via our MHSD 56 clinic sites.

B. Why is this success significant?

Many of the people we serve are homeless, and this program allows us to link them to direct clinical behavioral health services and intensive case management services to address social determinants of health (SDOH) for improve sustained overall functioning. This initiative is significant because it addresses a critical gap in care for one of the most vulnerable populations. By leveraging multi-agency collaborations, MHSD is working to ensure that individuals who are homeless will have access to comprehensive care that addresses both their mental illness, substance use, physical and social needs, ultimately promoting stability and reducing barriers to recovery.

C. Who benefits and how?

The homeless population benefits directly from this initiative, as they receive easier access to essential services. Additionally, the broader community benefits from the reduction in emergency service utilization and the improved well-being of individuals who are better supported in their recovery journeys.

D. How was the accomplishment achieved?

MHSD's leadership team played a crucial role in facilitating partnerships and ensuring that services were aligned with the specific needs of the homeless population.

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

Yes.

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

Yes.

**Accomplishment #4: AI Subcommittee and Behavioral Healthcare Technology**

A. What was achieved?

MHSD established an AI Subcommittee dedicated to exploring and implementing

advanced behavioral healthcare technology solutions. The subcommittee focused on three key areas: AI Research in Behavioral Healthcare, identification of MHSD processes where AI technology could bring efficiencies, and the identification of AI technologies and products used in behavioral healthcare. Additionally, the subcommittee prioritized strengthening cybersecurity measures to protect sensitive patient data, the development of MHSD Connect (MHSD's patient portal), and enhancements to the Electronic Health Record (EHR) system.

B. Why is this success significant?

The creation of the AI Subcommittee is significant because it positions MHSD at the forefront of technological innovation in behavioral healthcare. By integrating AI and other advanced technologies, MHSD can improve patient outcomes, streamline operations, and enhance data security. The MHSD AI Subcommittee meets bimonthly and is tasked with identification and implementation of targeted strategies using AI tools to advance clinical and administrative services and operations. The AI Subcommittee is dedicated to leveraging artificial intelligence to enhance clinical and administrative services. Three key initiatives of the subcommittee are: MHSD AI Policy; Education and Training; and Adoptions.

C. Who benefits and how?

Patients benefit from more personalized and efficient care through AI-driven insights and tools such as MHSD Connect. MHSD staff benefit from improved EHR functionality and stronger cybersecurity measures, which protect both patients and the organization.

D. How was the accomplishment achieved?

Success was achieved through strategic planning, collaboration with technology experts, and investment in the necessary infrastructure. MHSD's leadership provided the vision and support needed to explore these advanced technologies, ensuring that all initiatives aligned with the agency's mission.

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

Yes.

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

Yes.

**Accomplishment #5: Open Minds Third Party Consultation for Fiscal Process**

## A. What was achieved?

A plan for growth through diversification of funding sources. MHSD engaged in a consultative relationship with Open Minds. The purpose of the consultation was to provide recommendations in the areas of redesign on the fiscal services department, KPIs for the fiscal service department, regional competition for MHSD and a plan for growth. The following recommendations for fiscal growth were provided:

1. Acquisition of Smaller Providers
2. Membership Substitution
3. Organic Growth through Performance Improvements
4. Growth via CCBHC Certification
5. Partnerships with Hospitals and Other Entities
6. Implementation of Alternative Payment Models (VBR)

## B. Why is this success significant?

The Louisiana payment system provides very low margins for services. Success is thus dependent on very low service cost and very high volume. In this type of environment, a provider should grow to the largest size possible to assure economies of scale and sustainability. There are substantial needs and a strong market for services in the three parish regions that MHSD manages, but the payment environment makes traditional forms of growth dangerous to a provider. Safer forms of growth are preferred for MHSD. They include merger and acquisition, partnerships with hospitals and other entities, maximizing productivity in existing systems, use of CCBHC grant dollars, and VBR payment models.

## C. Who benefits and how?

Benefits individuals with behavioral health conditions, but it also benefits the broader community by promoting fiscal sustainability to enable continued care delivery to community members.

## D. How was the accomplishment achieved?

MHSD's leadership team played a crucial role in facilitating partnership and collaboration with Open Minds, fostering timely and attainable strategies to promote growth.

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

Yes.

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

Yes.

### **Accomplishment #6: Established In-house Call Center Support**

## A. What was achieved?

In June 2025, call center support for MHSD was brought in-house and staffed with agency

and contract workers. The was in response to feedback received from clients related to customer experience with our previous vendor.

B. Why is this success significant?

The call center is often the first point of contact between the MHSD and those in need of mental health, addiction, and/or IDD services. It is a must that calls be appropriately triaged and that those callers receive proper information and guidance to expedite care delivery.

C. Who benefits and how?

Benefits individual with behavioral health conditions, but it also benefits the broader community by focusing on prevention and early intervention and promoting health and wellness for all.

D. How was the accomplishment achieved?

Support of MHSD Executive Leadership and coordinated efforts of special working group comprised of MHSD agency staff. Swift ability to cross-train active staff and acquire additional staff to supplement the call center capacity contributed to this accomplishment.

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

Yes.

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

Yes.

### **Accomplishment #7: Gambling Recovery Services & Launch of Evive Gambling Application**

A. What was achieved?

Our Communications team collaborated with the developers of EVIVE, a new app designed to support individuals in gambling recovery, to create a comprehensive marketing strategy for EVIVE roll out in the Louisiana market. EVIVE is the leading digital health platform for gambling behavior change, serving state partners across the nation. The intent is to bridge this critical gap in care by reaching the 99.5% of people experiencing gambling harm who never access traditional state funded support services.

As part of the rollout, we are actively promoting the app in clinics using printed materials (flyers, stickers) and a promotional video displayed on clinic monitors. Additional outreach tools are in development to further increase visibility and access.

MHSD staff attended the National Conference on Problem Gambling, where we engaged with national leaders and stakeholders to inform and strengthen our programming. We met with the EVIVE app developers to discuss the next steps in the app's implementation timeline and ensure alignment with statewide efforts.

We also participated in the LASACT Conference, a statewide event focused on addiction and recovery. MHSD was featured as an exhibitor to promote Evive and highlight the broad range of services offered by the agency.

Training: We continued to prioritize workforce development and community capacity building with the following trainings facilitated by Dr. Haskins (Board Chair and President Emerita of the Maryland Council on Problem Gambling) and co-trainers from Mosaic Counseling:

- 30-Hour Problem Gambling Training (Cohort 3) March 20 – April 11
  - 18 participants, including MHSD staff and community partners
- Advanced “Booster” Training June 20
  - 17 participants from Cohorts 1 and 2
- 12-Hour Faith-Based Problem Gambling Training Series July 7 – 18
  - 21 clergy members and faith leaders participated in sessions tailored to supporting congregants with gambling issues

B. Why is this success significant?

Improves the standard and quality of care of the addiction program.

C. Who benefits and how?

Persons served and their families and MHSD program staff.

D. How was the accomplishment achieved?

Success was achieved through strategic planning, MHSD leadership, and efforts of the MHSD Regional Health Director and Addictions team.

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

Yes.

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

Yes.

### **Accomplishment #8: MHSD Patient Portal**

A. What was achieved?

MHSD Connect is a behavioral health portal for scheduling, secure communication, and tele-health services. Designed with your needs in mind, MHSD Connect launched on April 2, 2024.

B. Why is this success significant?

MHSD Connect adds a layer to the patient experience and lends itself to convenience and efficiency.

C. Who benefits and how?

Patients benefit from this by streamlining part of the patient experience. They have

appointment reminders including details about upcoming appointment. Form can also be completed through the portal.

D. How was the accomplishment achieved?

Success was achieved through strategic planning, collaboration with technology experts, and investment in the necessary infrastructure. MHSD's leadership provided the vision and support needed to explore these advanced technologies, ensuring that all initiatives aligned with the agency's mission.

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

Yes.

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

Yes.

**Accomplishment #9: Contingency Management**

A. What was achieved?

Metropolitan Human Services District (MHSD) introduced a Contingency Management (CM) program to increase engagement and retention in Addictive Disorders (AD) services. CM is an evidence-based intervention that reinforces positive behaviors, such as consistent attendance and treatment adherence, with tangible incentives.

The program was integrated across MHSD's clinics to address ongoing challenges with treatment participation and follow-through. Participants who meet identified benchmarks—such as attending scheduled therapy sessions, completing group interventions, or achieving negative drug screens—receive structured rewards. This approach promotes accountability and reinforces recovery-oriented behaviors.

B. Why is this success significant?

This is significant because low engagement and early drop-out have long been barriers to achieving optimal treatment outcomes in substance use disorder care. By embedding Contingency Management into routine practice, MHSD is aligning with nationally recognized best practices that strengthen client motivation, improve retention, and enhance long-term recovery outcomes.

Additionally, this marks a step forward in operationalizing innovative behavioral interventions at the system level.

C. Who benefits and how?

Individuals with substance use disorders benefit directly through increased motivation, structure, and reinforcement to sustain their participation in treatment. Families and communities benefit from improved treatment retention, which supports recovery, reduces relapse risk, and contributes to overall community health and safety.

D. How was the accomplishment achieved?

Success was achieved through strategic planning, MHSD leadership, and efforts of the MHSD Regional Health Director and Addictions team.

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

Yes.

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

Yes.

### **Accomplishment #10: Co-Occurring Disorders Learning Community**

A. What was achieved?

Metropolitan Human Services District (MHSD) established a Co-Occurring Disorders Learning Community designed to strengthen workforce capacity in addressing addictive disorders and co-occurring mental health conditions. This initiative includes a structured professional development learning series tailored for both clinical and administrative staff.

The series combines in-person training sessions with flexible, self-paced virtual courses, allowing staff to deepen their knowledge of addiction science, treatment models, and system integration strategies. The curriculum emphasizes practical application, evidence-based practices, and interdepartmental collaboration to enhance service delivery across MHSD's continuum of care.

B. Why is this success significant?

This is significant because co-occurring disorders represent a major challenge in behavioral health, requiring staff to integrate knowledge across multiple domains of care. Historically, addiction services and mental health services have been siloed, leading to fragmented care and poor outcomes. The Learning Community directly addresses this gap by ensuring MHSD staff are equipped with the skills and knowledge to recognize, treat, and coordinate services for individuals with complex needs.

C. Who benefits and how?

Individuals served by MHSD benefit from more effective, coordinated care as staff apply enhanced skills to assessment, treatment planning, and service delivery. Clinicians and administrative staff benefit from access to continuing education that supports professional growth and reinforces evidence-based practices.

D. How was the accomplishment achieved?

Success was achieved through strategic planning, MHSD leadership, and efforts of the MHSD Regional Health Director and Addictions team.

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

Yes.

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

Yes.

**Accomplishment #11: Target Integration of MHSD Behavioral Health and IDD**

- A. What was achieved?

Metropolitan Human Services District (MHSD) undertook targeted integration efforts to bridge the gap between Behavioral Health (BH) services and Intellectual/Developmental Disabilities (IDD) services. These efforts included the development of an integrated EHR and cross-training for staff to address the unique needs of individuals with co-occurring BH and IDD conditions. During FY24-25, IDD and the Quality and Data Management (QDM) division expounded integration efforts, designing a project for the EHR buildout to support IDD staff workflow. IDD staff training was also implemented.

- B. Why is this success significant?

This integration is significant because it addresses the complex and often unmet needs of individuals with co-occurring behavioral health (BH) and intellectual/developmental disabilities (IDD). By combining resources and expertise from both fields, MHSD can provide more comprehensive and person-centered care, reducing the fragmentation of services and improving outcomes for this vulnerable population.

- C. Who benefits and how?

Individuals with co-occurring BH and IDD conditions benefit directly from this initiative as they receive more coordinated and holistic care tailored to their unique needs. Their families also benefit from the support and guidance provided. Additionally, MHSD staff benefit from the cross-training and enhanced collaboration, which allows them to deliver more effective services.

- D. How was the accomplishment achieved?

This accomplishment was achieved through deliberate collaboration between MHSD's Behavioral Health, IDD, and QDM teams.

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

Yes.

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

Yes.

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

**MHSD has made significant strides toward achieving the goals outlined in its 2020–2025 Strategic Plan.** Building on this momentum, MHSD has developed the 2026–2031 State Strategic Plan to guide its continued progress. Strategies implemented to date have generally proven effective, as evidenced by performance indicators. Ongoing performance measurement, data analysis, and related insights demonstrate a positive return on investment (ROI), particularly in linking performance outcomes to district budgeting decisions.

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

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

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

MHSD has made substantial progress on several key initiatives that align with community needs, including:

- Expanding access to behavioral health and intellectual/developmental disability (I/DD) services
- Advancing the Data-Based Performance Initiative
- Delivering Mental Health First Aid training
- Launching innovative behavioral health programs

These achievements are largely attributed to the proactive leadership of MHSD Executive Leadership, whose early investment of resources laid the foundation for

success. Progress reflects a coordinated, agency-wide effort to improve both access to care and the efficiency of service delivery. The Certified Community Behavioral Health Clinic (CCBHC) grant has been instrumental in this progress, providing critical funding, staffing, and consultative support.

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

**Progress is anticipated to accelerate in the coming months.** To sustain this momentum, MHSD is proactively developing strategies that minimize disruption to service delivery, even in the face of an expected budget reduction. The agency remains focused on identifying and addressing opportunities for greater operational efficiency while continuing to meet both administrative and clinical demands. Looking ahead, MHSD will prioritize efforts that enhance quality of care, ensure fiscal sustainability, and strengthen corporate compliance.

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

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

**While MHSD has not identified any initiatives with significant lack of progress, several operational challenges have emerged that impact capacity.**

These include difficulties in recruiting and retaining licensed clinical staff, as well as preparing for an anticipated budget reduction. Progress on collaboration with the Veterans Administration (VA) has been slower than expected, primarily due to challenges in identifying a dedicated VA liaison to support the development of referral procedures.

Through the Certified Community Behavioral Health Clinic (CCBHC) project, MHSD is actively working to strengthen its partnership with the VA to ensure veterans have access to comprehensive behavioral health services. Current

priorities include staff training on veteran-specific needs, identifying a VA liaison, and formalizing referral protocols.

Additionally, efforts to advance integrated care have been hindered by staffing constraints and the need for clearly defined protocols and workflows.

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

The limited progress observed is primarily due to a combination of administrative and coordination challenges, as well as evolving state and federal mandates. MHSD will continue to closely monitor these projects throughout 2025–2026 to ensure alignment with strategic goals and timely resolution of barriers.

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

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

No. If not, why not?

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

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

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

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

#### A. Problem/Issue Description

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

**No significant departmental, management, or operational issues have been identified at this time.** MHSD remains committed to its mission of delivering high-quality behavioral health care. However, operations may be impacted by a range of factors related to state and federal budgetary mandates. MHSD will continue to monitor these developments closely throughout 2025–2026 to ensure continuity of care and organizational responsiveness.

#### B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?
  - No. If not, skip questions 2-5 below.
  - Yes. If so, complete questions 2-5 below.

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

## 5. Do corrective actions carry a cost?

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

Please discuss the following:

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

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

The LDH has a designated Audit Coordinator for financial audits. The Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit

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

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

- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
  
- Performance Progress Reports (Louisiana Performance Accountability System)**  
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
  
- In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning or strengthen program management initiatives.
  
- Benchmarking for Best Management Practices**  
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the

Department's undersecretary, if modifications or additions are needed.

- Performance-based contracting (including contract monitoring)**  
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.
- Peer review  
The MHSD Peer review methodology is defined by the Louisiana Office of Behavioral Health to address federal mandates.
- Accreditation review  
MHSD is accredited by CARF International. Accreditation methodology is defined by CARF International.
- Customer/stakeholder feedback  
Metropolitan Human Services District (MHSD) participates in various activities (e.g., surveying, hosting community forums, RAC participation, etc.) that involve obtaining input from persons served and other stakeholders. MHSD requests and collects input to help determine the expectations and preferences of its stakeholders and to better understand how the district is performing from the perspective of its stakeholders. Findings are used to create services that meet or exceed the expectations of persons served, the community, and other stakeholders
- Other (please specify):

C. Did your office complete any management reports or program evaluations during the fiscal year covered by this report? [Yes](#)

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

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

1. Title of Report: AP/Accountability Plan
2. Date Complete: 03/07/2025
3. Subject/Purpose: To guide the delivery of addictive disorders (AD), Developmental Disabilities (DD), and Mental Health (MH) services funded by appropriations from the state.
4. Methodology: Site monitoring consisted of a joint OBH and OCDD Review team to include data reviews, chart audits, and interviews with staff.

5. Cost: Allocation of committed staff time to the process for the day.
6. Major Findings: none
7. Major Recommendations: none
8. Action taken: MHSD responded as needed in writing with a Plan of Correction (POC) to any major findings.
9. Availability: AP is available in hardcopy and electronic file; report file will be available in same format.
10. Contact person for more information:
  - Name: Rochelle Head-Dunham, M.D.
  - Title: Executive Director/Medical Director
  - Agency & Program: 09-304 Metropolitan Human Services District (MHSD)
  - Telephone: 504-535-2909
  - E-mail: [Rochelle.Dunham@mhsdla.org](mailto:Rochelle.Dunham@mhsdla.org)

1. Title of Report or Program Evaluation: MHSD Operations Risk Management Audit
2. Date completed: 3/27/2025
3. Subject or purpose and reason for initiation of the analysis or evaluation: Annual Audit/compliance review
4. Methodology used for analysis or evaluation: Full site visits with auditor, sit down meeting with auditor to review required records.
5. Cost (allocation of in-house resources or purchase price): N/A
6. Major Findings and Conclusions: Status-Compliant
7. Major Recommendations:
  - a. Per the manual, supervisors shall see that all vehicles provided to employees are in safe operating condition, including the use of a monthly checklist.
  - b. Correct/repair any deficiencies/problems noted on the monthly vehicle checklists and document the corrections.
  - c. Perform and document Preventive Maintenance for each vehicle to include: a preventive maintenance procedure and schedule. It is recommended that the agency follow the suggested manufacturer's preventive maintenance (PM) on vehicles.
  - d. Provide verification that the DA 2041 was forwarded by fax or e-mail to the Claims Unit, within forty-eight (48) hours or two (2) business days of the vehicle incident/accident and maintain documentation for the audit.
8. Action taken in response to the report or evaluation:
  - a. Recommendation listed in 7a. was completed
  - b. Recommendation listed in 7b. was completed
  - c. Recommendation listed in 7c is in progress. Fleet Coordinator to catch up with preventive maintenance for all vehicles. Paperwork from previous Fleet Maintenance could not be found.
  - d. Recommendation listed in 7d was completed. Incident occurred around

the holiday, so there was a lag in ORM responding/receiving paperwork.  
9. Availability (hard copy, electronic file, website): Hard copy, and electronic file.

10. Contact person for more information:

Name: Rochelle Head-Dunham, M.D.

Title: Executive Director/Medical Director

Agency & Program: 09-304 Metropolitan Human Services District  
(MHSD)

Telephone: 504-535-2909

E-mail: [Rochelle.Dunham@mhsdla.org](mailto:Rochelle.Dunham@mhsdla.org)

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-305 MVA  
09-306 MVP

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Medicaid Executive Director:** Kimberly Sullivan

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

For each accomplishment, please discuss and explain each item below. Please answer ALL of the questions below. Please type your answer under the stated question. Do NOT delete any questions, bullets, boxes, Roman numerals or letters.

#### Accomplishment #1: Submitted 1115 Reentry Waiver Application to CMS

- A. What was achieved? Medicaid and the Office of Behavioral Health (OBH) drafted and submitted a Section 1115 demonstration application to CMS to request waivers and expenditure authority to provide select Medicaid benefits to incarcerated individuals up to 90 days prior to their release.
- B. Why is this success significant? Through this Reentry Demonstration, LDH aims to build upon current and planned initiatives and partnerships with the Department of Public Safety and Corrections (DPS&C) to promote seamless access to necessary Medicaid services both prior to and following release from jail or prison to facilitate a smooth transition into the community and reduce the likelihood of relapse and recidivism.
- C. Who benefits and how? Under the demonstration, individuals released from incarceration will gain access to select Medicaid benefits prior to their release. By providing pre-release Medicaid coverage, the demonstration aims to improve continuity of care during the transition period and assist with reducing hospitalizations, emergency department visits, and recidivism following release from incarceration.

- D. How was the accomplishment achieved? Medicaid and OBH collaborated closely for several months, holding regular workgroup meetings to design, draft, and submit the application.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, the Reentry Demonstration will enhance continuity of care for this population and support the agency's goal of making comprehensive, coordinated care and quality health services available to all who qualify.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes, the inter-agency workgroup created for this initiative brought together team members from both Medicaid and OBH. This collaboration ensured decisions were guided by input from both agencies and allowed the sharing of expertise, resources, and perspectives.

### Accomplishment #2: Utilization Management Changes for Pharmacy Savings

- A. What was achieved? In state fiscal year 2025, the Louisiana Department of Health (LDH) implemented significant utilization management changes to optimize pharmacy spending and ensure appropriate access to medications. Effective November 15, 2024, the Preferred Drug List (PDL) for both Fee-for-Service (FFS) and Managed Care Organizations (MCOs) was updated to include clinical authorization criteria for all GLP-1 receptor agonists—covering both preferred and non-preferred agents. Providers are now required to submit clinical evidence, such as HbA1C levels or a diagnosis of Type 2 diabetes, to obtain approval. This measure targets inappropriate use and encourages cost-effective prescribing, resulting in improved oversight and projected savings without limiting access for eligible patients. Additionally, effective March 1, 2025, quantity limits were introduced across multiple drug classes—including CNS stimulants, gastrointestinal agents, topical antibiotics, antipsychotics, ophthalmic agents, antidiabetic agents, inhaled glucocorticoids, and insulin-related products. These limits help prevent overuse, promote fiscal responsibility, and enhance program efficiency while maintaining quality patient care.
- B. Why is this success significant? The implementation of clinical authorization criteria for GLP-1 receptor agonists is significant for multiple reasons. Firstly, it addresses the high cost of these medications by ensuring their use is clinically appropriate for conditions like Type 2 diabetes, thereby reducing inappropriate prescribing and generating substantial cost savings for the Medicaid program. These savings support the sustainability of the program's budget, allowing funds to be redirected toward other critical healthcare priorities. Secondly, enhanced oversight of prescribing patterns strengthens program integrity and accountability. Additionally setting quantity limits on high-cost medications helps reduce overuse and waste, contributing further to Medicaid's financial sustainability. These limits also mitigate risks associated with misuse, dependency, and adverse effects, thereby promoting patient safety and aligning with broader public health goals to curb overprescribing. Importantly, patients with legitimate medical needs can still access higher quantities when clinically justified, ensuring equitable access across various therapeutic classes. Together, these changes enhance prescribing oversight, promote fiscal responsibility, and optimize pharmacy services

while maintaining quality care.

- C. Who benefits and how? Recipients benefit from improved medication safety through reduced risk of misuse, dependency, and adverse effects. The introduction of clinical authorization criteria for GLP-1 agonists, along with quantity limit edits across multiple drug classes, helps curb inappropriate prescribing. This results in significant cost savings for the Louisiana Department of Health Medicaid Program, enabling more efficient allocation of resources to other vital healthcare services and strengthening the program's fiscal sustainability.
- D. How was the accomplishment achieved? The successful implementation of clinical authorization criteria for GLP-1 agonists was the result of a coordinated effort. The Louisiana Department of Health (LDH), in collaboration with the University of Louisiana Monroe (ULM) and Gainwell Technologies, developed clinical authorization criteria to ensure GLP-1 agonists are prescribed only for medically justified conditions. Additionally, quantity limits were established for specific drug classes. These edits were thoroughly reviewed and approved by the Drug Utilization Board to ensure clinical appropriateness and alignment with Louisiana Medicaid's goals. Providers were notified well in advance of the November 2024 and March 2025 changes through targeted outreach efforts, facilitating a smooth transition to the new criteria.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes. By implementing clinical authorization requirements for high-cost GLP-1 agonists and setting quantity limits across multiple drug classes, these changes reduce inappropriate utilization and generate projected cost savings that support fiscal sustainability. Enhanced oversight of prescribing patterns strengthens program integrity by ensuring compliance with clinical criteria and quantity limits, preventing overuse. Together, these accomplishments advance the strategic plan by effectively balancing cost containment with patient access to necessary medications.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. This approach offers a replicable model for balancing cost control, patient access, and program integrity. Other agencies can adopt this methodology to improve oversight of high-cost medications, promote appropriate use, and maximize cost savings effectively.

### Accomplishment #3: Cell & Gene Therapy (CGT) Model Application Approved

- A. What was achieved? Participation in the Sickle Cell Gene Therapy Model enables the state to pursue supplemental and outcomes-based rebates on gene therapy claims. This approach improves access to innovative treatments while reducing costs for the state and aligning payments with patient outcomes.
- B. Why is this success significant? The SCD Gene Therapy Access Model is designed to improve the health of individuals with sickle cell disease by preventing the sickling of red blood cells, extending their lifespan, and reducing complications such as vaso-occlusive crises—painful episodes caused by blocked blood flow and oxygen deprivation to tissues. This model aims to expand access to transformative therapies that address the severe health challenges and low life expectancy associated with rare, severe conditions like sickle cell disease. Additionally, it supports states in more effectively managing the costs of innovative cell and gene therapies.

- C. Who benefits and how? The current Cell and Gene Therapy Access Model serves individuals aged 12 and older who have been diagnosed with Sickle Cell Disease. This model benefits patients by improving access to groundbreaking gene and cell therapies that have the potential to significantly reduce disease complications and improve quality of life. Additionally, healthcare providers benefit from streamlined pathways to deliver these advanced treatments, while states and payers gain tools to better manage the high costs associated with these therapies through innovative payment models. Overall, the CMS GCT model fosters improved health outcomes, cost-effectiveness, and sustainable access to life-changing treatments for patients with rare and serious conditions like sickle cell disease.
- D. How was the accomplishment achieved? In June 2024, CMS issued a State Request for Applications (RFA) to invite participation in the Cell and Gene Therapy (CGT) Access Model. According to CMS, 33 states, along with the District of Columbia and Puerto Rico, applied, were accepted, and signed State Agreements to participate in the model. Participation in the CGT Access Model is voluntary for both manufacturers and states.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, this accomplishment supports the Louisiana Department of Health's mission to allocate resources strategically and deliver healthcare services that are efficient, effective, and accessible to all.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. CMS's inclusive approach allows all Medicaid agencies to participate, exemplifying a best practice in broad stakeholder engagement. Their strategy emphasizes accelerating access to innovative therapies, improving patient outcomes, and aligning payment with results—principles that can benefit other departments and agencies seeking effective, outcome-driven healthcare solutions.

#### Accomplishment #4: Dental Incentive Payment Program (DIPP) Implementation

- A. What was achieved? The Medicaid Dental Incentive Payment Program (DIPP) increased access to dental care for Medicaid-enrolled children by incentivizing dental providers to deliver preventive and restorative services. Through performance-based payments, the program aims to improve provider participation rates, increased utilization of dental services, and reduced barriers to care. There are three key quality performance measures:

Measure Name	Description / Metric Details
DIPP-1: Timely Recall Visit	The rate of routine exams performed within 175 to 235 days from the previous exam, for patients aged one year and older.
DIPP-2: Twice Annual Fluoride	The rate of second topical fluoride applications performed within 175 to 235 days of the previous fluoride treatment, for children ages one through twenty.
DIPP-3: Restorative Care Rate	The rate of restorative services performed within 0 to 180 days of a routine exam, for patients ages three years and older

- B. Why is this success significant? This success is significant because oral health is directly

tied to overall health outcomes, particularly for children. Historically, Louisiana has faced challenges with low dental utilization among Medicaid members. The program helps address disparities by encouraging providers to serve more children, thereby improving population health outcomes.

- C. Who benefits and how? Medicaid beneficiaries (especially children): gain increased access to preventive and restorative dental services. Dental providers: receive financial incentives tied to quality and service delivery, making Medicaid participation more sustainable. The State of Louisiana: benefits from improved health outcomes, reduced long-term costs, and progress toward federal quality benchmarks.
- D. How was the accomplishment achieved? The program was achieved through a structured incentive payment methodology tied to specific performance metrics. Providers were rewarded based on measurable outcomes such as the number of Medicaid-enrolled children receiving dental visits and preventive services. Collaboration between LDH, dental benefit program managers, and providers ensured accountability and alignment with Medicaid's strategic goals.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes. It advances LDH's strategic goals by:
  - Expanding access to essential health services.
  - Improving health equity for underserved populations.
  - Promoting provider participation in Medicaid.
  - Driving measurable improvements in health outcomes.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. The DIPP model is a strong example of performance-based incentives. Its methodology—aligning financial incentives with health outcomes—can be replicated across other health and human services programs to improve access, provider engagement, health outcomes, and overall efficiency.

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- ◆ **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized? In January 2024, LDH began working with a new administration and new agency secretary. The agency goals and priorities changed. Medicaid is making significant progress in increasing efficiencies and eliminating waste. A new strategic plan was submitted in July 2025.

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

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

What was outlined in the strategic plan for the July 1, 2024 – June 30, 2025 was no longer applicable to the shift in goals that took place with the new administration in January of 2024. Medicaid began making significant progress on new goals beginning in January 2024.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Medicaid has revised its strategic plan and will continue to make progress.

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

None

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

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

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

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

No. If not, why not?

The strategic plan has been revised to better align with the priorities of new agency leadership. The new strategic plan focuses on improving the Medicaid program and increasing efficiencies.

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

On a Department-wide level, Performance-Based-Budgeting activities (including strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the Louisiana Department of Health Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback.

Recommendations go directly to the Assistant Secretaries or the Secretary, if modifications or additions are necessary. In addition, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be useful to improve strategic and operational planning, or program management operations.

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

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

What was outlined in the strategic plan for the July 1, 2024 – June 30, 2025 was no longer applicable to the shift in goals that took place with the new administration in January of 2024. Medicaid began making significant progress on new goals beginning in January 2024.

#### B. Corrective Actions

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

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

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

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

4. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur?
- How much progress has been made and how much additional progress is needed?

b. If not:

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

5. Do corrective actions carry a cost?

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
- b. How much has been expended so far?
- c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
- d. Will additional personnel or funds be required to implement the

recommended actions? If so:

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

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

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

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

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

Policy, research, planning, and/or quality assurance functions by contract

- Program evaluation by in-house staff
- Program evaluation by contract
  
- Performance Progress Reports (Louisiana Performance Accountability System)**  
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
  
- In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.
  
- Benchmarking for Best Management Practices**  
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.
  
- Performance-based contracting (including contract monitoring)**  
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.
  
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

**Report #1**

1. **Title of Report or Program Evaluation:**  
Continuity of Care for Newborns
2. **Date completed:**  
February 2025
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**  
Louisiana Department of Health (LDH) submits the following report in response to ongoing reporting provision of Act 311 of the 2013 Regular Louisiana Legislative Session. This report provides the incidence and causes of the re-hospitalization of infants born premature at less than 37 weeks' gestational age and within the first six months of life.
4. **Methodology used for analysis or evaluation: Cost (allocation of in-house resources or purchase price):**  
Act 311 requires an assessment of the incidence and causes of all re-hospitalizations of infants born premature at less than 37 weeks' gestational age and within the first six months of life. The report utilizes Vital Records data obtained from the Office of Public Health for establishing gestational age and Medicaid claims data/MCO encounter data stored in the Medicaid Data Warehouse for identifying the primary discharge diagnoses that triggered the re-hospitalizations.
5. **Cost (allocation of in-house resources or purchase price):**  
Compiled by University of Louisiana at Monroe (ULM) staff; falls within scope of work of contract.
6. **Major Findings and Conclusions:**  
The rehospitalization rate for infants born during calendar year 2023 who were born premature at less than 37 weeks gestational age and are in their first six months of life is 4.03%. The rehospitalization rate for 2022 births was 3.66%. This indicates that the rehospitalization rate in this group of newborns increased from the previous reporting year.
7. **Major Recommendations:**  
(Not Applicable)
8. **Action taken in response to the report or evaluation:**  
(Not Applicable)
9. **Availability (hard copy, electronic file, website):**  
[https://ldh.la.gov/assets/docs/LegisReports/Act311/Act311Report\\_January2025.pdf](https://ldh.la.gov/assets/docs/LegisReports/Act311/Act311Report_January2025.pdf)  
**Contact person for more information, including:**

**Name:** Kim Sullivan  
**Title:** Executive Director  
**Agency & Program:** Bureau of Health Services Financing (Medicaid)  
**Telephone:** 225-219-7810  
**Email:** Kimberly.Sullivan@LA.GOV

## **Report #2**

1. **Title of Report or Program Evaluation:**  
Louisiana Medicaid Diabetes and Obesity Report
2. **Date completed:**  
July 2025
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**  
Per Louisiana Revised Statute (RS) 46:2616 and RS 46:2617, an annual diabetes and obesity action plan submission is necessary to the Senate and House Committees on Health and Welfare after consulting with, and receiving comments from, the medical directors of each of its contracted Medicaid partners.
4. **Methodology used for analysis or evaluation:**  
Each Medicaid managed care plan is required to complete a template that requests data designed to meet requirements of RS 46:2617. The template consists of 12 reports that gather diabetes and obesity prevalence and utilization within each plan to address diabetes and obesity items in RS 46:2617. The resulting 60 reports aggregated across the five plans to yield 12 reports for Healthy Louisiana. The Healthy Louisiana reports are in the "Diabetes and Obesity Action Report for the Healthy Louisiana Program.
5. **Cost (allocation of in-house resources or purchase price):**  
Compiled by University of Louisiana at Monroe (ULM) staff; falls within scope of work of contract.
6. **Major Findings and Conclusions:**  
Managing obesity and diabetes is a complicated endeavor, and the strategies described in this report serve as a foundation for healthier Louisiana residents. Changes must occur in multiple parts of the health care system, community settings and in personal behaviors in order to affect the obesity and diabetes epidemic.
7. **Major Recommendations:**
  - a. Promote Well-Ahead Louisiana's Community Resource Guide as a tool to identify local (by parish) health-related resources. This resource is available at <http://wellaheadla.com/Well-aheadcommunity/community-resource-guide>
  - b. Encourage the use of community and faith-based organizations to promote the importance of healthy eating and physical fitness.
  - c. Encourage the use of outpatient nutritional services provided by registered dietitians for all patients and all diagnoses, not just those patients with diabetes and obesity.
  - d. Promote the use of diabetes self-management education (DSME) programs or incorporate elements of these programs into case management activities

for patients with diabetes. DSME programs have been associated with improved health outcomes for patients with diabetes.

8. **Action taken in response to the report or evaluation:**  
(Not Applicable)
9. **Availability (hard copy, electronic file, website):**  
[https://ldh.la.gov/assets/docs/LegisReports/ACT210/Act\\_210\\_Diabetes\\_Obesity\\_Report\\_Medicaid\\_2025.pdf](https://ldh.la.gov/assets/docs/LegisReports/ACT210/Act_210_Diabetes_Obesity_Report_Medicaid_2025.pdf)
10. **Contact person for more information, including:**  
**Name:** Kim Sullivan  
**Title:** Executive Director  
**Agency & Program:** Bureau of Health Services Financing (Medicaid)  
**Telephone:** 225-219-7810  
**Email:** Kimberly.Sullivan@LA.GOV

### **Report #3**

1. **Title of Report or Program Evaluation:**  
Medicaid Managed Care Quarterly Transparency Reports SFY 2025
2. **Date completed:**  
Quarterly 2025
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**  
In response to ACT 482 of the 2018 Regular Legislative Session, the Louisiana Department of Health (LDH) is required to submit the Medicaid Managed Care Quarterly Transparency report. This report includes only those expansion population counts and expenditures for individuals enrolled in an MCO for either full or partial benefits.
4. **Methodology used for analysis or evaluation:**  
The methodology updates for pulling data regarding earned income started in State Fiscal Year 2024 (July 1, 2023 to June 30, 2024) to assure that the income corresponds to the current reporting period. The five MCOs received payments to manage the care of individuals in the expansion population for medical, specialized behavioral health, pharmacy, and transportation services.
5. **Cost (allocation of in-house resources or purchase price):**  
Compiled by internal staff.
6. **Major Findings and Conclusions:**  
(Not Applicable)
7. **Major Recommendations:**  
(Not Applicable)
8. **Action taken in response to the report or evaluation:**  
(Not Applicable)
9. **Availability (hard copy, electronic file, website):**  
<https://ldh.la.gov/assets/docs/LegisReports/ACT482/ACT482SFY2025Q2.pdf>
10. **Contact person for more information, including:**  
**Name:** Kim Sullivan  
**Title:** Executive Director  
**Agency & Program:** Bureau of Health Services Financing (Medicaid)

**Telephone:** 225-219-7810

**Email:** Kimberly.Sullivan@LA.GOV

#### **Report #4**

1. **Title of Report or Program Evaluation:**  
Healthy Louisiana Claims Report
2. **Date completed:**  
Quarterly 2025
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**  
In response to Act 710 of the 2018 regular session of the Louisiana Legislature, the “Healthy Louisiana Claims Report” submitted to the Joint Legislative Committee on the Budget and the House and Senate Committees on Health and Welfare. The Act requires the Department to conduct a number of activities and analyses pertaining to each Medicaid managed care organization (MCO) for the purpose of ensuring each MCO’s compliance with the terms of its contract with the Louisiana Department of Health (“the Department” or LDH). The Act stipulates that results of these activities and analyses used to generate an initial report to the legislature and inform the contents of ongoing quarterly reporting.
4. **Methodology used for analysis or evaluation:**  
For each of these key measures, data reported at the statewide level, at the individual MCO level, and at the individual provider category level. Each MCO is also gathering data related to each MCOs’ educational efforts with providers about claims submissions, with a particular focus on those providers that have a high claims denial rate.
5. **Cost (allocation of in-house resources or purchase price):**  
Compiled by Burns & Associates
6. **Major Findings and Conclusions:**
  - a. Claims accepted and rejected by the MCOs
  - b. Claims paid and denied by the MCOs
  - c. Average time for the MCOs to process claims
  - d. Top reasons for denied claims
  - e. Encounter claims submitted to LDH by the MCOs that are accepted or rejected
  - f. Average time for the MCOs to submit encounters
  - g. Provider education related to claims adjudication
7. **Major Recommendations:**
  - a. Develop a common set of definitions for claims and encounter adjudication terms that all MCOs would use as well as the LDH fee-for-service payment system.
  - b. Review the MCO reports that focus on claims and consider modifying, consolidating, or eliminating existing reports, consider adding a report on encounter submissions.
  - c. Build guidance or requirements about the expectations that the MCOs will perform root causes analyses pertaining to claims adjudication and/or encounter submissions.

- d. Develop an audit protocol and conduct a periodic audit of a sample of claims denied by the MCOs to ensure that the claims denied in error by the MCO.
8. **Action taken in response to the report or evaluation:**  
Quarterly reports for claims and encounter submission, including standardization of terms and definitions, developed with stakeholder and MCO input; and data collection and reporting implemented for calendar year 2019 forward.
9. **Availability (hard copy, electronic file, website):**  
<https://ldh.la.gov/assets/docs/LegisReports/ACT710/HealthyLouisianaClaimsReportQ42023.pdf>
10. **Contact person for more information, including:**  
**Name:** Kim Sullivan  
**Title:** Executive Director  
**Agency & Program:** Bureau of Health Services Financing (Medicaid)  
**Telephone:** 225-219-7810  
**Email:** Kimberly.Sullivan@LA.GOV

### **Report #5**

1. **Title of Report or Program Evaluation:**  
LaCHIP Annual Report (Mid-Year)
2. **Date completed:**  
March 2025
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**  
This report is submitted per the guidelines in Louisiana Revised Statute 46:976 (C)
4. **Methodology used for analysis or evaluation:**  
Compilation of Medicaid eligibility program data.
5. **Cost (allocation of in-house resources or purchase price):**  
Compiled by in-house staff.
6. **Major Findings and Conclusions:**  
200,363 children and pregnant women have acquired access to critical healthcare coverage in SFY 2023. Studies have found that enrollment in the program has improved school performance among low-income children.
7. **Major Recommendations:**  
(Not Applicable)
8. **Action taken in response to the report or evaluation:**  
(Not Applicable)
9. **Availability (hard copy, electronic file, website):**  
[https://ldh.la.gov/assets/docs/LegisReports/LaCHIP/LaCHIP\\_Legislative\\_Report\\_SFY25\\_Mid-Year.pdf](https://ldh.la.gov/assets/docs/LegisReports/LaCHIP/LaCHIP_Legislative_Report_SFY25_Mid-Year.pdf)
10. **Contact person for more information, including:**  
**Name:** Kim Sullivan  
**Title:** Executive Director  
**Agency & Program:** Bureau of Health Services Financing (Medicaid)

**Telephone:** 225-219-7810  
**Email:** Kimberly.Sullivan@LA.GOV

### **Report #6**

1. **Title of Report or Program Evaluation:**  
Medicaid Forecast Report SFY 24/25
2. **Date completed:**  
Monthly
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**  
Provide the budget changes because of House Bill (HB) 516 from the 2021 regular session.
4. **Methodology used for analysis or evaluation:**  
Program staff develops budget projections based on utilization trends, enrollment trends, and other known factors affecting the management of the Medicaid program. Actual year-to-date expenditures come from the Medicaid Data Warehouse and ISIS.
5. **Cost (allocation of in-house resources or purchase price):**  
Compiled by in-house staff
6. **Major Findings and Conclusions:**  
(Not Applicable)
7. **Major Recommendations:**  
(Not Applicable)
8. **Action taken in response to the report or evaluation:**  
(Not Applicable)
9. **Availability (hard copy, electronic file, website):**  
[https://ldh.la.gov/assets/docs/LegisReports/MedicaidMonthlyForecast/MedicaidForecast\\_Feb-Apr2025.pdf](https://ldh.la.gov/assets/docs/LegisReports/MedicaidMonthlyForecast/MedicaidForecast_Feb-Apr2025.pdf)
10. **Contact person for more information, including:**  
**Name:** Kim Sullivan  
**Title:** Executive Director  
**Agency & Program:** Bureau of Health Services Financing (Medicaid)  
**Telephone:** 225-219-7810  
**Email:** Kimberly.Sullivan@LA.GOV

### **Report #7**

1. **Title of Report or Program Evaluation:**  
Act 540 Uncompensated Care Cost  
**Date completed:**  
November 2024
2. **Subject or purpose and reason for initiation of the analysis or evaluation:**  
In response to Senate Bill No. 337 (SB337/Act 540) of the 2008 Regular Session, the Louisiana Department of Health (LDH) submits the enclosed

report. In response to Senate Bill No. 337 (SB337/Act 540) of the 2008 Regular Session, the Louisiana Department of Health (LDH) submits the enclosed report.

3. **Methodology used for analysis or evaluation:**  
Hospitals that received Medicaid Disproportionate Share Hospital (DSH) Payments were required to report uninsured patient specific information which included name, dates of service, type of service, number of inpatient days, and number of outpatient visits, billed charges, and uninsured cash collections. Using each hospital's latest filed Medicare/Medicaid cost report, the cost to charge ratios were calculated and applied to the uninsured charges compiled from the survey to determine the uninsured costs. Inpatient routine, inpatient ancillary, and outpatient uninsured costs are separately identified.
4. **Cost (allocation of in-house resources or purchase price):**  
Myers & Stauffer, LC: as part of contract.
5. **Major Findings and Conclusions:**  
Not Applicable
6. **Major Recommendations:**  
Not Applicable
7. **Action taken in response to the report or evaluation:**  
Not Applicable
8. **Availability (hard copy, electronic file, website):**  
<https://ldh.la.gov/news/1454>
9. **Contact person for more information, including:**  
  - Name:** Kim Sullivan
  - Title:** Executive Director
  - Agency & Program:** Bureau of Health Services Financing (Medicaid)
  - Telephone:** 225-219-7810
  - Email:** [Kimberly.Sullivan@LA.GOV](mailto:Kimberly.Sullivan@LA.GOV)

### **Report #8**

1. **Title of Report or Program Evaluation:**  
Medicaid PDL (MPP) Response to Act 207 of the 2003 Regular Session
2. **Date completed:**  
March 2025
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**  
Act 207 (Senate Bill No. 305 of the 2003 Regular Session) requires the Louisiana Department of Health (LDH) to submit certain information on a semi-annual basis regarding the Medicaid buy-in program, the Medicaid Purchase Plan (MPP), to the Joint Legislative Committee on the Budget and to the House and Senate Health and Welfare committees. The MPP is an optional Medicaid program that provides healthcare coverage to individuals with disabilities who are employed and meet specific income requirements. MPP was implemented in January 2004 and provides full medical coverage that includes prescription drugs, hospital care, doctor services, medical

- equipment and supplies, and medical transportation.
4. **Methodology used for analysis or evaluation:**  
The report includes the status of MPP, the total annual gross income of the program's participants, and any recommendations for expanding coverage in the program. Revised Statute 24:772 also requires that the report be submitted to the President of the Senate and to the Speaker of the House. This report contains data for the first six months of State Fiscal Year (SFY) 2025.
  5. **Cost (allocation of in-house resources or purchase price):**  
Compiled by internal staff
  6. **Major Findings and Conclusions:**  
MPP enrollees are taxpaying residents whose estimated combined gross earned income during the first six months of SFY 2025 totaled \$29,379,416, contributed approximately \$2,954,117 in federal taxes (including FICA and federal income tax) and approximately \$476,407 in state taxes. Total income is estimated based on information provided by members or system checks through the Louisiana Department of Revenue. Income information provided for one or more months is used to project 12 month totals. Tax information is estimated using current tax tables.
  7. **Major Recommendations:**  
Not Applicable
  8. **Action taken in response to the report or evaluation:**  
Not Applicable
  9. **Availability (hard copy, electronic file, website):**  
[https://ldh.la.gov/assets/docs/LegisReports/ACT207/MPP\\_LegislativeReport\\_SFY25\\_MidYear.pdf](https://ldh.la.gov/assets/docs/LegisReports/ACT207/MPP_LegislativeReport_SFY25_MidYear.pdf)
  10. **Contact person for more information, including:**  
**Name:** Kim Sullivan  
**Title:** Executive Director  
**Agency & Program:** Bureau of Health Services Financing (Medicaid)  
**Telephone:** 225-219-7810  
**Email:** [Kimberly.Sullivan@LA.GOV](mailto:Kimberly.Sullivan@LA.GOV)

### **Report #9**

1. **Title of Report or Program Evaluation:**  
Medicaid Preferred Drug List Annual Report SB 689 of the 2004 RS - HB 369 of the 2005 RS – SFY 16-20
2. **Date completed:**  
July 2025
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**  
The Louisiana Department of Health and Hospitals (DHH) preferred drug list (PDL) program has been in operation since 2002 by Provider Synergies, L.L.C. Provider Synergies is an affiliate of Magellan Medicaid Administration, Inc., and a Magellan Rx Management company

(“Magellan”). Louisiana is entering the twelfth year as one of six states participating in the multi-state purchasing program, The Optimal PDL Solution (TOP\$). Louisiana was one of three states that initially participated in the multi-state purchasing pool, TOP\$, in 2005. The six states now participating in TOP\$ are Louisiana, Maryland, Idaho, Wisconsin, Nebraska, and Connecticut.

4. **Methodology used for analysis or evaluation:**  
This review summarizes the results of the PDL program for fiscal year 2023-2024 (FY2024) and the first quarter of fiscal year 2024-2025 (FY2025). This report includes MCO data.
5. **Cost (allocation of in-house resources or purchase price):**  
Magellan Rx Management Company
6. **Major Findings and Conclusions:**  
In SFY 2024, supplemental rebate collections totaled approximately \$195 million, of which approximately \$61 million remained with the state.
7. **Major Recommendations:**  
Not Applicable
8. **Action taken in response to the report or evaluation:**  
Not Applicable
9. **Availability (hard copy, electronic file, website):**  
[https://ldh.la.gov/assets/docs/LegisReports/PreferredDrugList/PharmacyPDL\\_ReportSFY2024.pdf](https://ldh.la.gov/assets/docs/LegisReports/PreferredDrugList/PharmacyPDL_ReportSFY2024.pdf)
10. **Contact person for more information, including:**  
**Name:** Kim Sullivan  
**Title:** Executive Director  
**Agency & Program:** Bureau of Health Services Financing (Medicaid)  
**Telephone:** 225-219-7810  
**Email:** [Kimberly.Sullivan@LA.GOV](mailto:Kimberly.Sullivan@LA.GOV)

### **Report #10**

1. **Title of Report or Program Evaluation:**  
Act No. 670 – “Lorri Burgess’ Law” – Senate Bill 298 of the Regular Legislative Session 2022
2. **Date completed:**  
March 2025
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**  
This report is submitted pursuant to Senate Bill 298 of the 2022 Regular Legislative Session, which requires the Louisiana Department of Health (LDH) to conduct an annual review of all medications and forms of treatment for sickle cell disease (SCD) that are eligible for coverage under the Louisiana Medicaid program. The report shall be submitted to the Senate Committee on Finance, the House Committee on Appropriations, and the Senate and House committees on health and welfare.
4. **Methodology used for analysis or evaluation:**  
The annual review should include input from the general public, particularly

- those persons or groups with knowledge and experience of SCD treatment.
5. **Cost (allocation of in-house resources or purchase price):**  
Compiled by internal staff
  6. **Major Findings and Conclusions:**  
Study findings show that covered medications, treatments, and services are available to Louisiana Medicaid members with SCD but may be underutilized. From routine preventive care to SCD specialty care, there are multiple opportunities to better ensure that adults and children with SCD receive the recommended care.
  7. **Major Recommendations:**  
Study findings show that covered medications, treatments, and services are available to Louisiana Medicaid members with SCD but may be underutilized. There are multiple opportunities to better ensure that adults and children with SCD receive the recommended care. These opportunities include, but are not limited to:
    - Annual TCD ultrasound screening to evaluate stroke risk, which was used in 15.7% of Louisiana Medicaid-enrolled children ages 2 to 16 with SCD.
    - Treatment with hydroxyurea to reduce vaso-occlusive pain episodes and other vaso-occlusive complications was used by 34.4% of Louisiana Medicaid-enrolled children with SCD.
    - Pneumococcal vaccination to prevent severe bacterial infection was provided to 54.5% of Louisiana Medicaid-enrolled children younger than age 2 who had SCD.
    - Routine preventive care with a hematologist to co-manage care, which was less common in adults with SCD than in children with SCD, indicating challenges in transitions of care.
  8. **Action taken in response to the report or evaluation:**  
Not applicable.
  9. **Availability (hard copy, electronic file, website):**  
[https://ldh.la.gov/assets/docs/LegisReports/Act670/LA\\_2024\\_SickleCellBill298\\_F1.pdf](https://ldh.la.gov/assets/docs/LegisReports/Act670/LA_2024_SickleCellBill298_F1.pdf)
  10. **Contact person for more information, including:**  
 Name: Kim Sullivan  
 Title: Executive Director  
 Agency & Program: Bureau of Health Services Financing (Medicaid)  
 Telephone: 225-219-7810  
 Email: [Kimberly.Sullivan@LA.GOV](mailto:Kimberly.Sullivan@LA.GOV)

## **Report #12**

1. **Title of Report or Program Evaluation:**  
HCR 17 R.S. 2024 - Mental Health Counseling in Public Schools Report
2. **Date completed:**  
February 2025
3. **Subject or purpose and reason for initiation of the analysis or evaluation:**

The Study of Best Practices to Increase Mental Health Counseling in Public Schools is a report submitted according to House Concurrent Resolution NO. 17 of the 2024 Regular Legislative Session, which requests that the state Department of Education (LDOE), the Department of Children and Family Services (DCFS), and the Louisiana Department of Health (LDH) collaborate to increase mental health counseling in public schools.

4. **Methodology used for analysis or evaluation:**  
Internal staff
5. **Cost (allocation of in-house resources or purchase price):**  
(Not Applicable)
6. **Major Findings and Conclusions:**  
(Not Applicable)
7. **Major Recommendations:**
  - Medicaid is in the process of implementing a new Centers for Medicare and Medicaid Services (CMS) administrative rule that is designed to reduce the administrative burden of billing in the SBMP. Rather than submitting individual claims for each service provided, LEAs will be able to complete roster billing, which allows states to compute a rate representative of multiple services delivered. LEAs would multiply that rate on a quarterly or monthly basis by the number of Medicaid-enrolled students who receive a covered service within the service period. These quarterly/monthly payments would then be reconciled to actual costs at the end of each year. This streamlined billing method is anticipated to enhance LEA compliance and potentially eliminate the need for some LEAs to utilize third-party billing vendors.
  - Increase access to behavioral health services in schools by allowing LEAs to use Provisional Licensed Professional Counselors (PLPCs), Provisional Licensed Marriage and Family Therapists (PLMFTS), and Licensed Master Social Workers (LMSWs) to provide assessment and therapeutic services within their scopes of practice.
  - Medicaid is in the process of completing a new MCO request for proposals (RFP). CMS guidance encourages state Medicaid agencies proactively to include schools during the MCO re-procurement and contracting processes to provide opportunities to shape new or revisit existing MCO requirements. The Louisiana Department of Health is reviewing examples from other states and considering how MCOs can be more proactive in school settings.
8. **Action taken in response to the report or evaluation:**  
(Not Applicable)
9. **Availability (hard copy, electronic file, website):**  
<https://ldh.la.gov/assets/docs/LegisReports/HCR17Report011425.pdf>
10. **Contact person for more information, including:**  
**Name:** Kim Sullivan  
**Title:** Executive Director  
**Agency & Program:** Bureau of Health Services Financing (Medicaid)  
**Telephone:** 225-219-7810

**Email:** [Kimberly.Sullivan@LA.GOV](mailto:Kimberly.Sullivan@LA.GOV)

# Annual Management and Program Analysis Report

## Fiscal Year 2023-2024

**Department:** Louisiana Department of Health (LDH)  
09-307 Office of the Secretary

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

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

**Accomplishment:** LDH Announces \$15 Million in H.E.R.O Funding to Train Healthcare Workforce

A. What was achieved?

The Louisiana Department of Health (LDH) announced a funding initiative of \$15 million aimed at training the future healthcare workforce. The Healthcare Employment Reinvestment Opportunity (H.E.R.O.) Fund offers matching grants to universities, technical colleges, healthcare systems, hospitals, agencies and associations that are focused on expanding the healthcare pipeline in Louisiana.

The objective of the H.E.R.O. Fund is to enhance the availability of high-demand healthcare professionals and to facilitate access for graduates of these in-demand roles into positions within nursing homes and other health industry collaborators in the State of Louisiana, thereby improving retention of healthcare workers in the state.

The Louisiana Department of Health is tasked with the oversight of this program and serves as the primary agency responsible for announcing awards and providing reimbursements for the proposals that are awarded.

The H.E.R.O. Fund sought grant applications from healthcare training and education programs, as well as healthcare industry partners, to address growing employment demands.

B. Why is this success significant?

The H.E.R.O. Fund represents a significant initiative aimed at bolstering Louisiana's healthcare industry and enhancing access to medical services for its residents, particularly those in underserved regions.

By focusing on the development of Louisiana's healthcare workforce, this initiative addresses not only today's requirements, but also lays the groundwork for future needs. A strong healthcare workforce is the backbone of a healthy society.

Across the nation, and particularly in Louisiana, the state is confronted with critical shortages in the healthcare workforce, and the Louisiana Department of Health (LDH) is dedicated to addressing those issues head-on. The H.E.R.O. Fund is an excellent funding opportunity that is expected to have a meaningful impact and potentially broaden programs in areas of high workforce demand, such as nursing, allied health, and behavioral health.

C. Who benefits and how?

The H.E.R.O. Fund will support projects that aim to meet local, regional or state workforce demands for high-demand healthcare professions. High-demand areas include, but are not limited to, certified nursing assistants, paramedics, licensed practical nurses, registered nurses, certified medical assistants, primary care providers, nurse practitioners, licensed professional counselors, respiratory therapists, occupational therapists, radiology technologists and more. Training must benefit students and healthcare organizations within the State of Louisiana.

The H.E.R.O. Fund will:

- Increase capacity and student enrollment in identified healthcare credentials,
- Increase program completion and/or exam/certification pass rates,
- Provide incentives that financially support students (i.e., stipends or tuition forgiveness) upon employment in Louisiana healthcare facilities or training programs,
- Provide incentives for high-demand healthcare professionals to practice in Louisiana with an emphasis on medically underserved areas,
- Support dual enrollment programs between high school career and technical programs and other healthcare programs,
- Support strategies for healthcare organizations to increase career pathways, internships and apprenticeship programs, and
- Raise awareness of and interest in a broad variety of healthcare occupations and reduce the barriers to access to the healthcare programs necessary to pursue these occupations, including financial barriers.

D. How was the accomplishment achieved?

The H.E.R.O. Fund was established in 2021 with the aim of enhancing the capacity of nursing and allied health programs. Managed by the Louisiana Board of Regents and

the HealthWorks Commission, the fund initially awarded approximately \$4 million in grants to support one program in each region of the state.

In 2024, State Representative Brach Myers introduced [new legislation](#) HB 329 (Act 607) shifting the direction of the program to LDH and broadening the program's scope to encompass a wider range of individuals and institutions. The fund sought grant applications from healthcare training and education programs and healthcare industry partners whose intent was to meet the growing employment demands for nursing, allied health professionals, and other high-demand health care providers.

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

Yes, this program contributes to the success of LDH's strategic plan by strengthen Louisiana's healthcare industry and improving access to care for residents. It also contributes to our strategic goal of protecting and promoting health for Louisiana residents.

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

Yes, effective collaboration helps influence policy, ensure smooth implementation of legislation, and achieve shared goals.

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- ◆ **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?
- ◆ **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
  1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example:

Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
- Other? Please specify.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?
- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:
1. To what do you attribute this lack of progress? For example:
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
    - Is the lack of progress due to budget or other constraint?
    - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
    - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?
- ♦ **Has your department revised its strategic plan to build on your successes and address shortfalls?**
- Yes. If so, what adjustments have been made and how will they address the situation?
- No. If not, why not?
- ♦ How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and

updated, and utilized for management decision-making and resource allocation? Use as much space as needed to explain fully.

**III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?** (“Problems or issues” may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. “Problems or issues” may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. “Problems or issues” may or may not be related directly to strategic plan lack of progress.)

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

**A. Problem/Issue Description**

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

**B. Corrective Actions**

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

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

Unsure, as there are probably corrective actions that all sections must take to address the contracts and procurement problems.

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

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

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

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

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

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

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

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

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

**Performance Progress Reports (Louisiana Performance Accountability System)**

The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

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

Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

**Benchmarking for Best Management Practices**

The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

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

LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

- Peer review  
 Accreditation review  
 Customer/stakeholder feedback  
 Other (please specify):

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

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

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each report, please discuss and explain each item below.

1. Title of Report or Program Evaluation:
2. Date completed:
3. Subject or purpose and reason for initiation of the analysis or evaluation:
4. Methodology used for analysis or evaluation:
5. Cost (allocation of in-house resources or purchase price):

6. Major Findings and Conclusions:
7. Major Recommendations:
8. Action taken in response to the report or evaluation:
9. Availability (hard copy, electronic file, website):
10. Contact person for more information:
  - Name & Title:
  - Agency & Program:
  - Telephone:
  - E-mail:

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-309 South Central Louisiana Human Services Authority

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Kristin Bonner, MHA, BSN, RN

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

For each accomplishment, please discuss and explain each item below.

#### Accomplishment #1: Assisted Outpatient Treatment (AOT) Court:

A. What was achieved?

South Central Louisiana Human Services Authority (SCLHSA) applied for and received a Federal grant from SAMHSA for \$2,000,000 to begin a court program in collaboration with the 32<sup>nd</sup> Judicial District Court for individuals with serious mental illness (SMI) in Terrebonne Parish. Although AOT court is an involuntary court order; it provides structured community-based treatment such as therapy, medication, case management, and supportive services to individuals with serious mental illness who struggle with voluntary treatment adherence.

B. Why is this success significant?

Terrebonne AOT emphasizes individualized treatment planning, coordinated care, and intensive supports such as Assertive Community Treatment (ACT), therapeutic injections, and case management to directly address the barriers that prevent this

population from remaining in voluntary care. This not only enhances safety for the individual and the community, but also improves quality of life, restores dignity, and reduces the strain on emergency, judicial, and healthcare systems.

AOT programs are significant because it translates into measurable outcomes: safer communities, lower costs, and, most importantly, improved long-term recovery and stability for people who are often the most vulnerable and hardest to reach.

C. Who benefits and how?

Adult individuals, their families, and the community in which they live will benefit from participating in AOT court. Specifically, by court-ordered treatment, adherence to medication regimes, reducing hospital visits, and reducing the number of arrests and days spent in jail by individuals enrolled in the AOT program.

La R.S. 28:66 describes criteria for civil involuntary outpatient treatment as a respondent may be ordered to obtain civil involuntary outpatient treatment if the court finds that all of the following conditions apply:

- (1) The respondent is eighteen years of age or older.
- (2) The respondent is suffering from a mental illness.
- (3) The respondent is unlikely to survive safely in the community without supervision.
- (4) The respondent has a history of lack of compliance with treatment for mental illness.
- (5) The respondent is, as a result of his mental illness, unlikely to voluntarily participate in treatment.
- (6) In view of the treatment history and current behavior of the respondent, the respondent is in need of involuntary outpatient treatment to prevent a relapse or deterioration which would be likely to result in the respondent's becoming dangerous to self or others or gravely disabled as defined in R.S. 28:2.
- (7) It is likely that the respondent will benefit from involuntary outpatient treatment.

D. How was the accomplishment achieved?

The development of the AOT Court Program was achieved by reaching out in several of our parishes to judges who may be interested in mental health and had available time to hear cases on their docket. We had to secure a judge who was willing to agree to the AOT Court program, before SCLHSA could apply for the SAMHSA grant. Once the judge in Terrebonne Parish was secured, the application process began. SCLHSA received notice of the award September 2024 and initiated the hiring of the Project Director and developing the program plans, performance indicators and committees.

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

Yes

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

Yes, nationally, the success of Assisted Outpatient Treatment (AOT) court programs demonstrates that individuals with serious mental illness who historically cycle through crisis services, hospitalizations, and even the justice system can achieve stability and recovery when provided with structured, court-supervised, community-based care.

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

The South Central Louisiana Human Services Authority continues to utilize all Strategic Plan strategies with a concentrated focus on utilization management, monitoring and related follow-up activities, client engagement, and positive outcomes to achieve the Authority's objectives and strategies.

***Goal I: To provide core behavioral health services to children and adults and appropriate supports and waiver services to citizens with developmental disabilities by providing person-centered care that promotes quality of life.***

SCLHSA specifically, related to the AOT Court Program, are the following:

Objective IV: Establish the infrastructure to develop and implement an Assistive Outpatient Treatment (AOT) Program.

Strategies:

- 4.1 Create an AOT Management Team by hiring an AOT Program Director and AOT Case Manager to oversee the treatment planning process for the patient/client and monitor progress in meeting goals and objectives for court review of case on an ongoing basis.
- 4.2 Align with key stakeholders to create an AOT Steering Committee.
- 4.3 Develop policies, procedures, training for stakeholders, and the referral processes.
- 4.4 Identify patients/clients who would benefit from AOT services in Terrebonne Parish to engage in program.

#### 4.5 Replicate the AOT program in other parishes

Performance Indicators:

- Number of clients in the AOT program.
- Compliance with SAMHSA grant funding and reporting requirements.

***Goal II: Create an engaged and motivated workforce by providing programmatic leadership, direction, infrastructure and tools necessary to grow professionals in a manner that expands agency capacity, team member accountability and fiscal integrity.***

SCLHSA has made efforts to create a workforce to reach the goal by addressing specific strategies such as, the leadership team has invested significant time and resources in developing a comprehensive onboarding process to ensure team members feel confident, supported and well prepared for their roles prior to reporting to their domiciled site. New team members receive a multi-department training that includes electronic health record use, safety review, fiscal processes, IT orientation and clinical workflow review. The results include higher new-team member satisfaction, smoother integration into clinic workflows, fewer early errors, reduced reliance on existing staff for training, and improved retention during the first year of employment.

The Human Resource team has been recruiting for vacant positions on Indeed and through the State Civil Service website. Vacancies have been filled in social service counseling positions this year. Where the past several years there have been minimal to no candidates applying. SCLHSA retains a qualified team for agency through multiple motivational and pay incentive mechanisms, such as premium pay for licensed social workers and licensed practice counselors, as well as, payment for supervising new counselors.

SCLHSA continues to educate workforce on services provided by Behavioral Health with Integrated Primary Care and Developmental Disabilities Programs to assist with cross training for use with future strategies.

***Goal III: Research and implement steps congruent with current and future federal and state trends in behavioral health structure, clinical best practices and billing opportunities to optimize sustainability of the agency.***

SCLHSA has made positive strides in initiating the Assisted Outpatient Treatment (AOT) program. Developing policies, procedures, participant handbook, as well as other judicial documents. Hiring program staff and developing the grant budget has been a struggle due to external factors such as the restructuring at the federal level and consistent staff within SAMHSA. Progress is expected to gain momentum with the AOT program as we enroll participants.

SCLHSA is making strides in exploring and developing community partnerships to promote agency goals. The marketing plan now includes the OB/GYN providers in our

region promoting medications for substance use patients. SCLHSA also partners with Family Preservation Court, which is funded by the State Supreme Court, to provide outpatient treatment for parents to regain custody of their children. As partners to the EMBRACE program for pregnant mothers who are using addictive substances, SCLHSA also provides medication and treatment to these women before delivery.

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

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

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

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

None

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

1. To what do you attribute this lack of progress? For example:

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

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

None

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

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

No. If not, why not?

SCLHSA leadership has moved the establishment of an Assisted Outpatient Treatment (AOT) Court Program in one of the seven parishes in the SCLHSA catchment area from a long-term goal and revised the objective/strategies to a current goal with an implementation plan.

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

South Central Louisiana Human Services Authority continuously communicates, monitors, reports, and implements corrective action/process improvement activities with regard to Strategic Plan Goals, Objectives, Strategies and Performance Indicators via a broad range of venues (from individual supervision to performance reporting available to staff).

The Executive Management Team reviews, edits, and adopts the Strategic Plan with the SCLHSA Board each year. The group also develops, adopts, and implements cross-divisional annual performance improvement initiatives to insure SCLHSA will meet and/or exceed Strategic Plan Goals and Objectives and to support the successful sustainability of the Authority. The Executive Management Team delivers quarterly progress reports to the Board and Senior Management.

SCLHSA informs employees about Strategic Plan Goals, Objectives, Strategies and Performance Indicators via monthly Manager Meetings. The team members are involved in data collection, analysis, and reporting of Performance Indicator outcomes. Managers lead discussion about the Performance Improvement Plan during staff meetings, reporting progress, obtaining staff input, and emphasizing accountability for reaching goals and objectives. The Executive Director schedules quarterly All-Team meetings each year at each of the Behavioral Health Centers and Developmental Disabilities office. Performance improvement is a routine part of the agenda.

The Executive Director holds the Executive Management Team accountable on both an individual and group basis for the successful implementation of the SCLHSA Strategic Plan and Performance Improvement Initiatives. Each SCLHSA staff member has job-

specific performance factors and expectations included in his/her annual planning document to support Authority Goals.

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

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

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

#### A. Problem/Issue Description

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

The most pressing challenge is the unknown fiscal stability, which is driven by the federal and the state governments, decreased federal block grant allocations, and shrinking Medicaid enrollment. These overlapping pressures constrain the ability to plan, implement, or sustain programs confidently.

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

Yes, this budget uncertainty is affecting strategic priorities. Even well-designed corrective actions or efficiency measures may be rendered ineffective, or reversed, if funding shifts. Without stable funding, strategic momentum stalls and the organization risks repeatedly backtracking rather than moving forward.

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

While SCLHSA experiences the day-to-day effects across administration, clinical services and operations departments, the challenge originates at a broader level. Fiscal constraints faced by LDH/OBH flow downward throughout the system affecting both state oversight and local service delivery.

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

Stakeholders include internal staff, clinicians, clients, families, community partners, and ultimately all community residents who rely on SCLHSA behavioral health and developmental disabilities services. Disruptions due to enrollment reductions or funding changes could negatively impact continuity of care and affect trust.

5. How long has the problem or issue existed?

While fiscal pressures have existed for several years, they have been realized in the last fiscal year (FY2025), with reductions planned in FY2026 and additional reductions and efficiencies into FY2027.

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

The challenge is driven primarily by external fiscal factors (reductions in federal block grant funding, declining Medicaid enrollment post-continuous coverage era and economic constraints) that influence the state budget. These factors place SCLHSA in a position where forecasting and proactive planning is difficult. The inherent complexity of multi-stream funding and decision-making timelines often results in unintentionally forcing SCLHSA and fellow LGEs into reactive postures.

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

Continued financial instability and declining enrollment could lead to disruptions in service delivery, difficulty sustaining critical programs, and challenges in retaining skilled staff. This would impair care quality, destabilize service access for clients, and undermine efforts toward efficiency and strategic goals, impacting performance and outcomes across both SCLHSA and LDH.

B. Corrective Actions

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

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

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

- A potential solution could be to utilize a portion of the established Human Services Interagency Council (HSIC) meeting as a structured joint planning forum between LDH and the LGEs to develop multiple “contingency roadmaps” based on varying funding levels and enrollment scenarios. Ensuring LGEs are engaged early in statewide fiscal and policy

conversations, not just informed, so operational implications can shape decision-making with buy-in and feasibility in view. This approach allows both entities to co-create priorities and preserve programs under different circumstances.

- SCLHSA is researching the potential to create a program structure that can scale up or down relatively easily in response to funding shifts, while helping to preserve and adapt core functions accordingly.

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

No

4. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur?
- How much progress has been made and how much additional progress is needed?

b. If not:

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

No, SCLHSA is researching ways to provide treatment services while enacting efficiencies and creating additional revenue streams.

5. Do corrective actions carry a cost?

No. If not, please explain.

SCLHSA is exploring additional funding opportunities that are cost neutral. There is no cost associated with improving communication and strategic planning.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
- b. How much has been expended so far?
- c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

- d. Will additional personnel or funds be required to implement the recommended actions? If so:
- Provide specific figures, including proposed means of financing for any additional funds.
  - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

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

A. Check all that apply.

- Internal audit**  
 SCLHSA programs conduct departmental audits to ensure services provided meet the intended outcomes and quality of care through the Compliance Department. Through review of key processes, business functions and outcomes of care are designed, measured, and assessed by all appropriate services and disciplines in an effort to improve performance. Internal audit tools, associated findings, and corrective action plans also provide leadership with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

A fiscal monitor is assigned to each grant and contract for ongoing monitoring of budgets, the scope of work and deliverables. Quarterly, SCLHSA Fiscal staff meets with the Clinical Director, Deputy Director and Executive Director to review contracts, amends the budget, if needed, and discusses usage and outcomes.

- External audits (Example: audits by the Office of the Legislative Auditor)**  
 State of LA Civil Service, Office of Risk Management, Louisiana Department of Health's Office (LDH), Office of the Legislative Auditor (LLA), Commission on Rehabilitation Facilities (CARF), and the Healthy Louisiana Medicaid Plans are among those who review and SCLHSA's processes and procedures.

The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

LDH, Centers for Medicare & Medicaid (CMS), and other credentialing agencies also conduct audits and monitoring for compliance with program standards and accountability for funds received to administer programs.

The Office of Behavioral Health (OBH) and Office for Citizens with

Developmental Disabilities (OCDD) audit SCLHSA as set forth in the Accountability Plan, i.e. ongoing bi-monthly data reporting and bi-annual on-site audits.

- Policy, research, planning, and/or quality assurance functions in-house**  
SCLHSA utilizes CARF standards to measure conformance of programs. Accredited programs have measures related to the accessibility, efficiency, effectiveness, and satisfaction of clients and stakeholders. Indicators reflect the quality of community-based human services and supports provided by SCLHSA to persons with Substance Use Disorders, Developmental Disabilities, Mental and/or Physical Health all as part of our integrated approach to health care.
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)**  
SCLHSA participates in the required Louisiana Performance Accountability System (LaPAS) system. The LDH Division of Planning and Budget coordinates and reviews entries of the data on a quarterly basis for all LDH agencies, including the LGEs. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. LaPAS indicators are reflected in our Strategic Plan.
- In-house performance accountability system or process**  
SCLHSA conducts in-house performance monitoring activities identified in our agency's performance indicators as outlined by CARF, including the business functions and clinical programs. The results are reviewed quarterly and annually with findings detailed in our minutes. Activities including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System (LaPAS) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the each LDH agency, including the LGEs.
- Benchmarking for Best Management Practices**  
The LDH Division of Planning and Budget reviews and provides feedback in regards to the development of objectives, performance measures and strategies for each of the LGEs. SCLHSA compares benchmarks internally and externally, when available in performance-based budgeting activities. Recommendations are made directly to the agency's Executive Director if modifications or additions are needed.
- Performance-based contracting (including contract monitoring)**

LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

Peer review

Accreditation review  
SCLHSA is accredited by CARF. The comprehensive survey is held every three years. The last survey was January 24-26, 2024 and expires December 31, 2026.

Customer/stakeholder feedback

Other (please specify):

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

Yes. Proceed to Section C below.

No Skip Section C below.

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

1. Title of Report or Program Evaluation: Office of Behavioral Health Accountability Plan
2. Date completed: OBH conducts an onsite review during the first half of the fiscal year and a virtual review during the second of the fiscal year. Noted are the dates of the onsite and virtual reviews, respectively, for each Behavioral Health Center (BHC) Site. Lafourche BHC (LBHC) 9/18/24 and 2/14/25; River Parishes BHC (RPBHC) 9/18/24 and 2/13/25; St. Mary BHC (SMBHC) 9/20/24 and 2/13/25; and Terrebonne BHC (TBHC) 9/20/24 and 2/14/25.
3. Subject or purpose and reason for initiation of the analysis or evaluation:  
The Office of Behavioral Health Accountability Plan evaluation is conducted to ensure compliance with state standards, assess service quality, and monitor operational effectiveness across Behavioral Health Center sites. The reviews provide oversight, identify areas for improvement, and support continuous quality enhancement in service delivery.
4. Methodology used for analysis or evaluation:  
A standardized state-developed review tool was used to evaluate compliance with federal block grant requirements and LGE contractual obligations. The process included review of policies, practices, workflows, and case files. Compliance was

scored, with deficiencies documented for follow-up.

5. Cost (allocation of in-house resources or purchase price):  
Conducted using existing staff and state resources; no additional purchase costs incurred.
6. Major Findings and Conclusions:  
September 2024 onsite review identified missing federal confidentiality notice language (§ 2.22) at all sites. February 2025 virtual review found no deficiencies at any of the sites.
7. Major Recommendations: No major recommendations were found during either site review at any of the SCLHSA sites.
8. Action taken in response to the report or evaluation: SCLHSA has modified the Client handbook to include the Federal United States Attorney Offices contact information and removed the local United States Attorney Offices' contact information.
9. Availability (hard copy, electronic file, website): Available in electronic format upon request; maintained by SCLHSA Behavioral Health Clinical Department.
10. Contact person for more information:  
Name & Title: Misty Hebert, Deputy Director  
Agency & Program: South Central Louisiana Human Services Authority  
Behavioral Health and Integrate Primary Care programs  
Telephone: (985) 876-8812  
E-mail: Misty.Hebert@la.gov
1. Title of Report or Program Evaluation: Developmental Disabilities Accountability Plan
2. Date completed: 4/10/2025
3. Subject or purpose and reason for initiation of the analysis or evaluation: The purpose of the Human Services Accountability Plan (AP) Annual Monitoring Preliminary Report is to provide results from validating the accuracy of performance indicator data reviewed according to the operational instruction #F-7 Quality Partnership: Reporting and Verification of Performance Measures and Quality Management Initiatives for Developmental Disabilities Services. Monitoring occurs on an annual basis for performance indicators shown in the outcome measures in Section II: D of the Human Services Accountability Plan (AP) as agreed by the Office for Citizens with Developmental Disabilities (OCDD) and the Human Service Interagency Council (HSIC). Records are also reviewed for Flexible Family Fund (FFF), Individual and Family Support (IFS), Preadmission Screening and Resident Review (PASRR), System Entry,

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Certifications, New Opportunities Waiver (NOW), Children's Choice (CC) Waiver, Supports Waiver (SW) and Residential Options Waiver (ROW) to determine compliance with program policies and guidelines.

4. Methodology used for analysis or evaluation:

During the validation process, performance indicator data submitted quarterly is reviewed. Supporting documentation, which included data reports, monitoring reports, and financial reports provided during the validation process, is verified to determine the accuracy and reliability of data submitted. Corrective Action Plan (CAP) developed and implemented to address performance indicators that did not meet performance standards are reviewed and feedback is given by the Review Team, which may recommend that revisions and additional strategies be included. In addition, a CAP may be requested for a performance indicator where the performance standard has not been met and there appears to be no performance improvement. The Quality Enhancement Section staff conducts the review.

5. Cost (allocation of in-house resources or purchase price):

Conducted using existing staff and state resources; no additional purchase costs incurred.

6. Major Findings and Conclusions:

South Louisiana Human Services Authority (SCLHSA) met the performance standard for 25 performance indicators (or 96%) monitored.

7. Major Recommendations: None

8. Action taken in response to the report or evaluation: No corrective actions needed.

9. Availability (hard copy, electronic file, website): Available in electronic format upon request; maintained by SCLHSA Developmental Disabilities Office.

10. Contact person for more information:

Name & Title: Kristin Bonner, Executive Director

Agency & Program: South Central Louisiana Human Services Authority – Developmental Disabilities

Telephone: (985) 858-2931

E-mail: Kristin.Bonner@la.gov

1. Title of Report or Program Evaluation: Office of Risk Management

2. Date completed: 3/13/2025

3. Subject or purpose and reason for initiation of the analysis or evaluation:  
The ORM audit evaluates compliance with state risk management standards, including administrative, developmental disabilities (DD), and mental health (MH) program areas. The purpose is to ensure adherence to safety protocols, training requirements, and statewide risk management policies.
4. Methodology used for analysis or evaluation:  
ORM auditors conducted a structured review of records, policies, and documentation to verify compliance with training and safety requirements. Site visits and file reviews were used to assess completion of mandated courses and adherence to ORM guidelines.
5. Cost (allocation of in-house resources or purchase price):  
Audit completed using in-house staff resources in coordination with ORM; no additional purchase costs incurred.
6. Major Findings and Conclusions:  
Administrative Office received a 98.1% compliance rating. Mental Health Office received a 98.17% compliance rating. Developmental Disabilities Office received a 100% compliance rating. The auditor found defensive driving training (ORM Standard 2.3.3) was expired for some employees, exceeding the required 3-year renewal timeframe at both the Administrative Office and Mental Health Office.
7. Major Recommendations:  
Strengthen internal monitoring of defensive driving training to ensure timely completion prior to the 3-year expiration.
8. Action taken in response to the report or evaluation:  
SCLHSA implemented an internal reminder notification for staff with upcoming defensive driving expirations. The tracking system is in place to ensure courses are completed before the date of the 3-year deadline.
9. Availability (hard copy, electronic file, website):  
Available in electronic format upon request; maintained by SCLHSA Safety and Risk Management Coordinator.
10. Contact person for more information:
  - i. Name & Title: Misty Hebert, Deputy Director
  - ii. Agency & Program: South Central Louisiana Human Services Authority
  - iii. Telephone: (985) 876-8812
  - iv. E-mail: Misty.Hebert@la.gov
1. Title of Report or Program Evaluation: Civil Service Audit
2. Date completed: 10/07/2024

3. Subject or purpose and reason for initiation of the analysis or evaluation: The audit is focused on personnel actions for compliance with Civil Service rules.
4. Methodology used for analysis or evaluation: Civil Service auditors conducted a structured review of personnel files, personnel actions, hiring documentation, position descriptions and HR processes. The evaluation included sampling records, verifying compliance with state rules, and interviewing HR staff as needed.
5. Cost (allocation of in-house resources or purchase price): No cost.
6. Major Findings and Conclusions: No areas of concern. Required correction – For one detail, the employee was given an overall PES evaluation of “Not Evaluated” for which the employee was not eligible. Corrective Action Required: SCLHSA must ensure that employees are correctly assigned an overall performance evaluation of “Not Evaluated” in accordance with Civil Service Rule 10.6(b).
7. Major Recommendations: No recommendations.
8. Action taken in response to the report or evaluation: HR Department made the correction.
9. Availability (hard copy, electronic file, website): Electronic file
10. Contact person for more information:
  - i. Name & Title: Macy Comeaux, HR Director
  - ii. Agency & Program: SCLHSA Administration
  - iii. Telephone: 985-876-8876
  - iv. E-mail: macy.richard@la.gov

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-310 Northeast Delta Human Services Authority

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Dr. Monteic A. Sizer

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

For each accomplishment, please discuss and explain each item below.

By implementing the agency's Five-Year Strategic Plan and alignment with the overarching vision, mission, and tenets, Northeast Delta Human Services Authority (NEDHSA) experienced continual growth and realized numerous outstanding accomplishments during FY24-25. These accomplishments resulted from the careful and deliberate planning of new programs, special initiatives and services, establishment of new community partnerships, expansion of current services, and a continued focus on the specific needs of the individuals served.

In addition to the continuation of excellent care and services provided, NEDHSA has continued to exceed our footprint in Region 8 as we extend not only services but education, resources, innovation, and a sense of community to those NEDHSA comes in contact with. Below are those achievements accomplished during FY24-25 that aligns with NEDHSA's Five Year Strategic Plan.

#### Accomplishment #1: Integrated Care Network and Services:

##### A. What was achieved?

NEDHSA successfully implemented numerous special initiatives that stem from our integrative approach inclusive of behavioral health and primary care. The key component of NEDHSA's innovative approach to our client-centered integrated care program involves the formal establishment of partnerships with community-based agencies and programs along with the continuation of creating innovative ways to extend services. The development and

maintenance of a successfully integrated service network are vital to the operation and administration of the integrated approach. Ongoing relationship-building efforts and communication through regular meetings, community involvement, education, innovation, and outreach continue to be the driving forces underlying the agency's success and improved outcomes of the individual served.

In FY4-25, NEDHSA provided services to 23,326 services and of those services, 9,454 were billable services and 13,871 were non-billable services. Of these non-billable services, it should be noted these are reported to be a combination of client phone calls (out of clinic medication check via phone, welfare checks, therapeutic-based calls-not including reminders), and/or case management calls with other healthcare professionals to discuss client treatment plan. In addition to providing these services, NEDHSA's messaging for agency awareness, resources, and services to vulnerable population's garnered 890,557 impressions and 32,764 engagements.

In FY24-25, NEDHSA continued to utilize Recite Me ensuring that the agency's website is inclusive to all by supporting people who are neuro-diverse, visually impaired, speak English as a second language, or are of old age. Recite Me offers a range of on-demand accessibility solutions to help comply with ADA and WCAG standards while ensuring NEDHSA's website is user-friendly for individuals with disabilities, situational challenges, and language needs, through customization and translation options. The Recite Me cloud-based assistive toolbar makes the agency's website more inclusive by allowing visitors to customize their content so they can read and understand it in ways that work best for them.

### **NEDHSA and Ochsner LSU Health Monroe Signed Agreement to Enhance Integrated Care Services for Northeast Louisiana**

Northeast Delta Human Services Authority (NEDHSA) and Ochsner LSU Health Monroe have entered into a new partnership to strengthen health care services for citizens of Northeast Louisiana, specifically focusing on pregnant women with substance use disorders and their dependent children. This collaboration, formalized through a Memorandum of Understanding (MOU), is designed to improve residents' access to behavioral and physical health services across Region 8, emphasizing integrated, coordinated care.

The agreement outlines a commitment from both organizations to create a seamless system of referrals and access to essential health services. NEDHSA will prioritize admissions for pregnant women struggling with substance use disorders at its R.I.S.E Treatment Center. This treatment center provides substance abuse treatment and detoxification residential/inpatient care to pregnant women and women with children. The dependent children will also receive services based on need and age. Pediatric and obstetric care will be provided to the women and children by Ochsner LSU Health Monroe, including preventative care, primary care, and emergency services not available through the R.I.S.E Treatment Center. The partnership aims to expand access to quality health services in the region, ensuring that rural and underserved communities receive the care they need. Both organizations are committed to addressing the social factors that impact health, particularly for vulnerable populations, through their combined efforts.

NEDHSA Executive Director Dr. Monteic A. Sizer said, “We can effectively help our citizens meet many of their physical and behavioral health needs; however, we cannot solve complex societal problems alone. We need a shared vision and a laser-like focus on solutions.” “We are connecting more strategically and leveraging our assets to impact upstream or those systemic factors that cause higher rates of downstream outcomes like mental illness, addiction, primary health care challenges, and poverty,” Dr. Sizer said. “By working with Ochsner LSU Health Monroe, we are not only improving the accessibility of behavioral and physical health services but also creating a system that supports the overall well-being of some of our most vulnerable citizens.”

This MOU is part of both organizations’ ongoing efforts to eliminate barriers to healthcare access and improve the quality of life for residents of Northeast Louisiana.

### **NEDHSA Launches Veterans Suicide Awareness Campaign as part of their Operation Leave No Veteran Behind Initiative**

Northeast Delta Human Services Authority (NEDHSA) announced the launch of a new campaign for veteran suicide awareness. This campaign aims to raise awareness and encourage community support for veterans and their families. As part of this campaign, NEDHSA will offer Veterans Suicide Awareness lapel pins in Region 8. In collaboration with community partners, NEDHSA will distribute pins to veterans and their family members.

Dr. Monteic Sizer said, “It’s time to break down the stigmas that often keep veterans from accessing potentially life-changing services.” Dr. Sizer added, “We will do our part to ensure that our region’s military veterans receive quality mental health, addictive disorder, primary care, and related social supports such as housing, employment, and food. No military veteran should ever be abandoned, alone, suicidal, hungry, or homeless. They should have a safety net that meets their needs.”

### **NEDHSA research to be published in BMC Primary Care Journal**

Northeast Delta Human Services Authority’s research article, “The Assessment of Mental and Physical Health Outcomes Over Time in An Integrated Care Setting,” will be published in BMC Primary Care Journal. The study presents encouraging findings on integrated care models that combine behavioral and physical health services. The results demonstrate that individuals with mental health challenges experienced notable improvements in depression and anxiety symptoms over time, while maintaining stable physical health indicators such as systolic blood pressure and glycated hemoglobin.

Dr. Dependra Bhatta, NEDHSA’s Director of Behavioral and Primary Health Analytics, said, “Our study examined the impact of integrating primary care into a behavioral health setting, offering a more coordinated approach for individuals living with mental health conditions. We observed improvements in mental health outcomes and stability in key physical health indicators, such as blood pressure and blood glucose levels.” Dr. Bhatta said the findings are significant because they show that when care is better coordinated, especially in communities where access to comprehensive services is limited, patients can make meaningful progress.

Executive Director Dr. Monteic A. Sizer said, “This report’s publication in the BMC Primary Care Journal validates our empirical focus and overall population health improvement desires in Louisiana’s Delta. We are honored to have our research featured in such a prestigious journal.” Dr. Sizer also stated, “I established our analytics department to better help us measure the outcomes and efficiencies of our internal operations and also be able to know more about the social, environmental, psychological and primary health-care needs of the thousands of vulnerable patients we serve regionally. With this data focus and our commitment to continuous improvement, we are well on our way to further transforming our region and the lives of those we serve.”

### **Day of Service Health Fair**

Northeast Delta Human Services Authority (NEDHSA) announced its partnership with the Junior League of Monroe and hosted the second annual “A Day of Service” event on Saturday, June 29, 2024, at the Powell Street Community Center. The “A Day of Service” event offered children and adults games, activities, and educational resources.

The “A Day of Service” event is an initiative that aims to bring together behavioral and primary health resources, services, and information from NEDHSA and other community organizations, volunteers, and individuals who seek to improve population health in Ouachita Parish. NEDHSA Executive Director Dr. Monteic A. Sizer said, “Our work is based on empathy, understanding, shared respect, and earned trust. We are after real outcomes for vulnerable people and communities. Population health transformation occurs when people trust you to help them solve problems. We intend to be problem solvers.” The Junior League of Monroe President Haley Holley said, “NEDHSA’s steadfast goal and dedication to building a healthier and more successful tomorrow perfectly match the purpose of The Junior League of Monroe.”

### **Harm Reduction and Opioid Mitigation Strategies for Louisiana’s Delta**

Northeast Delta Human Services Authority (NEDHSA) and The Louisiana Mental Health Association (LAMHA) have collaborated to present “Harm Reduction and Opioid Mitigation Strategies in Louisiana’s Delta,” an effort to bring information, education, and solution-oriented strategies to the Delta Region. LAMHA’s Executive Director Melissa Silva said this event allows regional leaders to collaborate on solving a community problem. “Only through a collective approach that addresses all the social determinants of health and barriers to care will we begin to experience the opioid crisis abate,” Silva said.

NEDHSA Executive Director, Monteic A. Sizer noted, “We will be executing some of the most innovative opioid mitigation strategies in the nation. We will deliver evidence-based prevention, treatment, and messaging strategies across the entire 12 parishes of the Louisiana Delta. Harm-reduction and NARCAN distribution machines will be placed in every parish NEDHSA serves. We will be engaging citizens in their homes, communities, schools, churches, and places of business.”

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

These success outline the importance of meeting the need of our citizens where they are.

Ensuring they have adequate, assessable, and exceptional care no matter the existing determinants of health presenting. Additionally, it shows that NEDHSA is successfully completing agency set goals and its implemented strategic plan.

C. Who benefits and how?

As seen in the integration of collaborations mentioned in NEDHSA's various partnerships and initiatives through education in prevention and understanding the increasing rate of mental health and substance use cases, NEDHSA continues to work regionally to increase awareness and decrease barriers to the access of quality healthcare that are directly linked to social determinant of health.

D. How was the accomplishment achieved?

NEDHSA continues to be innovative in creating ground-breaking programming and well placed services that directly align with the needs of the citizens serviced in Region 8.

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

Yes, this accomplishment contributed to the success of NEDHSA's strategic plan. (See Section II below).

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

Yes, NEDHSA utilizes and implements best management practices reflected in the agency's vision, mission, and tenets. Additionally, NEDHSA's STAY Campaign and Phoenix Clinic are two programs that reach across departmental structures to ensure everyone is reached at every level of care and demographic. The STAY Campaign targets high-risk groups that are prone to suicide ideations (teens, military-active and veterans, and those who are dealing with social determinates of health). The Phoenix Clinic assist those persons with co-occurring developmental disabilities and behavioral healthcare issues. This clinic aims to assist in filling a significant service gap for those who are in need for healthcare services, not only for them but for their family members and caregivers as well.

### Accomplishment #2: Prevention & Wellness:

NEDHSA successfully implemented several Prevention and Wellness programs and initiatives, which serve as an integral part of our integrative behavioral health and primary care approach. The NEDHSA Prevention program uses research-based curriculums, environmental strategies, coalition-building, and other proactive and data-driven strategies to prevent and reduce risk-taking behaviors. NEDHSA Prevention and Wellness services include the arts and wellness, information dissemination, formation and implementation of community coalitions, initiatives in recovery and harm reduction, community education and alternative activities for youth, and continuation of school-based interventions. Below is a summary of prevention activities for FY24-25:

A. What was achieved?

**Northeast Delta HSA Recovery Month activities, initiatives for NELA**

Northeast Delta Human Services Authority (NEDHSA) announced its continued commitment to the National Recovery Month (Recovery Month) and hosted a series of activities and initiatives throughout the month of September. NEDHSA's Recovery Month activities and initiatives include daily social media messaging and in-person events for the public.

The Recovery Day Celebration highlighted and celebrated people in recovery from substance use and mental disorders, along with treatment providers promoting that recovery is possible in all forms. This day of celebration, within Recovery Month, is part of a national observance that promotes the societal benefits of prevention, treatment, and recovery. The event featured speakers with lived experiences, NARCAN Training, health and wellness activities, interactive games and crafts, food, and music provided by SNAZZ Band.

“Mental illness and substance use disorders must be immediately addressed holistically and with compassion. We are all in a state of recovery from something. Our Recovery Month celebration is intended to recognize our collective humanity and desire to unify around things that matter.” – Dr. Monteic A. Sizer, NEDHSA Executive Director

**Northeast Delta HSA to host JiggAerobics Health and Fitness Event on October 16 at Monroe Civic Center**

This event is part of the #getfitHSA initiative that supports the NEDHSA's integrated care model to increase access to healthy activities and inform communities about staying fit and active.

“We know physical fitness plays a critical role in positive health outcomes. So, when we combine our physical fitness initiatives with our prosocial mental health and primary healthcare mitigation strategies, we can expect to see overall regional population health improvements,” Dr. Sizer said. “By hosting events like JiggAerobics, we are providing an opportunity for citizens of northeast Louisiana to further learn about the interconnectedness of their mental health, physical health, and spiritual well-being.”

This nationally recognized model includes collaboration with regional partners in prevention, education, business, and regional municipalities and parishes. It helps NEDHSA create opportunities to reduce barriers to quality healthcare that arise from negative societal health determinants such as poverty, joblessness, and access to adequate housing.

**NEDHSA, Strauss Theatre partner to bring award-winning musical “Next to Normal” to the stage**

Northeast Delta Human Services Authority (NEDHSA) and Strauss Theatre partnered to

produce multiple showings of “Next to Normal,” a musical that has garnered a Tony Award and Pulitzer Award with themes that include mental health, grief, medical ethics, suburban malaise, and attempting to define “normal.”

Executive Director Dr. Monteic A Sizer said, “We must do different things to educate, engage, and inspire the public. We’re helping people in our region to understand mental health issues with this innovative prevention approach.” Strauss Theatre Center President Scott Frick said, “Bringing musicals like “Next to Normal” to the community theater provides a powerful platform to address and explore mental health issues in an engaging and empathetic way. By partnering with the NEDHSA, Strauss aims to not only enrich the community but also foster essential conversations about mental health awareness and support,” Frick said. “This musical will offer a profound look into the challenges of mental illness, encouraging dialogue and understanding in a setting that is both impactful and accessible.”

### **NEDHSA’s Prescription Drug Take Back Day**

Northeast Delta Human Services Authority’s Prescription Drug Take Back event resulted in 12 boxes filled with prescription drugs for a total weight of 206 pounds. The event allows NEDHSA’s Opioid Misuse and Abuse Prevention Program team to educate the community about the risks of abuse of prescription and over-the-counter medications left unsecured in the home.

In addition to the take-back boxes, NEDHSA has also placed Narcan boxes at the Behavioral Health Clinics in Tallulah and Winnsboro with plans for the clinics in Columbia, Bastrop and Ruston.

Take-back boxes are located at:

- Monroe Behavioral Health Clinic (4800 S. Grand St, Monroe, LA 71202)
- Monroe Police Department (700 Wood St, Monroe, LA 71201)
- ULM Police Department (Filhiol Hall, 3811 Desiard St, Monroe, LA 71201)
- Richwood Police Department (2710 Martin Luther King Drive, Richwood, LA 71202)
- Jonesboro Police Department (100 4th St, Jonesboro, LA 71251)
- Tensas Parish Sheriff Department (212 Hancock St, St. Joseph, LA 71366)
- Tallulah Police Department (500 E. Green St, Tallulah, LA 71282)
- East Carroll Parish Sheriff Department (400 First St, Lake Providence, LA 71254)
- Grambling Police Department (2045 W. Martin Luther King, Jr. Ave, Grambling, LA 71245)

### **HSA’s Annual Art is Therapy Festival features music, vendors, health fair**

The festival helps promote the agency’s adoption of art as one of its integrated health care, evidence-based prevention, communications and treatment strategies to help serve and educate the community and individuals with co-occurring disorders and developmental disabilities.

NEDHSA is using “Art As Medicine” to explore new methods of healing through the exploration of artistic expression. Creating art and viewing it are methods that can provide “medicine” for the spirit. The festival brought communities together and gave space for personal expression through all the artistic and creative activities.

“We believe there is medicine in creative expression and the arts can help a person come alive in ways traditional treatment options can’t,” NEDHSA Executive Director Dr. Monteic A. Sizer said. “We intend to help create an environment where dreams are realized, families are strong, bodies are healthy, community institutions are thriving and spirits are renewed.”

### **NEDHSA host Bawcomville Bash: Faith, Hope & Healing Festival**

The festival is aimed at garnering support for the town’s vulnerable populations. “As I continue to contemplate the challenges ahead for vulnerable people and communities in the Louisiana Delta and across the state, I have become more confident and resolved to work even more collaboratively across service sector silos so that system improvements can be made,” NEDHSA Executive Director Dr. Monteic A. Sizer said. “Vulnerable people and fragile communities deserve solutions to problems from those who lead behavioral and primary health care systems.”

### **Northeast Delta HSA collaborates with the City of Tallulah to host a 1K/5K**

Northeast Delta Human Services Authority (NEDHSA) partnered with the City of Tallulah as the title sponsor of the 5th Annual 1K/5K Walk/Run. NEDHSA’s title sponsorship is one facet of its #getfitHSA initiative that supports the NEDHSA’s integrated care model to increase access to healthy activities and inform communities about staying fit and active.

Executive Director Dr. Monteic A. Sizer said the agency has “always worked to create opportunities for citizens of Northeast Louisiana to engage in healthy activities and learn about the interconnectedness of their mental and physical health. Fitness plays a vital role in mental health and, when coupled with proper exercise, is a strong predictor of positive health outcomes.... this level of comprehensive wellness is the foundation of the agency’s focus towards providing behavioral and primary care services.”

### **NEDHSA, Strauss Theatre partner to bring award-winning musical "Next to Normal" to stage**

Northeast Delta Human Services Authority (NEDHSA) and Strauss Theatre partnered to produce multiple showings of "Next to Normal," a musical that has garnered a Tony Award and Pulitzer Award with themes that include mental health, grief, medical ethics, suburban malaise, and attempting to define "normal."

NEDHSA Executive Director Dr. Monteic A Sizer said, "We must do different things to educate, engage, and inspire the public. We're helping people in our region to understand mental health issues with this innovative prevention approach." "We believe there is medicine in creative expression, and the arts can help a person come alive in ways traditional treatment options can't," Dr. Sizer said.

### **NEDHSA, host Town Hall Meetings in Bawcomville, La and Franklin Parish**

Northeast Delta hosted two pre-town hall and town hall meeting in Ouachita and Franklin parishes. The purpose of the meeting was to create a strategic plan to combat the alarming rise of opioid use in Bawcomville and to focus on behavioral and prevention related services for youth and seniors in Franklin Parish. Each town hall meeting was successful with events and sponsored activities stemming from the meetings.

### **NEDHSA Launches Sponsorship Request Portal for Community Funding Opportunities**

Northeast Delta Human Services Authority (NEDHSA) announced the launch of its new Sponsorship Request Portal, designed to assist qualified local non-profit organizations and individuals seeking financial support for community-focused events and services. This initiative aligns with NEDHSA's ongoing commitment to providing high-quality, competent care and excellent customer service to the people of Northeast Louisiana.

The portal serves as a streamlined application process for those requesting funds to support initiatives that align with NEDHSA's strategic objectives. NEDHSA cannot guarantee that the full amount requested will be awarded and is based on the availability of funds. Sponsorships are not recurring, and each request must be submitted via the portal. As the agency continues to identify specific funding opportunities and address gaps in services, the information collected through the portal will play a vital role in forming new regional partnerships.

Executive Director Dr. Monteic A. Sizer said, "No agency or community can solve complex health problems vulnerable populations are challenged with alone. I believe that as a government agency, we can and are effectively helping our citizens meet many of their physical, behavioral health, financial, and social needs," Dr. Sizer said. "However, the government can't solve complex societal problems alone, and so this is our call and challenge to others to work with us to bring hope and healing to those who are hurting in our region."

### **NEDHSA Evidence-Based School-Based Programs**

Northeast Delta Human Services Authority (NEDHSA) provides annual contracts to identified areas throughout Region 8 that are required to complete a set of outlined outcomes indicative to an evidence-based model. These school-based programs are required to provide primary prevention services that are Evidence-Based Programs (EBP) for children in 3rd—10th grade to reduce behavior problems and address causal factors such as poor social skills, peer pressure, and poor decision-making skills. Activities are inclusive of prevention strategies and education, Alternatives, Problem Identification and Referral, and a Community-based Process.

Skills and activities focused on include, but not limited to:

- Teach students the necessary skills to resist social (peer) pressures to smoke, drink, and use drugs
- Help students to develop greater self-esteem and self-confidence
- Enable students to effectively cope with anxiety
- Increase their knowledge of the immediate consequences of substance abuse
- Enhance cognitive and behavioral competency to reduce and prevent a variety of health

risk behaviors

- Resist using tobacco products
- Are aware of misleading social information that facilitate tobacco use
- Have skills that encounter the social pressure to achieve approval by using tobacco
- Appreciate the physical consequences that tobacco use may have on their lives

These strategies aim to enhance the ability of the community to effectively provide prevention and treatment services for alcohol, tobacco, and drug abuse disorders. Activities within these strategies include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.

B. Why is this success significant?

The initiatives implemented through NEDHSA's Prevention & Wellness programs proves the successful implementation of NEDHSA's Integrated Behavioral Health and Primary Care Model which is vital to ensuring meeting citizens where they are to meet the need to enter them into the health care system desired. These prevention efforts are critical to providing these integrated services.

C. Who benefits and how?

As seen in the integration of collaborations mentioned in NEDHSA's Prevention & Wellness partnerships and initiatives through education in prevention and understanding the increasing rate of substance use cases within our youth population, declining in mental health solutions for youth and veterans, and physical fitness awareness, NEDHSA continues to work regionally to increase awareness and decrease barriers to the access of quality healthcare that are directly linked to social determinant of health.

D. How was the accomplishment achieved?

NEDHSA continues to be innovative in creating ground-breaking programming and well placed services that directly align with the needs of the citizens serviced in Region 8.

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

Yes, this accomplishment contributed to the success of NEDHSA's strategic plan. (See Section II below).

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

Yes, NEDHSA utilizes and implements best management practices reflected in the agency's vision, mission, and tenets.

### Accomplishment #3: Developmental Disabilities:

NEDHSA continues to be committed to creating and providing innovated resources to the persons in our region to ensure each person, no matter the circumstance, reach their full human potential. The purpose of NEDHSA's Developmental Disabilities Departments is 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 for their choice. NEDHSA's Executive Director, Dr. Monteic A. Sizer, continues to ensure advocacies through the Developmental Disabilities program are appropriately placed, attainable, and provided.

#### A. What was achieved?

Under the Developmental Disabilities umbrella, there are two core specializations that continue to show significant growth and outcomes related to meeting the daily needs to this population: Waiver Services and Home and Community Based Services. Waiver Services is a Medicaid Home and Community-Based Waiver program that allows greater flexibility to choose where they want to live and to use services and support that best fit their needs. This service is provided in the home or in the community. During FY25, there were 57 Medicaid Waiver participants that were certified for waiver support services, with 53 active private provide agencies and 3 support coordination agencies. In addition, through the Flexibility Family Funds Program and Family Support, NEDHSA was able to assist with funding \$1,389,838.04 to our Developmental Disabilities clients and families. Below is a summary of DD activities for FY24-25:

#### **Your Life: Envision, Learn, Achieve | Developmental Disabilities Summit**

Northeast Delta Human Services Authority put on the state's first-ever Developmental Disabilities Summit! Our goal was to empower persons with developmental disabilities to advocate for better health, better quality of care, and increased success in employment goals.

This summit was inclusive of panel guest providing stories of lived experiences and provided answers to questions guest may have had. The discussion panel was led by a panel of professionals, family members, and self-advocates.

The keynote speaker, President of IntellectAbility Dr. Craig Escude, provided a detailed presentation on the concepts of diagnostic overshadowing. Specifically, the causes of illness and death in people with IDD in addition to exploring the connections between adverse behaviors and underlying treatable health conditions. Dr. Escude concluded his presentation with discussion related to the complexities of mental health conditions in people with IDD and offered guidance to those in attendance on how to improve future healthcare visits.

#### **NEDHSA and Genoa Healthcare Partner to Provide Flu Shots and COVID-19 Vaccinations to Vulnerable Populations**

Northeast Delta Human Services Authority (NEDHSA) and Genoa Healthcare joined forces to offer flu shots and COVID-19 vaccinations to existing NEDHSA Developmental Disability clients in the region. This agency-focused vaccination event is part of NEDHSA's ongoing efforts to ensure that vulnerable populations have access to essential preventative healthcare services. Both insured and uninsured individuals were eligible to receive the

vaccines, with flu shots were available for those 7 years old and above and COVID-19 vaccines offered for individuals 17 years old and above.

Executive Director Dr. Monteic A. Sizer said this event is another extension of the “agency’s commitment to addressing the complex healthcare needs of the region’s most at-risk populations. By providing these vaccination events, we’re showing the region that we’re focused and committed to delivering lifesaving care to vulnerable people and communities,” Dr. Sizer said.

### **Christmas with HSA**

Northeast Delta Human Services Authority alongside our contracted agency, Families Helping Families, celebrated Christmas with over 100 visitors at our Developmental Disabilities Services Office. During this open house event, visitors were encouraged to create Christmas ornaments and to take home or decorate the tree in our lobby.

This was an opportunity for NEDHSA staff, community leaders and partners, and the DD community to engage and find commonality. Programs such as this continues to bridge a gap between our most vulnerable population and those who can provide them with their everyday needs and access to care.

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

NEDHSA continues to be a leader in advocacy and in creating programs and access to care and resources, especially to those in our community who are among our most vulnerable population. The significance of the success of NEDHSA’s Developmental Disabilities Programs is noted in the amount of funding providing to ensure housing was either established or upgraded for the needs of the persons served, monthly stipends provided to families of those who met the requirements, or incontinence supplies were readily available. Additionally, the innovation of creating new formats to engage in needed discussions and exposure about our most vulnerable population is to be highlighted due to the influence it has had in a ripple effect for other summits of this kind.

#### **C. Who benefits and how?**

Those who are directly affected or families who are care takers of those who have developmental disabilities who reside within NEDHSA’s location areas are beneficiaries of these services. As the single point entry into Louisiana’s developmental disabilities system, NEDHSA provides funding for those individuals and families to continue to live and thrive in our community as well as provide monitoring of mandated programs under Medicare/Medicaid.

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

NEDHSA’s underline of “meeting people where they are” is a driving force of accomplishing all goals set, this achievement in particular is no different. With our compassionate Development Disability staff who prioritizes the need of the person and work with local

providers via trainings, implementations of state regulations, and providing NEDHSA resources through our Integrated Care Network.

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

Yes, this accomplishment does contribute to the success of our strategic plan. (See Section II below.)

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

Yes, this level of support, both financially and philosophically should be shared with other executive branch departments and agencies.

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

NEDHSA Strategic Plan goals were implemented as specified in the FY2020-2025 Strategic Plan. The continuation of monitoring and tracking the progression of agency goals have been also been implemented in the FY2022-2027 Strategic Plan. The strategies being implemented are providing positive outcomes that are integrating across departments and throughout the region as desired. The continuation and reach of services are evident of the agency's strategies, implementations, and investment in high standards of care.

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

1. To what do you attribute this success? For example:
  - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
  - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas?)

Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
- Other? Please specify.

NEDHSA's success is contributed to monthly and quarterly statistical data that is analyzed to provide real, tangible information to assist with providing our staff, stakeholders, and Region 8 with progressions made throughout NEDHSA's departments. Additional to the review and analyzing of gathered statistical data, NEDHSA has created an innovative dashboard system that represents a groundbreaking advancement in data management. Which empowers NEDHSA with a centralized platform that seamlessly houses, collects, and integrates all critical data sources. By leveraging real-time analytics, intuitive, and visualizations it eliminates silos, enhances decision-making, and drives operational efficiency across complex organizational ecosystems.

In speaking to appropriateness to funding and auditing, proper and effective use of grant funding is also an active supporting measure in NEDHSA's growth and operations. Additional evidence of this is the 100% Louisiana Legislative Audit Report completed in July 2025. This report is a direct reflection of how NEDHSA ensures accurate financial reporting, the proper utilization of public funding, and compliance with applicable laws and regulations were being followed. Additionally, NEDHSA was awarded a 3 year CARF Accreditation in October 2024. Both the LLA and CARF Auditors gave NEDHSA high praises on how organized documents were, how efficient staff are, and how much the organization does on behalf of Region 8.

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

Currently, our progress is not expecting an accelerated gain or pace. We are continuing to be focused on moderate, measurable, and sustainable gains.

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

1. To what do you attribute this lack of progress? For example:

- Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
- Is the lack of progress due to budget or other constraint?

- Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
- Other? Please specify.

No lack of progress to mention at this time.

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

No lack of progress to mention at this time.

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

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

No. If not, why not?

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

Our strategic plan is centrally located on the agency's intranet for all employees to view. A large percentage of the performance indicators are also reported in LaPAS and through AP reviews. As leadership makes data-driven decisions about management and funding, we consider the performance indicators to help us determine how to streamline our funds and processes for improved outcomes.

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

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

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

## A. Problem/Issue Description

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

Northeast Delta Human Services Authority, per the signed contract with Louisiana Department of Health, has been tasked with oversight of the region Support Coordination Agencies (SCA) which is contracted with the Louisiana Department of Health to provide services on behalf of the Office for Citizens with Developmental Disabilities (OCDD). This linkage has posed a disadvantage in the oversight process for NEDHSA to ensure accountability and successful outcomes. Corrective Action for deficits and issues stemming from the SCAs and the private agencies contracted with them are often delayed and lack proficiency and quality to the standards to which they are held. It is also noted that various contributing factors have led to the decreased standards of care provided by these agencies along with compliance with OCDD policies and procedures, including high turnover rates of the support coordination agencies. To date, reporting numbers are continuing to get worse as this issue is not being resolved and more waiver linkages are being made. While numbers are increasing in this region, it is acknowledged that it is a statewide issue and not an isolated issue. OCDD has acknowledged this and the OCDD Support Coordination Performance are in agreement that the agency revamping to try to assist with bringing all Support Coordination agencies into compliance is the first step in an ongoing process. However, NEDHSA is continuing to be held to the non-satisfactory resolution in specific areas due to this outcome and additional staff is still needed to reach more of our population with our growing numbers to ensure the needs and advocacy efforts are still met.

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

This problem or issue is not affecting the progression of NEDHSA's strategic plan. Continuation of documentation and voicing this concern to those who can effectively make these changes will continue to be done and documented.

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

Developmental Disabilities Department is the department experiencing these issues.

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

Persons served are directly affected by the quality of services provided by the SCA's and the private care agencies.

### 5. How long has the problem or issue existed?

These issues have been ongoing for upward of 6 years.

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

Noted possible causes of these issues are the current policy and structure of this system, along with the reporting infrastructures in place. It is also noted that the SCA's experiences high turnover rates, which also could affect these issues.

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

Failure to resolve these issues will continue to directly impact client services in consideration of the quality of services provided to our clients and the effective services rendered by care managers and staff. Not only the overall wellbeing of the client is at jeopardy, but ensuring all standards and requirements met within state contracts, governing bodies, loss in revenue to continue care, and staff turnover are all contributing factors.

#### B. Corrective Actions

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

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

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

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

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

A. Check all that apply.

- Internal audit**  
NEDHSA's Corporate Compliance Department conducts monthly, quarterly, and annual internal audits that provide fact-base and data-driven data for all NEDHSA connected departments, which are inclusive of all contracted parties as well. With information obtained and provided, we are able to pinpoint areas of needing improvements, a corrective action plan (if needed), and the fiscal status reports (if applicable). Additionally, NEDHSA tracks and documents other statistical data through our analytical department that assists with both internal and external auditing and reporting method.
- External audits (Example: audits by the Office of the Legislative Auditor)**  
NEDHSA is externally audited by Louisiana Legislative Auditor (LLA). The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities. In our 2025 LLA Report, NEDHSA was in full compliance and awarded a 100% Compliance Rating which is indicative of operational priorities in place and are in constant review internally for external presentation. In addition to the LLA, NEDHSA also is externally audited by CARF, OBH Accountability Plan Monitoring, and Civil Services. Like LLA, these auditing bodies ensure validity with compliance

regulations (both classified workforce, merit system practices, and clinical services), improve operational efficiencies already in place, ensures financial responsibility, and enhances public trust that NEDHSA already has a strong reputation for throughout the region. As reflective of NEDHSA's perfect scoring for the LLA Reporting, NEDHSA received a 3 year CARF Accreditation in 2024, 100% scoring during each of our bi-annual OBH Accountability Plan Monitoring, and continue to exceed required expectations for Civil Service requirements.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews NEDHSA Developmental Disabilities Department and its support care agencies for compliance with program standards and accountability for funds received to administer programs. With the most recent audit outcomes, NEDHSA Developmental Disabilities continues to exceed expectations in regards to services, documentation, and procedures related to holding support care agencies accountable.

Additionally, NEDHSA is externally audited by the Office of Risk Management (ORM) to ensure the best safety practices are being kept on an annual bases. With these reports, NEDHSA is able to ensure the safety of staff, clients, and visitors of all site facilities. NEDHSA continues to exceed all safety requirements set by ORM, CARF and other regulatory body's standards to ensure safety for our staff, clients, and visitors visiting our sites.

- Policy, research, planning, and/or quality assurance functions in-house  
The Executive Director, Dr. Monteic A. Sizer, has established the Corporate Compliance Department within NEDHSA as a department that updates, develops, and ensures implementation of policies throughout the agency. In addition to that, the Corporate Compliance department ensures quality assurance with involvement in peer reviews, quality assurance meetings and quarterly/annual reporting.
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract  
NEDHSA's Corporate Compliance Department conducts quarterly evaluations of all clinical services contracts via record review, invoice review, critical incident reporting (with analysis reporting), and additional analysis outcomes through TeleSage Outcome Measurement System (TOMS).
- Performance Progress Reports (Louisiana Performance Accountability System)**  
NEDHSA Corporate Compliance Department coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for its internal departments. Explanatory notes are provided for

positive or negative variances greater or less than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

NEDHSA gathers this information internally for all required departments for reporting purposes. During this time, all information is vetted and appropriately determined for accuracy prior to submission into the LaPAS system quarterly.

- ☒ **In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are completed in conjunction with NEDHSA Executive Management Team and the Fiscal Department. This section reviews all objectives, performance indicators and strategies for NEDHSA.

There is an annual review of NEDHSA's budgets along with monthly review by Executive Management and the Fiscal Department. At the end of each fiscal year, NEDHSA analyzes and evaluate the performance of our agency to determine if the information has provided its intended outcomes in the strategic and operational planning set, or recommendations for improvement are needed for the next fiscal year.

- ☒ **Benchmarking for Best Management Practices**  
NEDHSA's Executive Management Team (EMT) along with the Strategic Planning/Development Committee reviews, researches and develops objectives, performance measures and strategies to present to the Executive Director for approval that will benefit the agency and its recipients of services.

Recommendations are compared to benchmarks set from the previous fiscal year based on performance-based budgeting activities along with LDH and NEDHSA contractual guidelines and obligations. Additional recommendations are made directly to the Executive Director, if modifications or additions are needed.

- ☒ **Performance-based contracting (including contract monitoring)**  
All NEDHSA contracts are required to contain a Statement of Work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan. Each contract is then monitored quarterly or every 6-months (based on contract requirement) to ensure compliance with contract outcomes and deliverables are being met as outlined in their signed contracts.

- ☒ **Peer review**  
NEDHSA participates in OBH's annual peer-review process for Block Grant Funding.

Accreditation review  
NEDHSA is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). The most recent CARF review was successfully completed October 2024 with a 3 year accreditation awarded.

Customer/stakeholder feedback

Other (please specify):

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

Yes. Proceed to Section C below.

No Skip Section C below.

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

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

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-320 Office of Aging and Adult Services

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Garry Williams

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

#### Accomplishment #1: Maintained and increased access to home and community based services (HCBS):

**A. What was achieved?**

OAAS implemented several initiatives aimed at ensuring current home and community-based services (HCBS) participants receive appropriate services and at increasing access to HCBS. Additionally, OAAS staff worked to ensure participants maintained access to existing services and to add additional covered waiver services.

In SFY25, OAAS requested and received an additional 750 Community Choice Waiver (CCW) slots. OAAS Program Operations staff worked collaboratively with other OAAS Divisions and Support Coordination Agencies to certify 1,128 (as of 6.30.2025) participants, including the 750 additional waiver slots and waiver slots made available via attrition. This reflects a 59% increase in certification from the same time in FY24. New providers were also added in SFY25 including the growth of the newly opened Program of All-Inclusive Care for the Elderly (PACE) Center in Alexandria and four new Adult Day Health Care (ADHC) centers in Regions 1, 2, 4 and 5. OAAS staff in the Money Follows the Person and My Choice Louisiana programs worked to transition over 230 participants out of nursing facilities and back into the community with

appropriate waiver supports and services, 41% of which transitioned with the support of the Permanent Supportive Housing program. OAAS maintained all services within its programs to ensure compliance with CMS Maintenance of Effort requirements by developing reports and following up on data generated to ensure participant services were maintained at the level at which they were approved.

The Policy Development division updated the CCW Rule which added a new priority group. The day the new group went live there were 113 people on the waiting list. By the end of FY25 183 offers were made for the new group.

The Traumatic Brain and Spinal Cord Injury (TBSCI) Trust Fund program was able to successfully removed 39 applicants from the waitlist, making them eligible to receive services.

B. Why is this success significant?

These services and initiatives allow OAAS to continue to enhance and improve access to quality long-term services and supports for the elderly and people with adult-onset disabilities to live with dignity and independence in a safe and holistic environment.

C. Who benefits and how?

OAAS participants benefit from having additional long-term care options that allow them to access services in a manner that supports choice, informal caregiving, and effective use of public resources as is in line with OAAS's mission.

D. How was the accomplishment achieved?

OAAS analyzed program data collaborated with internal and external stakeholders on legislative initiatives, waiver and policy updates, and outreach efforts to maintain and increase access to HCBS.

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

Yes, these initiatives contribute to improving access, quality, and outcomes for populations receiving and at-risk of needed long-term supports and services which are in direct alignment with goals I and IV of the OAAS FY 27-31 strategic plan.

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

Yes, analyzing program data to identify and implement strategies to efficiently certify individuals into waiver and to streamline other processes and is a best practice that should be shared with others agencies and replicated where applicable.

Accomplishment #2: Increased stakeholder engagement to inform participant choice, streamline policies and procedures, and enhance quality of care:

A. What was achieved?

OAAS made concerted efforts to improve communication, outreach, and training to

both internal and external stakeholders. OAAS implemented several outreach campaigns, including letters, phone calls, and community events to inform participants and families of the services offered through OAAS programs.

In SFY25, OAAS continued stakeholder meetings with providers and Support Coordination Agencies (SCA) in an effort to provide them with accurate and up-to-date information on program and rule changes, program successes and opportunities, and to obtain their feedback on OAAS processes and procedures. As a result of this collaboration, OAAS implemented several initiatives at the request of providers, including but not limited to:

- Adding an exception and review/approval process for a spouse/Legally Responsible Individuals
- Establishing an SCA workgroup
- Finalizing the SCA Standards of Practice updates to include language related to educational requirements and other language clean up
- Initiating required annual continuing education online training for certified interRAI Home Care (iHC) assessors
- Creating and distributing a landlord engagement flyer with OAAS programmatic information
- Entering into an MOU with DCFS to streamline benefits summary for the Permanent Supportive Housing (PSH) program and establishing partnerships to expedite benefits letters to PSH participants
- Finalizing updates to the renamed Traumatic Brain and Spinal Cord Injury to come into compliance with ACT 278 of the Louisiana 2024 Regular Legislative Session
- Prioritizing outreach to nursing facilities to improve Money Follows the Person (MFP) program visibility

OAAS received approval from CMS to use American Rescue Plan Act funds to support training for Direct Service Workers (DSW) on dementia and the implementation of a DSW online training platform. Funds are also being utilized to provide Adult Day Health Care centers (ADHCs) with technical assistance. ADHCs have gone through the application and approval process and technical assistance will begin in FY26. Other initiatives that began in FY25 and will continue into FY26 include an in-home monitoring pilot, implementation of a mass communication tool for those receiving services, housing support, and Community Choices Waiver registry analysis.

OAAS's Nursing Home Resident Trust Fund (NHRTF) staff has received CMS approval for all projects submitted in SFY25 after implementation of a new application and approval process. Louisiana was the first state in CMS Region 6 to receive approval on new projects submitted after programmatic changes were implemented in SFY24. As a result, NHRTH staff has provided assistance to several states who have reached out with question related to best practices in both SFY24 and SFY25. There was a federal communication and approval freeze for proposed programs, projects, extensions or continuations from 3.27.2025 through 5.31.2025. Since the end of the freeze, the NHRTF has resumed project proposal requests.

Adult Protective Services (APS) began a media campaign to increase visibility related to their services and population. APS has also begun reaching out to local law enforcement to ensure they are aware of the programs services due to high turnover in this area.

B. Why is this success significant?

OAAS programs are complex and our populations and their families must navigate eligibility requirements and the provision of services via multiple LDH agencies and external providers. Access to easy-to-read, accurate, and accessible program information is crucial to ensuring participants receive the services they need in the settings they wish. Additionally, alignment of OAAS policies and procedures and state rules with federal requirements led to streamlined program procedures which decreases duplication of effort and program confusion as well as and improves program compliance.

C. Who benefits and how?

OAAS staff, participants, and providers benefit from having clear, concise, easy-to-understand information on program services and requirements.

D. How was the accomplishment achieved?

OAAS staff engaged in regular stakeholder and legislative partnership meetings in order to achieve these successes. Staff conducted regular meetings to review, update, and disseminate revised program information and notices using plain language and accessibility standards. Additionally, staff performed outreach at 13 community events and collaborated with the Live at Home Coalition, ADHCs, and Support Coordination Executive Directors to schedule quarterly or biannual meetings with a goal of sharing information on best practices, policy and procedure updates, and program status updates.

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

Yes, streamlining OAAS policies, procedures, and processes and aligning them to federal requirements, and ensuring stakeholders are represented in decision making aligns to decreases duplication of effort, improves program compliance, and improves access, quality, and outcomes for populations served which are in direct alignment with goals I and IV of the OAAS FY 27-31 strategic plan.

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

Yes, all state agencies should have a vested interested in ensuring stakeholders have access to accurate program information in the manner and form most appropriate to them.

Accomplishment #3: Streamlined the Preadmission Screening and Resident Review (PASRR) Level 1 process through new system implementation:

A. What was achieved?

Through the implementation of the PASRR Level I contract, OAAS successfully transitioned from a manual, paper-based process to a modern, web-based software solution that leverages a federally compliant algorithm. This solution supports both nursing facility preadmission requests and status change resident reviews. Developed and maintained by the vendor Maximus US Services—an industry leader with over 25 years of PASRR expertise—the system reflects national best practices, incorporates continuous innovation, and is notably the first and only PASRR platform certified by CMS.

B. Why is this success significant?

This achievement represents a transformative step forward in compliance, efficiency, and quality of care. The new platform ensures:

- Alignment with ADA requirements
- Consistency and accuracy in determination practices
- Access to specialized PASRR expertise and national best practices

Together, these improvements strengthen the integrity of PASRR processes while enhancing the State's ability to serve individuals more effectively.

C. Who benefits and how?

The benefits of this system are wide-ranging, providing value to:

- Stakeholders (Louisiana Nursing Home Association (LNHA), Louisiana Hospital Association (LHA), and others): Improved transparency and confidence in determinations
- Clinician Reviews: More focused reviews and accurate determinations for individuals with PASRR-related conditions
- Providers/Nursing Facilities/State Users: 24/7 access to submit screenings, upload documentation, track residents in real time, and generate reports on demand
- The State: Real-time dashboards, data queues, and secure system-wide oversight
- All Users: Access to a comprehensive Provider Resource Library with written and audio training tools

D. How was the accomplishment achieved?

This success was the result of extensive collaboration among OAAS, OBH, OCCD, and OTS. After several years of collaboration and contract development between the State and the vendor, the project officially launched in October 2024, with full system Go-Live on March 10, 2025. The implementation was tailored to meet state-specific requirements, integrate workflows, and ensure secure data sharing across OAAS and Maximus.

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

Yes. This accomplishment directly supports OAAS's strategic goals by advancing

compliance, efficiency, data-driven oversight, and user accessibility.

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

Yes. This system represents a best practice that can be shared with other departments and agencies. Its flexible design offers opportunities to integrate additional processes, streamline workflows, and consolidate data management into one secure, centralized platform.

#### Accomplishment #4: Successful Transition of LDH-Operated Facility Investigations to OAAS – Adult Protective Services (APS):

- A. What was achieved?

OAAS – APS, in collaboration with the Louisiana Department of Health Bureau of Legal Services, the Executive Administration of state-operated facilities, and the Health Standards Section (HSS) successfully completed the transition of investigatory authority to APS for all allegations of abuse within state-operated facilities. This included resulted in the formal transfer of investigative responsibilities Pinecrest Supports and Services Center (PSSC) and Central Louisiana Supports and Services Center (CLSSC).

- B. Why is this success significant?

This accomplishment represents the establishment of a centralized, standardized, and independent process for investigating abuse and neglect in state-operated facilities, ensuring greater accountability and consistency across the Department.

- C. Who benefits and how?

The achievement enhances the operational capacity of OAAS, but more importantly improves the experience and outcomes for clients and their families by fostering greater trust in our system. Consistent policies ensure that families can anticipate standard responsiveness when concerns arise. They can be assured that complaints will be investigated promptly by an impartial and independent body, leading to improved safety and well-being for their loved ones.

- D. How was the accomplishment achieved?

The successful execution of this initiative is a direct result of the strong collaborative effort among the OAAS-APS, the Louisiana Department of Health Bureau of Legal Services, the leadership of the Executive Administration of state-operated facilities, and the HSS.

OAAS leadership has been instrumental in driving in-depth research and strategic planning with transition partners, leading to significant APS organizational restructuring and policy updates to effectively manage new and increased responsibly.

As a result of this restructuring, new APS positions were created and successfully staffed. OAAS also established a fully equipped, dedicated workspace for the APS

team, significantly enhancing their ability to serve the PSSC community. The transition further included comprehensive updates to APS policies and procedures, key revisions to facility operations, and the implementation of a robust training program to ensure all APS Facility staff across the state are well-prepared for their evolving roles.

To ensure consistent data entry and report management across LDH-operated facilities, SIMS database access has been extended to law enforcement and HSS. This has improved HSS's retrieval of APS facility investigation reports for state and federal regulatory requirements.

Effective April 1, 2025, OAAS began receiving facility investigations from PSSC and CLSSC, concurrently instituting its updated policies. OAAS continues post-transition monitoring and assesses all facility investigation activities.

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

Yes. This initiative directly supports OAAS Strategic Plan Programmatic of ensuring the timely completion of all vulnerable adult investigations, as establishing consistent policies and procedures enhances accountability and responsiveness in addressing abuse and neglect in all state-operated facilities.

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

Yes. This transition process demonstrated how cross-agency collaboration, structured policy updates, and intensive staff training can be successfully implemented to improve accountability and responsiveness.

### Accomplishment #5: Completion of Visitation Pavilion at Villa Feliciano Medical Complex:

- A. What was achieved?

Villa Feliciano Medical Complex (VFMC) finished construction and began utilization of the new Visitation Pavilion in SFY25. This was a project many years in the making, having begun in SFY22. The pavilion has already proved to be a great asset to VFMC clients and staff alike.

- B. Why is this success significant?

The pavilion allows clients and their visitors additional space to spend quality time together in an outdoor, shaded space. While there are many spaces which are shaded by trees, the pavilion provides a place with a smooth surface and multiple seating areas. The pavilion is not used strictly for when clients have visitors, VFMC now has the ability to host outdoor recreational functions in the pavilion. For example, holiday parties, recreational activities such as bingo, fruit socials, and outdoor cooking, and even employee engagement festivities.

- C. Who benefits and how?

Clients, their visitors, and VFMC staff all benefit for the new construction. The pavilion is especially a benefit to those with mobility impairments as it meets with ADA accessibility standards. Having the ability to facilitate activities outside, both as planned by VFMC staff and recreationally, are supported by best practices as research shows that spending time outdoors improves mood and overall satisfaction.

D. How was the accomplishment achieved?

Capital for the pavilion were acquired through federal COVID-19 funding, Cares Act Funding directly associated with COVID-19 mitigation efforts. VFMC worked with a vendor to design a space that would be easily accessible by clients and provide a useable outdoor space. VFMC then contracted with a vendor in 2021 and began construction in 2023. The pavilion opened for use on 10.31.2024. A small celebration was held on 12.12.2024 in conjunction with the annual VFMC Christmas parade.

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

Yes. VFMC is responsible for managing client care. The pavilion has enhanced patient care by providing an outdoor setting for recreational activities. VFMC strives to reduce boredom and isolation for its clients.

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

Yes. This project was specific to the needs of VFMC clients and followed regulatory infection control requirements set forth by CMS for Nursing Homes.

Accomplishment #6: Medical Record System Converted and Expanded at Villa Feliciano Medical Complex:

A. What was achieved?

Villa Feliciano Medical Complex (VFMC) expanded its Electronic Medical Record (EMR) program from server based American Health Tech (AHT) to a web based model, Point Click Care (PCC). VFMC was able to implement electronic prescription and medication administration process, which makes VFMC one of the few Nursing Homes in the State utilizing this technology. EMRs of this high level of functionality are mainly found in acute care hospital settings.

B. Why is this success significant?

- Improved work process by automating patient care
- Enhances patient care by providing direct care access remotely and more timely
- Reduces errors by ease of auditing and reporting
- Produces better overall patient outcomes

C. Who benefits and how?

All clients and staff benefit from a comprehensive electronic medical record. Electronic Medical Records (EMRs) benefit patients by improving the quality and safety of care through fewer errors and better coordination between providers, and by empowering

patients with easier access to their own health information and direct communication with their care teams. EMRs also lead to increased efficiency, resulting in faster diagnoses, quicker access to test results, and reduced duplication of tests and treatments.

D. How was the accomplishment achieved?

VFMC was notified that AHT was acquired by PCC on 03.01.2024. VFMC began planning for the transition from AHT to PCC by 06.01.2024. PCC go-live took place on 11.01.2024. PCC staff and VFMC trained super users were available to assist in the transition until 02.01.2025. There were a few minor obstacles during the initial weeks of implementation such as, log on / ID complications, census reconciliation, and some billing discrepancies. All obstacles were easily overcome by staff and are currently running smoothly.

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

Yes, the facility strives to remain progressive and stay current with the best practices available to the industry which is in direct alignment with administering and managing resident care programs.

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

Yes, all 24-hour facilities should implement and maintain the most recent IT advancements in their respective industries because Electronic Medical Records (EMRs) improve patient care, increase efficiency, reduce medical errors, and enhance patient safety. EMRs provide quick, digital access to comprehensive patient data, supporting better clinical decision-making, facilitating seamless communication between healthcare professionals, and allowing for secure storage of sensitive information.

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

OAAS aims to provide a system where adults in need of long-term services and supports can live with dignity and independence in a safe and holistic environment. OAAS has made progress toward this goal over FY24 by:

1. Promoting and developing health and Long Term Support and Services (LTSS) delivery systems that improve care and outcomes for 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 *Olmsted vs L.C.*

2. Timely completing investigations of abuse, neglect, exploitation, and extortion of vulnerable adults
3. Administering and managing resident care programs at Villa Feliciana Medical Complex
4. Administering and operating OAAS programs in a cost-effective manner while achieving high quality outcomes

The commitment, achievements, and work towards this vision and goals are evident by the achievements outlined in Section I of this report.

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

Significant progress has been made in all areas of OAAS.

- Utilizing data driven dashboards to visualize and manage performance and processes. Program Operations were able to set a record in certification and My Choice Louisiana (MCL) was able to greatly increase the success with milestones required for transitions, thereby driving forward progress to ending the Department of Justice (DOJ) Settlement Agreement. Training management in the skills needed to use data and dashboards to make operational decisions is the most significant accomplishment in this activity, as it represents a best practice for managing processes.
- A review of all OAAS positions as they relate to Medicaid match resulted in identification of an error in the cost allocation plan in which the department was not appropriately claiming the administrative match for approximately 120 positions within OAAS. As a result of catching this error and the resulting correction, OAAS estimates a savings of approximately \$8.2M in SGF in FY26.
- The newly opened PACE center in Region 6 continues to grow.
- OAAS added additional slots to the Community Choices Waiver pool and created a new priority group.

1. To what do you attribute this success?

This success is attributable to hard work and dedication of all OAAS staff; LDH Executive Management; collaborative work with other offices within LDH and partners within governmental agencies outside of LHD; elected Louisiana Congressional Members; and several external stakeholders. While OAAS led efforts specifically related to its own office's initiatives, it also worked in a support role in areas where needed. Each of the accomplishments represent an internal ability to review current practices and look for opportunities to improve. The self-examination was the first step in each successful endeavor by our agency.

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

Some of OAAS's progresses produced one-time gains, such as updates in policy and procedures. Several of OAAS's progresses are expected to continue and accelerate, such as the practice of using data and visually charting process metrics through dashboards; outreach and education when partnerships require it; and

internal review and field visits to give a comprehensive assessment of policies, procedures and staff satisfaction.

- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state “None.” However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:  
None. OAAS has been able to promote and develop LTSS, investigate abuse and neglect, and operate the office in a cost-effective manner.

1. To what do you attribute this lack of progress?
2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

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

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

While OAAS has made progress toward and achieved success in the goals mentioned above, updates were made in the FY27-31 strategic plan which will result in OAAS continuing to make advancements in serving our population. The five-year strategic plan will continue to be evaluated annually to determine if updates are needed.

No. If not, why not?

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

OAAS strategic goals and objectives are clear and have been consistent over time, administrative changes, and understood by all OAAS staff. OAAS has been fortunate in having access to data that allows management and staff to monitor program outcomes, often against national goals and benchmarks. This allows OAAS to adjust strategies as needed to attain office objectives. Because OAAS administers Medicaid funded programs, OAAS works very closely with that agency and other LDH offices to assure strategies and goals are aligned.

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

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

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

**Problem / Issue #1: Waitlist Reduction and Service Alignment:**

**A. Problem/Issue Description**

1. What is the nature of the problem or issue?  
While OAAS has made significant efforts to reduce the waitlist, ultimately there continues to be more people requesting services than there are available slots. Additionally, current waiver, policy, and procedure documents do not support a comprehensive continuum of care model for participants currently enrolled in OAAS programs or for those waiting for services. The updates needed to develop a comprehensive continuum of care model will likely require additional funding and significant time to develop as waiver and rule documents will need to be modified with support and feedback from internal and external stakeholders.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)  
Yes. OAAS’s mission is 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. While we are able to offer services, the Office is unable to reach all of the population requesting services. While this is in part due to availability to slots, it is also greatly affected by the Support Coordination Agencies’ (SCAs) ability to maintain workforce and capacity to handle caseloads which will be discussed in greater detail in the next section of Part III.
3. What organizational unit in the department is experiencing the problem or issue?  
HCBS Waiver Operations, Permanent Supportive Housing, TBSCI, SPAS and Policy.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)  
Participants and internal and external stakeholders are impacted by the problem.

5. How long has the problem or issue existed?  
Waitlist numbers decreased during the COVID PHE, reaching an all-time low in December 2022, but have steadily increased since January 2023. The issue with a continuum of care and alignment of services exists due to the structure and content of current waiver requirements which have been in effect since 1.1.2011.
6. What are the causes of the problem or issue? How do you know?  
The growing population of older adults translates to a greater need for services. Additionally, changes to existing HCBS waiver delivery systems require consistent, incremental work that will take years to implement fully.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?  
As more people request additional services, waitlist numbers continue to increase and the amount of time from service request to service receipt continues to increase.

#### B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?
  - No. If not, skip questions 2-5 below.
  - Yes. If so, complete questions 2-5 below.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
  - a. If so:
    - What is the expected time frame for corrective actions to be implemented and improvements to occur?
    - How much progress has been made and how much additional progress is needed?
  - b. If not:
    - Why has no action been taken regarding this recommendation?
    - What are the obstacles preventing or delaying corrective actions?
    - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?
5. Do corrective actions carry a cost?
  - No. If not, please explain.

- Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

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

## Problem / Issue #2: Home and Community Based Services (HCBS) Service Infrastructure Issues:

### A. Problem/Issue Description

1. What is the nature of the problem or issue?  
Even if OAAS were to receive funding to accommodate requests for services for all eligible participants, current provider and workforce infrastructure issues would make it near impossible to provide the necessary services they need in the settings they wish. SCAs and providers frequently report issues with pay, hiring, and retention. The most comprehensive of these activities are not actionable without support from LDH leadership and increased funding. There are areas of the state in which there are few or no providers for various program services. Additionally, the lack of available safe, affordable, and accessible housing affects our ability to transition eligible participants from a nursing facility into the community continues to be problematic, which is compounded by the current Louisiana Housing Corporation freeze on housing choice vouchers.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)  
Yes, OAAS is unable to fill existing waiver slots due to SCA and DSW infrastructure issues. OAAS is unable to transition eligible participants into the community with supports and services due to the lack of appropriate housing.
3. What organizational unit in the department is experiencing the problem or issue?  
All organizational units within OAAS are experiencing the problem.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)

Participants and internal and external stakeholders are impacted by the problem.

5. How long has the problem or issue existed?  
Workforce issues became apparent during the COVID PHE, and have steadily become more apparent over time. Housing issues have been present since 2009.
6. What are the causes of the problem or issue? How do you know?  
Workforce issues, pay issues, increased workload with no corresponding increase in workers, pay, or other supports. Affordable housing availability is exacerbated by disasters in Louisiana.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?  
OAAS participants will have to wait longer for services even once linked to a waiver. For MCL, inability to transition participants out of nursing facilities puts LDH in jeopardy of not meeting the requirements of the DOJ Agreement. A lack of workers, housing, and consistent and stable in-home supports puts our participants at risk.

#### B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?
  - No. If not, skip questions 2-5 below.
  - Yes. If so, complete questions 2-5 below.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
  - a. If so:
    - What is the expected time frame for corrective actions to be implemented and improvements to occur?
    - How much progress has been made and how much additional progress is needed?
  - b. If not:
    - Why has no action been taken regarding this recommendation?
    - What are the obstacles preventing or delaying corrective actions?
    - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?
5. Do corrective actions carry a cost?
  - No. If not, please explain.
  - Yes. If so, what investment is required to resolve the problem or issue? (For

example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

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

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

The LDH has a designated Audit Coordinator for financial audits. The Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and

operation of state programs and activities.

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

- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
  
- Performance Progress Reports (Louisiana Performance Accountability System)**  
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
  
- In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.
  
- Benchmarking for Best Management Practices**  
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.
  
- Performance-based contracting (including contract monitoring)**  
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a

monitoring plan.

- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

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

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-324 Louisiana Emergency Response Network

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Paige Hargrove

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

For each accomplishment, please discuss and explain each item below.

#### Accomplishment #1: Passage of Dedicated Funding Bill for LERN:

- A. What was achieved?  
Act 194 passed in 2025 Regular Legislative Session, which adds nominal amount to fines for DUI, speeding, drag racing and reckless driving. Monies are to be paid to the Treasury for deposit into the Louisiana Emergency Response Network Fund.
- B. Why is this success significant?  
Achieving a dedicated funding source is significant because once funds accumulate, it allows LERN to augment/support existing systems of care without asking for additional state general funds.
- C. Who benefits and how?  
The citizens of Louisiana, hospital partners (nurses and physicians) and EMS providers will benefit from expansion of education offerings for trauma, stroke, STEMI and MCI. Additionally, potential implementation of tele-medicine (pending amount of funds generated) will facilitate a more informed and efficient transfer process for patients possibly needing transfer to a higher level of care. This also allows us to continue medical director contract support for expert guidance in our systems of care.
- D. How was the accomplishment achieved?

This was accomplished over years of work by LERN staff and stakeholders educating legislators on LERN's statewide mission and the importance of funding. LERN previously tried three times unsuccessfully, to pass legislation for dedicated funding. Over the years, we built a coalition of support. LERN has four legislators on the LERN Board, two Senators and two Representatives. One of the Representatives sponsored the bill and the others supported it through the process. Additionally, the LERN Board consists of 25 other board members who educated their legislators on LERN's mission and the importance of the bill passing.

- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, goal 2: to maximize the return on investment (ROI) of state dollars and supplement general fund dollars with alternative funding sources.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?  
No, this process is not unique to LERN and other agencies are aware of how to get a bill passed.

### Accomplishment #2: Adoption and implementation of Adult Trauma Transfer Guideline:

- A. What was achieved?  
The LERN Board adopted and the LERN team implemented an Adult Trauma Transfer Guideline to facilitate trauma emergency department to emergency department transfers.
- B. Why is this success significant?  
This is significant because of the high denial rates the LERN Communication Center was encountering when trying to transfer injured patients from outlying community hospitals to our trauma centers. After implementing the new guideline and educating all of the trauma centers, we have seen the denial rate drop from 29% to 4%. We separated the transfer categories into emergent and non-emergent. All emergent denials require an MD to MD conversation. Previously, the transfer center would deny without discussing with the physician. Time is of the essence when transferring injured patients. This process cut down on the denial rate and subsequently the time it takes to move a patient from one emergency department to another one for definitive care.
- C. Who benefits and how?  
Injured patients benefit by receiving efficient triage and transfer to definitive care. Community hospitals also benefit from being able to quickly transfer patients whose needs are above the scope of care they can provide.
- D. How was the accomplishment achieved?  
This was accomplished by utilizing the LERN Communication Center denial data to communicate and measure the severity of the problem. From here, we utilized the expertise of the LERN trauma medical director to develop the guideline. We worked with the trauma center leadership to edit and finalize the guideline. After implementation, we allowed for feedback and have since amended the guideline based on identified opportunities for improvement. The LERN Call Center sends a daily denial report to every trauma center. This allows for next day follow-up on every denial. Over time, the denials have decreased to 4%.

- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, it fits with Goal 3 of the strategic plan: Ensure that all citizens gain access to the statewide networks for trauma and time sensitive related illnesses.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?  
It is a best practice to include regional stakeholders in any process impacting their practice. Including our partners in the process engages them in the process and helps for successful implementation. It is also best practice to have a subject matter expert lead related initiatives

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

Yes, we are progressing towards meeting the goals and objectives set forth by our strategic priorities. Returns on investment are being met, as evidence by the efficiencies in ED to ED trauma transfers due to development and implementation of the Adult Transfer Guideline, less than 5% secondary transfer rate for patients directed by the LERN Communication Center (LCC) and expansion is networks for trauma, stroke, STEMI and Burn. The systems of care for trauma, stroke and STEMI are providing access to citizens for these time sensitive conditions.

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

- Fourteen Louisiana Trauma Centers are participating in the Trauma Quality Improvement Program (TQIP). The collaborative allows us to look at benchmark risk-adjusted outcomes as a state system against all nationally participating TQIP centers. It facilitates system-level trauma center quality improvement, identification, and sharing of best practices among collaborative participants. Based on the TQIP data the collaborative developed a hip fracture guideline to help formalize an approach to hip fracture care to improve postoperative outcomes and reduce mortality. The adopted guideline is available to all hospitals.
- We do not have a comprehensive trauma registry. We have 14 hospitals submitting data to the state trauma registry. This is up from seven in CY 16. Hospitals are now submitting data quarterly. Annual reports are posted to the LERN Website. <https://lern.la.gov/trauma/trauma-registry/> Based on data from the 14 hospitals submitting data in 2024, the highest cause of injury is falls, followed by motor vehicle crashes and then assault. The highest cause of mortality is falls, then firearm discharge, followed by motor vehicle crashes. We now have access to the Louisiana Inpatient

Hospital Discharge Data (LaHIDD) base and Vital Records. This allows us additional visibility on where trauma patients are being treated and allows for targeted education.

- We now have fourteen designated trauma centers in the state.
  - Ochsner LSU Health Shreveport – Level I Trauma Center
  - Ochsner LSU Health Shreveport – Level II Pediatric Trauma Center
  - University Medical Center New Orleans – Level I Trauma Center
  - Children’s Hospital New Orleans – Level II Pediatric Trauma Center
  - Rapides Regional Medical Center – Level 3 Trauma Center
  - Our Lady of the Lake Regional Medical Center – Level 1 Trauma Center
  - Our Lady of the Lake Children’s Hospital - Level II Pediatric Trauma Center
  - North Oaks Medical Center – Level 2 Trauma Center
  - Ochsner Lafayette General Medical Center – Level 2 Trauma Center
  - Lakeview Regional Medical Center – Level 2 Trauma Center
  - St. Tammany Parish Health System – Level 3 Trauma Center
  - Lake Charles Memorial Hospital – Level 3 Trauma Center
  - Ochsner LSU Health Monroe – Level 3 Trauma Center
  - St. Francis Medical Center – Level 3 Trauma Center
- Hospitals are updating the burn screen in the ESF-8 portal daily, providing transparency in burn bed availability statewide. Children’s Hospital New Orleans is working to become a burn center. Additionally, the LERN Board updated all burn educational materials to reflect American Burn Association guidelines for burn care and resuscitation.
- LERN continues to teach trauma specific courses statewide. In CY 2024, we taught 123 trauma classes, reaching 2,539 students.
- In response to recommendations from the ACS-COT Trauma Systems Consultation, the LERN Board chartered the Louisiana Trauma System Consultation Research Panel to evaluate LERNs operating model. Through this process, we are beginning discussions to consider adding Level 4 trauma centers to the state trauma system. Adding Level IV centers could augment rural hospital readiness and improve visibility on injury patterns in the state by adding Level 4 center data to the registry.

**Goal 2: Maximize the return on investment (ROI) of state dollars and supplement of general fund dollars with alternative funding sources.**

- LERN successfully passed Act 194 in the 2025 Regular Session of the Louisiana Legislature. The law provides additional fines for offenders of operating a vehicle while impaired, including a \$25 fine upon the conviction of a first offense, a \$50 fine upon the conviction of a second offense, a \$100 fine upon conviction of a third offense, and a \$250 fine upon conviction of a fourth offense. The law provides additional fines for offenders of reckless operation of a vehicle, including a \$5 fine upon the conviction of a first offense and a \$25 fine upon conviction of a second or more offense. The law provides additional fines for offenders of reckless operation of an off-road vehicle of \$5 upon conviction. The proposed law provides additional fines for offenses, including exceeding the maximum speed limit, general speed law, and drag racing and racing on public roads and certain property. The law requires all mentioned fines be collected by the sheriff and

forwarded by the state treasurer within thirty days of collection. After the funds are allocated to the Bond Security and Redemption Fund, the law requires the state treasury to deposit collections from the fund to the Louisiana Emergency Response Network Fund.

- The LERN Call Center tracks secondary transfers as part of its performance metrics. The LERN benchmark is less than 5%. Secondary transfers, especially for time-sensitive illnesses such as trauma, stroke and STEMI, are detrimental to patient outcomes. A considerable number of these transferred patients undergo potentially preventable, repeated CT scans adding radiation dose to patients and costs to the healthcare system. Patients directed by the LERN Call Center (LCC) have a 4% secondary transfer rate as compared to 47% of patients requiring a secondary transfer when not directed by LERN. Cutting down on secondary transfer's saves money. We are not able to attribute a dollar amount to this efficiency. We continue to depend on the state general fund for LERN Operations.
- We received \$40,000 in grant funding to support the EMS Registry.
- Anticipated returns on investment are being realized in terms of efficient use of resources.
- Moving to a state owned building has reduced annual rent significantly and cost of ancillary services.
- We continue to look for grant funds.
- \$15,000 grant funds from Living Well Foundation for Agra-med and Acute Burn Life Support classes.

**Goal 3: Ensure that all citizens gain access to the statewide networks for trauma and time sensitive related illnesses.**

- The expansion of the number of trauma centers from two in 2011 to 14 in 2025 provides 90% of the population with access to a trauma center within a 60-minute drive time. This is up from 40% in 2011.
- LERN developed a Trauma Program status for those hospitals working towards trauma center designation. This expands access to high-level trauma care. Ten hospitals have taken advantage of this process and subsequently passed verification by the American College of Surgeons (ACS):
  - North Oaks Medical Center
  - Lakeview Regional Medical Center
  - Lake Charles Memorial Hospital
  - St. Tammany Parish Hospital
  - Lafayette General Medical Center
  - Ochsner LSU Health Shreveport Pediatric Trauma Center
  - Our Lady of the Lake Children's Hospital
  - Children's Hospital New Orleans
  - Ochsner LSU Health Monroe
  - St. Francis Medical Center
- When considering the fourteen Verified Trauma Centers, 90% of the population have access to a trauma center within a 60-minute drive time.
- When the LERN Board's vision of a verified trauma center in each of the LDH regions is achieved, 97% of the population will have access to a trauma center within a 60-minute drive time. The LERN Trauma Medical Director provides consultative services to all

centers to help them achieve and maintain verification. LERN has a 100% success rate in ACS verification and re-verification.

- In CY 2024, the LERN Board implemented the adult trauma transfer guideline. This has significantly reduced trauma transfer denials from approximately 30% to 4%. This process facilitates efficient movement of patients to definitive care. Additionally, LERN tracks trauma transfer denials and shares a daily report with all trauma centers. This transparency helps each center to evaluate, in close to real time, processes related to transfer acceptance. This result in a higher acceptance rate and decreases cross-region or state transfers, allowing patients to receive care closer to home.
- 100% of the population has access to the LERN Call Center for assistance with direction to the most appropriate resourced hospital for trauma, burn stroke or STEMI.
- LERN’s targeted trauma, stroke and STEMI education to rural hospitals helps increase their readiness to treat patients with these time-sensitive conditions who present to their facility via private vehicle.
- LERN established criteria for six levels of stroke hospitals. This past year we changed the nomenclature for Stroke Bypass Hospital to “Stroke Referral Center”. The Board’s rationale for this change is two-fold. First, they felt “bypass” hospital had a negative connotation. Secondly, the LERN Board wanted these hospitals to participate in stroke education and set education requirements for the Stroke Referral Centers. This is important because although EMS does not bring stroke patients to a “Referral Center”, the hospital will continue to have stroke patients arrive by private vehicle. The LERN Board wants to ensure readiness at these rural hospitals. The LERN Levels are Comprehensive Stroke Center (CSC), Thrombectomy Capable Stroke Center (TSC), Primary Stroke Center (PSC), Primary Stroke Center with Endovascular (PSC-E), Acute Stroke Ready Hospital (ASRH), and Stroke Referral Hospital. A Stroke Referral Hospital does not have the capability to provide expedient care to stroke patients. LERN has built a network of stroke centers that provides the public access to either a CSC, TSC, PSC/PSC-e, or an ASRH to 99.3% of the population. Hospitals attest to their level every two years.
- Performance metrics for stroke meet or exceed national benchmarks:
  - Door to Needle for Acute Stroke Ready Hospitals = 52 minutes with 68.6% of treated patients receiving alteplase within 60 minutes, 35.5% within 45 minutes and 5% within 30 minutes. National benchmark is 60 minutes.
  - Door to Needle for CSC, TSC and PSC = 41 minutes
- LERN purchased a Tableau subscription to provide a public facing dashboard of state stroke data for our hospital and EMS partners and for the general public. The dashboard is accessible at <https://lern.la.gov/lern-stroke-system/metrics/>. The metrics provide regional stroke performance for:
  - Door in Door Out Time
  - Door to Needle Time
  - Percent of patients arriving within 3.5 hours of Last Seen Normal
  - Fibrinolytic Administration Rate
- LERN established criteria for STEMI Receiving centers which require 24/7/365 access to a cardiac catheterization lab. There are 36 STEMI Receiving Centers in the state. These 36 hospitals provide 97.6% of the population with access to a STEMI Receiving Center within a 60-minute drive time. LERN continues to successfully collect this data

from all 36 Receiving Centers and two Referral Centers (and from 2 referral centers).

- The LERN STEMI Medical Director provides individualized quarterly feedback reports to each receiving center. LERN continues to distribute feedback reports to the referral centers. The reports provide them with the time it takes them to transfer STEMI patients out of the ED to the Receiving Center where they can receive emergent PCI. The state median for Door to PCI is 58 minutes, far better than the national benchmark of 90 minutes. The median transfer time for referral centers is 51 minutes, much longer than the national benchmark of 30 minutes, but improved from last year. LERNs strategic plan focuses on improving this metric. Additionally, LERN will continue to teach 12 Lead ECG classes statewide. In CY 2024, LERN taught 18 classes reaching 375 students.
- LERN purchased a Tableau subscription to provide a public facing dashboard of our State STEMI Data for our hospital and EMS partners and for the general public. The dashboard is accessible at <https://lern.la.gov/lern-stemi-system/metrics/>. It provides data on:
  - Time to Referral Hospital ED without Lytic Administration prior to transfer, Door to PCI by Region, First Medical Contact to PCI (without transfer) by region and First Medical Contact to PCI by Region for Transferred Patients.
- LERN continues to meet with the LERN Burn workgroup to implement and evaluate the state burn system. LERN continues with mass notification/resource update drills with the American Burn Association, statewide burn centers and the Southern Regional Burn Consortium.
- LERN continues to teach the Stroke Recognition and Response (SRR) class. LERN taught 22 classes, reaching 275 students. Additionally, we taught 15 basic stroke classes, reaching 429 students.

**Goal 4: Establish and codify protocols that specify the role of LERN in ESF-8 activities.**

- Continue LERN's role in the ESF-8 to include manager of the EMS Tactical Operations Center during a disaster.
  - LERN involvement in disaster drills throughout the state. Statewide Disaster Preparedness Manager integrated with nine regional Healthcare Coalitions and Office of Homeland Security Emergency Preparedness operations. Working on finalizing continuity of operations plan. Provided updated Mass Casualty Incident (MCI) training to partners in all regions related to how the LCC functions and collaborates with EMS during an incident.
  - Established core-planning team for the development of a tri-regional EMS education day for EMS, fire, and law enforcement.
  - LERN Disaster Preparedness Manager developed a new MCI training and this has been implemented in all regions except for region 1.
  - Began process of conducting at least one operation-based exercise with each LERN Call Center communicator in the calendar year. This is to validate individual performance in response to mass causality operations.
- ♦ **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and

discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

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

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

LERN made significant progress in facilitating trauma transfers. The progress would not have been made without the interventions by LERN.

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

The decrease in the trauma transfer denial rate from 30% to 4% is directly related to LERN actions. The key actions are:

- Daily tracking of denials and transparency in sharing denial report with all trauma centers. When peer hospitals can see who is accepting or denying patients, the group collectively work to accept patients.
- Developing and implementing a new adult trauma transfer guideline.
- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success? The progress is related to LERN collaboratively working with the 14 trauma center medical directors, trauma program managers and transfer centers to determine the best path forward. LERN's trauma medical director, Dr. Michael Sutherland, led this group. He developed the framework and solicited feedback from hospital partners until we had a guideline we could all support.
- Other? Please specify.

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

The progress will continue, but will never get to a 0% denial rate. There are denials that will be unavoidable, but we now have a guideline that has been implemented and is working.

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

1. To what do you attribute this lack of progress? For example:

- Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?

The major area we are experiencing a significant lack of progress on is, lessening the dependence on the state general fund for LERN funding. This is not a management issue. LERN successfully passed Act 194 in the 2025 Regular Legislative Session. The Act provides an additional fine for specific diving offenses, which will be deposited into the LERN fund. All judges and sheriff's offices have been informed on the new law. In time, we hope to utilize this fund for any additional LERN budgetary needs.

LERN needs a comprehensive trauma registry. Currently only the 14 trauma centers/programs contribute injury data to the registry. Without a comprehensive registry, it is difficult to measure system improvement and to target injury patterns.

- Is the lack of progress due to budget or other constraint?  
The registry is a funding issue for hospitals. It is difficult for smaller community hospitals to identify staff to input trauma registry data. In the past, the Louisiana Hospital Association pushed back on mandatory data collection.
- Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
- Other? Please specify.

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

The reliance on the state general fund will continue until funding from Act 194 begins to be deposited in the LERN fund. LERN has spoken to the Treasury and it takes some time before funds are generated. The registry will continue to be an issue until as a state we legislate mandated participation and purchase a registry capable of integrating EMS registry data with trauma registry data.

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

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

The LERN Strategic Priorities are set for a 3-year interval. Each year the LERN Board reviews the strategic priorities and adjusts 12-month goals and the action items to achieve goals. In November 2024, we developed new strategic priorities for 2025-2028. We consulted with the American College of Surgeons Committee on Trauma to evaluate Louisiana's Trauma System. We used recommendations from this report when developing the 2025 – 2027 three-year strategic plan.

No. If not, why not?

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

The LERN Board adopts a 3-year strategic plan. The Executive Director provides a report to the LERN Board of Directors (BOD) at least quarterly. This report includes progress to goals for each strategic priority. The LERN Board re-evaluates the strategic goals for each priority annually and annual goals are updated to help advance each priority. The LERN Tri-Regional Coordinators inform the Regional Commissions. The Tri-Regional Coordinators also submit quarterly Commission Activity Reports (CAR) that provide information on what is being done at the regional level to achieve strategic priorities. The strategic plan is posted to the LERN website.

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

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

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

#### A. Problem/Issue Description

1. What is the nature of the problem or issue?  
LERN relies on State General Fund (SGF) in order to run the network. This is a concern due to the anticipated impact of the Big Beautiful Bill to the state budget. LERN operations are at risk if budget cuts are implemented due to reliance on SGF. We are anticipating funding from Act 194.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)  
This problem is not currently affecting progress of LERNs strategic plan because our planning accounts for existing appropriation. The strategic plan will be affected if cuts are implemented to LERN in the future.
3. What organizational unit in the department is experiencing the problem or issue?

LERN only has one department and our mission covers four core components (Trauma, Stroke, STEMI, and Disaster Response)

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

Our external public, hospital and EMS providers will be impacted by reductions in education and support provided.

5. How long has the problem or issue existed?

LERN's reliance on the state general fund has existed since LERN was first funded in 2006. LERN has twice unsuccessfully attempted to pass legislation for dedicated funding – separate from the state general fund.

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

As previously stated, anticipated impacts from the Big Beautiful Bill may cause budget cuts. The LERN Board will consider this when establishing the next 3-year strategic plan. LERN is almost 100% funded by the SGF.

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

Impact and consequences will depend on the extent of budget reduction required by the legislature and any funds from Act 194, which could offset budgetary concerns. Impacts range from maintaining LERN Call Center operations to decrease in education provided to EMS, hospitals, and to lay public.

## B. Corrective Actions

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

No. If not, skip questions 2-5 below. (Due to passage of Act 194, LERN funding bill)

Yes. If so, complete questions 2-5 below.

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

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

4. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur?
- How much progress has been made and how much additional progress is needed?

b. If not:

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

5. Do corrective actions carry a cost?

No. If not, please explain.

We established a dedicated funding source in the 2025 Regular Legislative Session. Most trauma systems are funded via a tax or fee dedicated to operating the system. LERN passed the bill, but await courts and municipalities to comply, which will provide dedicated funding.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

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

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

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

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

- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
  
- Performance Progress Reports (Louisiana Performance Accountability System)**  
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
  
- In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.
  
- Benchmarking for Best Management Practices**  
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary,

as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

- Performance-based contracting (including contract monitoring)**  
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.
- Peer review  
 Accreditation review  
 Customer/stakeholder feedback  
 Other (please specify): Case review process. All reviews tracked in Access Data Base.

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

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

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

1. Title of Report or Program Evaluation: LERN Annual Report FY 23-24
2. Date completed: March 2025
3. Subject or purpose and reason for initiation of the analysis or evaluation:  
Required by LERN Legislation La. R.S. 40:2845.
4. Methodology used for analysis or evaluation: Data included in the report is obtained from call center data, from EMS Registry, State Trauma Registry and education tracking log.
5. Cost (allocation of in-house resources or purchase price): \$1250
6. Major Findings and Conclusions: Progress is being made in all of LERN core missions: trauma, stroke, STEMI and Disaster Preparedness/Response
7. Major Recommendations: Continue implementation of strategic plan.

8. Action taken in response to the report or evaluation:
9. Availability (hard copy, electronic file, website): available on the LERN Website at <https://lern.la.gov/about-lern/annual-report/>
10. Contact person for more information:  
Name & Title: Paige Hargrove, Executive Director  
Agency & Program: Louisiana Emergency Response Network  
Telephone: (225)756-3440  
E-mail: [Paige.Hargrove@La.Gov](mailto:Paige.Hargrove@La.Gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-325 Acadiana Area Human Services District

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Asst. Secretary (or Ex. Director):** Brad Farmer

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

#### Accomplishment #1: CCBHC PDI Grant:

##### A. What was achieved?

AAHSD was awarded a Certified Community Behavioral Health Clinic Planning, Development, and Implementation (CCBHC-PDI) grant from SAMHSA effective October 1, 2022; this is a \$3.8million four-year award. AAHSD has been working closely with an external consulting group; the University of Louisiana; and the Office of Behavioral Health during this development phase. Our program attestation was reviewed and accepted by SAMHSA effective January 1, 2024. This means that AAHSD has gained Federal recognition as a CCBHC. Additionally, AAHSD was surveyed by CARF International in October 2023 and earned a Three-Year Accreditation for the CCBHC program. AAHSD was the first organization in the country to earn this designation.

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

This model of care will improve the quality of services provided to our community by providing a framework for best practices and aligning services with community needs. The requirements (performance standards) are 'above and beyond' State licensure standards and current contractual indicators. It will assist AAHSD in expanding services and will provide a structure to sustain operations. Currently, AAHSD is working with the Louisiana Department of Health, Office of Behavioral Health to develop a State

Certification process for CCBHCs. This process will help support the State's efforts to be recognized as a demonstration state and this will have a major impact upon ongoing funding (prospective payment system) for services.

C. Who benefits and how?

AAHSD benefits from technical assistance, training, and consultation; along with external funding. The entire service population benefits from expanded services, increased quality of care, and professional collaborations. This program will also ensure AAHSD adequately addresses the needs of Veterans seeking services.

D. How was the accomplishment achieved?

As part of the ongoing process, AAHSD has appointed an internal Project Director to oversee all efforts with this program. AAHSD has contracted with an external consulting group for ongoing technical assistance and with the University of Louisiana to serve as the project evaluator. Additionally, AAHSD conducts regular project meetings with both of these groups and has invited the Office of Behavioral Health to participate as well as a way to enhance communication with State officials. AAHSD also has monthly calls with the identified Grants Project Officer (GPO) from SAMHSA. As part of the governance structure requirement per Federal guidelines, AAHSD has initiated a Consumer Advisory Council, made up of persons with lived experience, family members, and veterans of the armed services (this is not required but we have included this criteria to ensure meaningful input from this population).

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

Yes

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

Yes

**Accomplishment #2: Same Day Access grant:**

A. What was achieved?

AAHSD participated in a technical assistance project and implemented the Same Day Access model. This project went 'live' on January 8, 2024. From January 8, 2024 – June 30, 2025, AAHSD conducted 3,167 comprehensive assessments for persons seeking services. Of those assessments, approximately 94% were admitted to AAHSD for services; others either declined care or were referred to more appropriate providers. These were provided 'on demand' and were not scheduled appointments; this project has eliminated any waiting time for access to services.

B. Why is this success significant?

This project will work in tandem with our CCBHC efforts and will greatly increase service accessibility. This is recognized as a 'best practice'. A secondary benefit is increased service capacity for ongoing non-intake appointments. Our focus on service

access and efficiency has also increased the number of persons we are able to serve. In December 2021 the average number of persons seen per day was 160; in December 2024 the average number of persons seen per day was 338.

- C. Who benefits and how? All persons seeking services from AAHSD. This has eliminated a traditional 'waiting list' for services.
- D. How was the accomplishment achieved? AAHSD worked with MTM Services to complete a gap analysis of our systems and to implement necessary changes. AAHSD appointed a Same Day Access Team to guide implementation and this Team continues to meet and monitor our progress and makes recommends changes as needed.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes

**Accomplishment #3: Just In Time grant:**

- A. What was achieved?

Very similar to the Same Day Access program last year, AAHSD has been invited to participate in a technical assistance project to implement a 'Just in Time' program (JIT). The JIT project focuses on revamping the scheduling process for prescribers so that persons served have more timely access to those staff members. AAHSD has only had one planning session and two follow-up sessions to date. The project has an implementation target date of prior to the end of calendar year 2024.
- B. Why is this success significant?

This will increase accessibility to evaluation and medication services for persons served. This will increase overall efficiency of clinical operations as well. And as noted above, this is considered a best practice.
- C. Who benefits and how?

All persons being served by AAHSD. This will provide more timely access to prescribers for medically-necessary care. For the organization itself, this standard of care will allow us to demonstrate conformance/compliance with licensure and accreditation standards. AAHSD implemented the Just in Time (JIT) Prescriber Scheduling model (also developed by MTM Services). In conjunction with the SDA model this has greatly decreased the waiting time from diagnostic assessment to psychiatric evaluation, and ongoing care. In January 2024, the waiting time was 22.75 days; in December 2024 this had decreased to 6.52 days.
- D. How was the accomplishment achieved?

Utilization of a nationally-recognized consulting firm to help set-up the system and an internal team for ongoing monitoring and revisions.

- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) It will.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? It will.

**Accomplishment #4: Partnership with Families Helping Families to provide a Easter baskets for children with developmental disabilities and/or dealing with mental health issues in the community:**

- A. What was achieved? Partnered with Families Helping Families to give Easter Baskets to kids with DD and/or Mental Health issues
- B. Why is this success significant? It allowed the community and children with developmental disabilities and/or mental health issues to interact and receive an Easter basket . Also provided children with DD and/or dealing with Mental Health issues the same opportunities available to all.
- C. Who benefits and how? Children with developmental disabilities and/or dealing with Mental Health issues and their families and the community. It helped build relationships and showed the community the abilities of people with DD and/or dealing with Mental Health issues.
- D. How was the accomplishment achieved? AAHSD collaborated with Families Helping Families. Easter baskets were collected through their networks and all assisted with delivery of the baskets to the children.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes

**Accomplishment #5: Continued Partnership with OCDD regarding the tiered waiver system:**

- A. What was achieved? Partnered with OCDD for the continued administering of the tiered waiver system.
- B. Why is this success significant? It changed the way the request for waiver services registry (waiting list) is implemented. It has gone from a first come first serve registry to as needs based screening process.
- C. Who benefits and how? Individuals with developmental disabilities and their families. It will allow quicker access to home and community based services.
- D. How was the accomplishment achieved? OCDD partnered with the district and authorities throughout the state to screen all of the individuals on the registry. Once done, the needs of those individuals were established. Priority was given to those with the highest, most urgent need.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes

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

**Accomplishment #6: Partnership with the City of Lafayette Parks and Recreation Department to provide a Christmas Extravaganza for people with developmental disabilities and all kids within the community**

- A. What was achieved? Partnered with City of Lafayette Parks and Recreation Department to give a Christmas party for people with developmental disabilities and all kids within the community.
- B. Why is this success significant? It allowed the community and children with developmental disabilities to interact to break down barriers and stereotypes. It provided a safe environment people could celebrate Christmas, participate in dancing, arts and crafts and be allowed to visit Santa.
- C. Who benefits and how? Children with developmental disabilities and their families and the community. It helped build relationships and showed the community the abilities of people with DD.
- D. How was the accomplishment achieved? Collaboration with the City of Lafayette Parks and Recreation Department. Many community providers assisted in providing various activities to the individuals.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes

**Accomplishment #7: Partnership with the Aetna to provide inclusion event for trick or treating (Treats at the Village) for individuals with developmental disabilities in the community:**

- A. What was achieved? Partnered with the Aetna to give have an inclusive trick or treating experience in the community.
- B. Why is this success significant? It allowed the community and individuals with developmental disabilities to interact with the community to participate in trick or treating. Also provided individuals with DD the same opportunities available to all.
- C. Who benefits and how? Individuals with developmental disabilities and the community. It helped build relationships and showed the community the abilities of people with DD.
- D. How was the accomplishment achieved? AAHSD collaborated with Aetna.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes

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

**II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

AAHSD submitted our initial five-year Strategic Plan in June 2025. Thus far, our goals and objectives are being met and the plan is on target for successful completion.

**Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized? AAHSD is progressing towards accomplishing goals and objectives, such as: developing clear policy objectives; providing behavioral health treatment services as part of the State’s continuum of care; improving accessibility; increasing stakeholders’ involvement; and, providing quality services and supports. These strategies are effective in ensuring persons served receive the highest quality care.

- ♦ **Where are you making significant progress?** If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
  1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department’s contribution to the joint success? Other? Please specify. AAHSD is on target for making the progress that was projected in the five-year Strategic Plan. Progress is due largely to reorganizing our internal structure, developing new policies and procedures, utilizing the expertise of the Governing Board, conducting staff training, and implementing a team structure and approach to management. We are continually working to improve policies/systems and making necessary changes to become more effective and efficient.
  2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue on an ‘on-target pace’ as we conduct regular ongoing meetings of teams (Accreditation, Health/Safety,

Quality Improvement, and Senior Management), participate in ongoing external reviews, and conduct ongoing internal reviews. Our efforts so far have not been ‘one-time events’ but the building of infrastructure and operating systems to ensure ongoing success.

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

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

None

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

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

No. If not, why not?

The AAHSD five-year Strategic Plan gave a clear overview of goals and objectives to accomplish. The plan fully encompasses administrative and programmatic issues for ongoing review/improvement.

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

All senior managers gave input into the development of the strategic plan and received a copy of the final version. Senior managers shared this with their departments and staff. This strategic plan, along with the annual management report, is made available to all staff and is included as public information on our website so the community at large and other interested stakeholders can be fully informed as to these plans. The Strategic Plan was also

**shared with our Governing Board.**

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

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

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

**A. Problem/Issue Description**

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

**B. Corrective Actions**

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

No. If not, skip questions 2-5 below.

Yes. If so, complete questions 2-5 below.

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

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor) Office of the Legislative Auditor every two years.
- Policy, research, planning, and/or quality assurance functions in-house QI Team reviews client quarterly.
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)

**LAPAS Reports**

- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)  
Contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.
- Peer review  
Medical Doctors and OCDD peer review process
- Accreditation review  
CARF Accreditation—AAHSD received a 3-year accreditation
- Customer/stakeholder feedback AAHSD completes quarterly client satisfaction survey and an annual Stakeholder Survey.
- Other (please specify):  
Accountability Plan (AP) monitoring visits by OBH and OCDD

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

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

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

1. Title of Report or Program Evaluation AAHSD Management Report
2. Date completed June 2024
3. Subject or purpose and reason for initiation of the analysis or evaluation  
The AAHSD Management Report is offered as partial fulfillment of the standards set forth by CARF and is designed to summarize the results of the program plans; quality assessment; goals and objectives; the data collected in the areas of effectiveness, efficiency, service access, and consumer satisfaction; and from other operating systems and to provide a synopsis of ‘significant events’.
4. Methodology used for analysis or evaluation  
Review of AAHSD systems including: Corporate Compliance, Health and Safety (including Accessibility), Human Resources, Information Management, Outcomes Management System, Quality Improvement, and Risk Management.
5. Cost (allocation of in-house resources or purchase price) **In house resources**
6. Major Findings and Conclusions
  - AAHSD developed and signed a contract with LDH for services in Acadiana.
  - AAHSD clinical and administrative policies and procedures were reviewed by Civil Service, Office of Risk Management, and LDH.

- AAHSD received successful reviews from the MCOs, State licensure, and State contract performance indicators.
- 2024/2025 budget submitted and approved. AAHSD maintained operations within budgetary guidelines.
- AAHSD realized an increase in collections for self-generated revenue. AAHSD has doubled its self-generated collections in the past three years.
- Professional and service contracts maintained and monitored by AAHSD. Monitoring was increased to at least quarterly for all contracts (some monitored monthly). The monitoring process has received positive comments from two separate regulatory reviews.
- Employees completed Civil Service PES as required.
- AAHSD continued its employee training program/schedule and utilized two online training programs – LEO and Relias Learning. Targets and timeframes were met.
- All Senior Managers have maintained a succession plan for their respective areas.
- AAHSD did implement a new pay/performance structure as outlined by State Civil Service.
- AAHSD maintained credentialing by all five MCOs within the State plan.
- AAHSD conducted and/or participated in numerous public events, health fairs, community forums, and other professional forums. This is reflected by the increase in number of stakeholder surveys.
- AAHSD was monitored by: ORM, LDH/OBH and OCDD, LDH/Bureau of Health Standards, State Civil Service, and the Fire Marshal. All reviews were successful.
- AAHSD assumed operation of services, including the provision of crisis services within our designated area.
- AAHSD was trained and participated in OPH/Emergency Preparedness exercises/activities.

This report was made available to the Governing Board, all staff, and copies were available in all service locations for clients/visitors. A copy was sent to senior LDH officials as well as the entire ‘Acadiana Delegation’. Additionally, this report is posted on our website for public view.

7. Major Recommendations None
8. Action taken in response to the report or evaluation None
9. Availability (hard copy, electronic file, website)  
Located in the policy and procedure manual and website
10. Contact person for more information, including  
Name: Brad Farmer  
Title: CEO Agency & Program: AAHSD  
Telephone: 337-262-4190  
E-mail: Brad.Farmer@la.gov



# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-326, Office of Public Health (OPH)

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Tonya Joiner

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

#### Accomplishment #1: OPH Laboratory Discovers Rare Case of Antibiotic Resistant Tuberculosis

##### A. What was achieved?

On 9/19/2024, the Louisiana Office of Public Health's (OPH) Tuberculosis (TB) Laboratory received a respiratory sample for TB testing from a detainee at an Immigration and Customs Enforcement (ICE) detention center in south Louisiana. The state's Tuberculosis Control Program submitted the sample. Initial testing by the OPH TB Laboratory on 9/19/2024 indicated that the detainee potentially had active tuberculosis and may have been infected with a rare strain that was highly resistant to drugs that are routinely used for treatment. The Laboratory was able to provide these results to TB Control in less than 24 hours following specimen receipt allowing for a rapid response by the state's TB Control Program. Per OPH TB Laboratory Standard Operating Procedures, the sample was referred to the Centers for Disease Control and Prevention (CDC) and the Texas Department of State Health Service's (TDSHS) TB Laboratory for confirmatory testing.

In coordination with the CDC and TDSHS Laboratories, the OPH TB Laboratory was able to

confirm and report the presence of a highly resistant tuberculosis strain that is rarely encountered in the United States. These results provided to the state's TB Control Program allowed for timely initiation of the appropriate treatment for the detainee. In October of 2024, the state's TB Control Program began identifying potential detainee and staff exposure contacts at the ICE facility. Respiratory samples were collected on all identified contacts and referred to the Louisiana OPH TB Laboratory for analysis. In total, the Louisiana OPH TB Laboratory tested 141 samples from 43 identified exposure contacts. Due to the exceptional performance of OPH TB Laboratory Scientists, the Laboratory was able to provide results for exposure contact samples to the state TB Control program within 24 hours of sample receipt. Following the completion of testing, the Louisiana OPH TB Laboratory was able to report that none of the 43 identified exposure contacts had contracted tuberculosis due to the exposures.

B. Why is this success significant?

The detection of this rare infection in the detainee allowed for timely treatment of that individual. Screening exposed contacts allowed the state's TB Control Program to rapidly determine if exposures led to disease transmission.

C. Who benefits and how?

The exposure contacts received results quickly due to rapid testing.

D. How was the accomplishment achieved?

OPH TB Laboratory Scientists analyzed 141 samples, frequently working overtime to achieve rapid turnaround time.

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

This accomplishment contributes to the laboratory's Strategic Plan (Mission) of protecting the health and safety of the citizens and visitors to the State of Louisiana. By working with other state and federal partners, the OPH TB Laboratory provided accurate and timely laboratory results to citizens, public health programs, and state officials.

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

It is unlikely that this is a Best Management Practice that other departments or agencies would benefit from as lab testing is unique to the laboratory and requires specialized training and licensure.

Accomplishment #2: Bureau of Infectious Diseases/Infectious Disease Epidemiology Program Coordinates Response to Fatal H5N1 (Bird Flu) Infection in Louisiana

A. What was achieved?

This rapid and comprehensive public health investigation and response prevented the spread of H5N1 bird flu among individuals that were exposed to a patient diagnosed with bird flu or the patient's infected backyard flock of birds.

B. Why is this success significant?

Avian influenza A viruses, including viruses that cause H5N1 bird flu, are different from seasonal influenza viruses. Because most people lack immunity to avian influenza viruses, these viruses have the potential to cause a flu pandemic in people if they were to gain the ability to more easily infect and spread efficiently between people. This is why it is important for every human infection from avian influenza A viruses to be reported and investigated. Preventing additional human infections not only helps prevent individual illnesses, but it also helps prevent additional opportunities for the virus to mutate and gain the ability to spread more easily from person-to-person.

C. Who benefits and how?

The benefits of preventing the spread of emerging infectious diseases such as H5N1 bird flu are far-reaching and wide-ranging. In addition to causing human infections, H5N1 bird flu has had devastating effects on commercial and backyard flocks and has most recently affected dairy herds. Public health prevention efforts have the potential to save human lives, positively impact the safety and security of the food supply, and prevent economic losses resulting from infected commercial flocks and dairy herds.

D. How was the accomplishment achieved?

In large part, this accomplishment was achieved through the hard work, expertise, and dedication of highly trained public health epidemiologists. The bird flu public health investigation required the oversight of epidemiologists with expertise in emerging infectious diseases, viral respiratory diseases, and infection control as well as the local presence of boots-on-the-ground response ready epidemiologists. Partnerships with public health partners, such as the State Public Health Laboratory, the Bureau of Community Preparedness, the Bureau of Regional and Clinical Operations, and the Bureau of Media and Communications, were also key to the success of this investigation.

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

This accomplishment contributes to Objective VII of LDH's Office of Public Health strategic plan related to preventing the spread of communicable diseases through screening, education, health promotion, outreach, surveillance, prevention, case management and treatment. IDEpi's emerging infectious disease surveillance methods detected this case of H5N1 bird flu, and IDEpi epidemiologists conducted outreach and education with all exposed individuals. Any exposed

individual that developed respiratory symptoms was screened for H5N1 bird flu within 24 hours at the State Public Health Laboratory, and all exposed individuals were offered preventive treatment with antiviral post-exposure prophylaxis from the Strategic National Stockpile managed by the Bureau of Community Preparedness. These science-based disease control techniques contributed to the prevention of further spread of H5N1 bird flu.

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

Because this response was highly technical in nature, it does not offer broad applicability to other departments.

Accomplishment #3: The Louisiana Bridge Program: Expanding Lifesaving Addiction Treatment Access to the Emergency Department (Bureau of Regional and Clinical Operations)

- A. What was achieved?

The goal of the LA Bridge Program, launched in 2021, is to increase connections to evidence-based care for addiction in the emergency department, increase access to Narcan, and increase connections to ongoing care post discharge - while creating a welcoming environment for persons to seek out support for substance use disorder (SUD). The long-term goal of LA Bridge is to reduce overdose mortality rates in our community.

LA Bridge is currently operational in Calcasieu and Jefferson Davis parishes and focuses on three main components:

- **Evidence-based treatment for SUD:** Rapid buprenorphine initiation for opioid use disorder in the emergency department.
- **Culture of Care:** Creating a culture of care, a welcoming hospital space that offers treatment without stigma and patient-centered care with respect.
- **Connection to Care and Community:** Trained Substance Use Navigators (SUNs) connect patients to ongoing care in the community providing a warm walk through services as well as take home naloxone.

In FY 24-25, the LA Bridge program assisted individuals with substance use disorders, successfully linking 73% to care at discharge. In its year of inception, LA Bridge served 34 individuals in hospital emergency departments. In under 3 years, the program expanded from one hospital to five hospitals and served 457 individuals in 2024, with projection to serve 576 in 2025. Beyond assisting with opioid use disorders, the SUNs offer care navigation to all individuals who use substance use. The LA Bridge team has developed relationships with treatment providers across SWLA and statewide to offer the best fit for the person served.

In FY24-25, LA Bridge began focusing efforts on maternal health and ensuring pregnant women and women 12 months post-partum get access to Medication-Assisted Treatment (MAT) services which is in alignment with LDH's Project M.O.M. (Maternal Overdose Mortality) initiative. The success of the LA Bridge program has piqued interest across Louisiana and statewide expansion efforts are underway.

B. Why is this success significant?

From initial implementation in 2022 (first full project year) to 2024 year end patient volume has increased 100%; buprenorphine initiation and/or prescribing from the ED has increased over 300%, Narcan distribution to patients in the ED has increased almost 100%, and patients linked at ED discharge to a community MAT provider has increased 400%. We consider this a great success. Furthermore, in Calcasieu Parish, deaths due to overdose decreased by 43% from 2021 to 2024.

C. Who benefits and how?

The overriding public health concern addressed by the LA Bridge program is overdose mortality. Increasing overdose mortality is a multilayer public health crisis with a number of drivers, including economic, structural, and racial inequities. Lack of access to care is a critical driver of overdose mortality. In addition, our current surge in overdose deaths is driven by the fentanyl toxicity of the drug supply along with the many barriers to evidenced-based treatment for SUD. The LA Bridge Program addresses those most at risk for overdose fatality, including those with substance use disorder.

D. How was the accomplishment achieved?

A unique strength of our region rests in its strong community leaders who advocate for collaboration across sectors and combining efforts and resources for the greater good. It is these partnerships and collaborations that led to the success of the LA Bridge program –particularly valuable was the partnership between our local health department medical director and local behavioral health (ImCal) executive director.

Specifically, Region V Office of Public Health and ImCal HSA led the charge for a collaborative partnership with SWLA Area Health Education Center, Lake Charles Memorial Hospital, CHRISTUS-Oschner Lake Area Hospital, West Calcasieu Cameron Hospital, Ochsner Jennings American Legion Hospital, the Partnership for a Healthier SWLA, and recently the LA Perinatal Quality Collaborative and the Region V Department of Children and Family Services to develop and implement strategies to address SUD in high-risk populations, specifically the intervention at the emergency department level.

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

Yes. Expansion of Behavioral Health services, particularly relating to SUD, is included in the LDH Strategic Plan.

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

Yes. LA Bridge is modeled after the National Bridge program and has been implemented across the country in several states. LA Bridge was awarded a 2025 Promising Practice Award from the National Association of City and County Health Officials (NACCHO). Promising Practices are awarded annually after a rigorous peer-evaluation process and are awarded to programs that are exemplary, replicable, and designed in response to a local public health need.

Accomplishment #4: Bureau of Nutrition Services Increases Access to Healthy Supplemental Foods for Pregnant and Postpartum Women and Children up to Four Years of Age

- A. What was achieved?

The Louisiana Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has seen a consistent increase in participation rates over the last three years. Overall, participation in WIC (defined as certified women, infants, and children with active benefits for the month) has increased by 4% in SFY25 with 103,247 participants in June 2025 and an overall increase of 24% in the last three years. This increase in participation in Louisiana WIC illustrates a consistent need for access to breastfeeding support, nutrition education, and nutritious supplemental foods during the critical periods of pregnancy, fetal development, and early childhood growth. In SFY26, the Bureau of Nutrition Services will explore and implement strategies to increase service capacity and continue to improve the shopping experience for WIC families.

- B. Why is this success significant?

As of August 2025, Louisiana WIC served 104,843 participants out of an estimated 224,450 eligible, leaving a coverage gap of 119,607 and a statewide coverage rate of 46.71%. Increasing WIC participation is a direct correlation to decreasing the coverage gap.

- C. Who benefits and how?

Beneficiaries are WIC participants, who are defined as certified women, infants, and children with active benefits for the month.

- D. How was the accomplishment achieved?

This was accomplished through outreach efforts by clinics and the State Agency, enhancements to the clinic and participant experience through training and technology, and an increased need for assistance with basic foods/groceries due to continued inflation.

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

Yes.

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

No.

Accomplishment #5: Louisiana Department of Health/Office of Public Health Receives Accreditation

- A. What was achieved?

In 2025, the Louisiana Department of Health, Office of Public Health achieved national reaccreditation through the Public Health Accreditation Board (PHAB), after having been initially accredited in 2019. PHAB is the sole national accrediting body for state and local health departments, supporting departments to improve quality, accountability, and performance.

- B. Why is this success significant?

Being reaccredited confirms that OPH continues to meet national standards and provides high quality public health services to the people of Louisiana. Reaccreditation assures Louisianans that they are served by a health department that meets national standards, and it assures taxpayers that OPH is an excellent steward of funds. In addition, going through the reaccreditation process was an opportunity for OPH to review a variety of internal processes and make improvements as needed. Therefore, the reaccreditation process helped OPH to continuously improve the performance of the agency.

- C. Who benefits and how?

The people of Louisiana benefit from being served by a health department that provides high quality public health services that meet national standards. The public and funding organizations are reassured that OPH uses taxpayer money responsibly and effectively. OPH employees can be proud to know that they work for a nationally accredited health department.

- D. How was the accomplishment achieved?

To attain reaccreditation, OPH underwent a rigorous process that evaluated its capacity to deliver essential public health services to communities statewide. OPH convened a committee consisting of subject matter experts in the domains pertaining to reaccreditation and worked with programs across the agency to prepare documentation to submit to PHAB. PHAB then met with OPH leadership and employees as part of a virtual site visit.

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

Yes. Becoming reaccredited was a goal in OPH's strategic plan.

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

Yes, it is recommended that other executive branch departments or agencies pursue accreditation if such an accreditation board or process exists for the relevant topic area.

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

The Office of Public Health has made significant progress towards the goals and objectives and is on target for its strategic plan overall. The accomplishments described in Section I are examples of OPH's progress in action. OPH engages in continuous quality improvement efforts across program areas to build on and accelerate gains.

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

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

One of OPH's goals is to leverage partnerships to improve the health and wellness of individuals

and communities. The LA Bridge project, described in Section I, is one example of how OPH has done that. This project, in addition to other efforts to address substance use disorders across the state, has resulted in a significant decrease of drug-involved deaths in the past year in Louisiana. This is one example of how OPH's leadership and collaboration with strategic partners results in positive health outcomes for Louisianans.

In addition, OPH continues to improve its data infrastructure. With federal funding assistance, OPH is making strategic investments in personnel and infrastructure to improve its ability to leverage data for public health improvements.

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

OPH will continue to develop, maintain, and facilitate partnerships to align efforts and increase overall impact on health and wellness of individuals and communities. Progress regarding advancement of OPH's data infrastructure is likely to continue at an accelerated pace.

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

None.

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

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

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

OPH revised its strategic plan for 2026-2031 to ensure that its objectives and strategies are reflective of the needs of the population and of the capacity of its programs to meet those needs.

No. If not, why not?

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

OPH’s Executive Management Team meets weekly, and Senior Management Team meets monthly, to ensure agency progress towards strategic goals. Regular leadership meetings and town halls are held across the agency to review, update, and ensure implementation of plans.

In addition, OPH has put a new performance management system in place that tracks performance in all program areas on a Tableau dashboard. Agency leadership and program personnel utilize this dashboard to visualize and monitor performance on a quarterly basis. Additional components of OPH’s performance management system flag performance shortfalls and prompt the initiation of quality improvement efforts where needed.

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

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

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

**Issue #1: Cost Allocation**

**A. Problem/Issue Description**

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

Cost allocation charges appear to be inconsistent across OPH's grants. Cost allocation charges have been difficult to estimate accurately in advance and seem to vary considerably due to factors that are not always clear. This is a problem because it makes grant budgets more difficult to manage, and when cost allocation charges are higher than anticipated, fewer funds are available for direct program expenses.

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

A major goal of OPH is to ensure efficient and effective utilization of resources. Highly variable and unpredictable cost allocation charges pose a challenge to this goal.

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

This issue is experienced by all programs that manage federal grants.

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

External stakeholders affected are the beneficiaries of the programs the grants are intended to serve. Internal stakeholders are OPH employees experiencing greater challenges managing these grants and having to provide services with fewer resources available.

5. How long has the problem or issue existed?

This issue has existed for several years, however, within the last one to two years it has become increasingly problematic. We believe this is in large part due to the conversion from ISIS to LaGOV and corresponding coding and cost allocation element algorithm setup issues.

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

OPH is currently investigating the causes of this issue.

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

Performance of the grant-funded programs is negatively impacted when cost allocation charges consume a larger-than-anticipated portion of the grant budget due to fewer funds being available for direct program expenses.

B. Corrective Actions

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

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

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

OPH has hired a consultant who is currently researching this issue to determine possible solutions.

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

Not in recent years.

4. Are corrective actions underway?
- a. If so:
    - What is the expected time frame for corrective actions to be implemented and improvements to occur?
    - How much progress has been made and how much additional progress is needed?

Corrective actions and improvements are expected to occur during the current fiscal year.

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

5. Do corrective actions carry a cost?

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

An existing consultant has been engaged.

- b. How much has been expended so far?

\$40,000

- c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

Yes.

- d. Will additional personnel or funds be required to implement the recommended actions? If so:
  - Provide specific figures, including proposed means of financing for any additional funds.
  - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

No.

## **Issue #2: Inadequate Controls over Payroll**

### **B. Problem/Issue Description**

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

LDH's legislative audit found that for the fourth consecutive year, OPH did not ensure that 100% of payroll expenditures were certified and approved.

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

This pertains to OPH's goal to increase operational capacity and infrastructure to ensure efficient and effective utilization of resources.

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

The Public Health Emergency Preparedness program and the HIV Prevention Activities program were named in the 2023 audit.

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

This issue affects OPH employees, supervisors, and time administrators. If this issue is not resolved, it could threaten OPH's grant funding, affecting OPH's program beneficiaries.

5. How long has the problem or issue existed?

This issue has existed for at least four years.

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

The audit stated that this problem was caused by OPH lacking sufficient controls to ensure electronic time statements were properly certified and approved in accordance with federal and state regulations.

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

Failure to adequately approve program expenditures increases the risk that unallowable costs could be reimbursed by the federal grantor.

#### B. Corrective Actions

2. Does the problem or issue identified above require a corrective action by your department?  
 No. If not, skip questions 2-5 below.  
 Yes. If so, complete questions 2-5 below
6. What corrective actions do you recommend to alleviate or resolve the problem or issue?

Recommended corrective actions include implementation of an updated time entry policy including earlier internal deadlines for employees and supervisors to certify and approve timesheets, enhanced training and orientation for Time Administrators, increased communication between Time Administrators, employees, and HR, and increased review and accountability measures implemented for time statements not certified and/or approved.

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

No.

8. Are corrective actions underway?
  - a. If so:
    - What is the expected time frame for corrective actions to be implemented and improvements to occur?
    - How much progress has been made and how much additional progress is needed?

Corrective actions and improvements have been implemented, and significant progress has been made. OPH is working to hold and sustain the gains that have been made thus far.

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

9. Do corrective actions carry a cost?

No. If not, please explain.

Corrective actions can be carried out by existing employees as part of normal job duties.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

c. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.

d. How much has been expended so far?

c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

d. Will additional personnel or funds be required to implement the recommended actions? If so:

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

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste and abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to

management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

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

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

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

- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
  
- Performance Progress Reports (Louisiana Performance Accountability System)**  
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
  
- In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or

additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

**Benchmarking for Best Management Practices**

The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

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

LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

28

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

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

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

**1. Title of Report or Program Evaluation:** SHHP-Wide Evaluation Plan

**2. Date completed:** Living Document

**3. Subject or purpose and reason for initiation of the analysis or evaluation:**

The Louisiana Office of Public Health's STD/HIV/Hepatitis program (SHHP) operates an array of public health interventions and programs designed to prevent, diagnose, and treat HIV, HCV, Syphilis, and other STDs. Additionally, SHHP's Research and Evaluation (R&E) Unit oversees multiple research projects and collaborations. Over several years, SHHP, formerly known as the

HIV/AIDS Program (HAP) expanded the scope of its work to include STDs, and more recently, viral Hepatitis. Consequently, SHHP's funding sources are more diversified and funding streams directed to specific programs or interventions are more diversified and "braided". There are often different expectations from funders regarding program evaluation and reporting for a single intervention. In late 2019, the newly formed Research and Evaluation Unit (R&E) initiated a series of interviews with key program staff to discuss existing and potential evaluation projects. In January 2021, the Research and Evaluation (R&E) Unit collected and compiled program evaluation information for all of SHHP's programs.

#### **4. Methodology used for analysis or evaluation:**

The SHHP-wide Evaluation Plan (SWEP)

- is a comprehensive reference for internal monitoring, evaluation, and research related to SHHP interventions, programs, and projects,
- functions as tool for Supervisors and Managers to monitor program performance and anticipate grant reporting deadlines,
- consolidates and describes monitoring and evaluation activities by intervention rather than grant or unit,
- updated, by the SHHP Research & Evaluation Unit, on a prescribed schedule

#### **5. Cost (allocation of in-house resources or purchase price):**

Cost is in-kind and allocated as part of grant activities and deliverables.

#### **6. Major Findings and Conclusions:**

Outcome and process monitoring efforts and results are outlined for these Program Interventions

- Community Health Workers
- Condom Distribution Document Review
- Disease Intervention Specialists (DIS)
- Health Models Documents Review
- Housing for Persons living with AIDS (HOPWA)
- LA Links – Linkage to HIV Care,
- HepConnect (Linkage to Cure)
- Louisiana Health Access Program (ADAP and HIP)
- Louisiana Youth Responsibility Education Program
- Overdose and Infection Prevention
- PrEP Screening and Uptake
- Rapid Start
- RW Part B Support Services

- Social Marketing
- Surveillance: Cluster Detection and Response
- TelePrEP
- Testing for HIV, HCV, Syphilis and other STIs
- Viral Hepatitis Prevention and Treatment
- Wellness Centers

**7. Major Recommendations:**

The funders accepted the reports with no recommendations or request for revisions.

**8. Action taken in response to the report or evaluation:**

SHHP will continue to administer and monitor program interventions using the SWEP.

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

Hard copy, monday.com

**10. Contact person for more information:**

**Name & Title:** Dr. Samuel Burgess, Director, STD/HIV/Hepatitis Program

**Agency & Program:** Louisiana Department of Health, Office of Public Health,  
Bureau of Infectious Diseases, STD/HIV/Hepatitis Program

**Telephone:** (504) 568-7474

**E-mail:** samuel.burgess@la.gov

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-327 Office of the Surgeon General

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Dr. Ralph Abraham

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

#### Accomplishment #1: Strengthened Collaboration across State Medical Boards:

A. What was achieved?

Established joint meetings between medical boards across the state to encourage collaboration, accountability, and problem-solving. Created a system for intervention and mediation when conflicts arise between boards.

B. Why is this success significant?

This initiative reduced siloed decision-making, improved efficiency, and built stronger accountability among boards. It also promotes consistency in regulations and standards that impact healthcare delivery.

C. Who benefits and how?

- Board members benefits from clearer communication and a structured way to resolve issues.
- LDH benefits from smoother coordination and reduced administrative delays
- Louisiana residents benefit through improved healthcare oversight and consistent protections across the system.

D. How was the accomplishment achieved?

Facilitated meetings for all boards, encouraged open dialogue, created shared accountability measures, and provided mediation when disputes arose.

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

Yes – it directly advances goals of improving interagency collaboration, regulatory efficiency, and public trust.

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

Yes – the framework of fostering collaboration, structured accountability, and conflict resolution can be adopted by other boards and agencies to improve statewide governance.

## Accomplishment #2: Promoted Personalized Patient Care Through Primary Provider

### Engagement:

A. What was achieved?

Encourage patients to return to their personal doctors for vaccines and other medical needs, ensuring healthcare decisions are tailored to each individual's circumstances. Expanded outreach by attending public events and healthcare conferences to speak on the importance of individualized care.

B. Why is this success significant?

This initiative highlights the importance of individualized medical care rather than a one-size-fits-all approach. By reinforcing the role of personal providers, it strengthens patient trust, reduces risks associated with generalize treatment decisions, and ensures unique health needs are properly addressed. Public advocacy also demonstrated leadership and visibility in advancing this message statewide.

C. Who benefits and how?

- Patients benefit from safer, personalized medical guidance, leading to better health outcomes and greater confidence in their care decisions.
- Providers benefit from a stronger connection with patients and recognition as the trusted source for individualized health advice.
- The state and public health system benefit from improved health outcomes, more consistent messaging, and stronger public trust in medical systems.

D. How was the accomplishment achieved?

Developed messaging to encourage patients to seek care from their personal providers, collaborated with healthcare boards to unify communications, and represented the initiative at public events and healthcare conferences to amplify the message and educate both professionals and residents.

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

Yes – it directly supports the goals of improving public health outcomes, reinforcing provider-patient relationships, and advancing statewide health equity through personalized care.

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

Yes – the combined strategy of promoting individualized care and engaging the public through events and conferences can serve as a best practice for departments seeking to strengthen both healthcare outcomes and public trust.

## Accomplishment #3: Virtual Medical Organization Coordination:

**A. What was achieved?**

Louisiana developed and implemented a virtual Medical Organization Coordination Network (MOCN) structure that is patient-movement focused and fully incorporated into emergency preparedness and response plans

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

This success ensures real-time coordination for patient movement across healthcare facilities, improving surge capacity management during disasters. It fills a critical gap in patient tracking, allocation of resources, and inter-facility transfers, which historically have been barriers during large-scale emergencies (e.g., hurricanes, pandemics).

**C. Who benefits and how?**

Patients benefit by receiving faster, safer, and more coordinated transfers during emergencies. Hospitals and healthcare facilities benefit from enhanced situational awareness and improved load-balancing of patient care. Emergency medical services and first responders benefit from streamlined communication and guidance for patient transport. State and local emergency management agencies benefit through improved coordination, data-driven decision-making, and more resilient healthcare infrastructure.

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

Leveraged federal Hospital Preparedness Program (HPP) funding and state resources. Conducted planning sessions with healthcare coalitions, EMS providers, hospitals, and public health agencies. Integrated the MOCN framework into statewide emergency operations and surge plans. Implemented training, exercises, and stakeholder engagement to ensure usability and sustainability.

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

Yes. The MOCN directly supports the FY 2024–2028 Strategic Plan by strengthening statewide emergency response capabilities, improving patient surge management, and ensuring continuity of healthcare delivery during disasters. This aligns with strategic goals related to preparedness, response coordination, and patient safety.

**F. Does this accomplishment or its methodology represent a Best Management Practice?**

Yes. The MOCN represents a scalable, innovative best practice in healthcare preparedness: It can be replicated in other states seeking to enhance patient movement coordination. It demonstrates how virtual coordination platforms can integrate into emergency response plans without requiring heavy infrastructure investment. Louisiana can share this model through national HPP forums, FEMA regional partnerships, and interagency briefings, positioning it as a leading example of effective healthcare surge coordination.

**Accomplishment #4: Medical Response & Surge Exercise:****A. What was achieved?**

The Louisiana Department of Health successfully planned, executed, and evaluated the BP1 Medical Response & Surge Exercise (MRSE). This large-scale, multi-agency exercise tested statewide capacity to manage a medical surge event, including patient triage, movement, and

resource allocation.

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

The MRSE provided a realistic test of healthcare system readiness under simulated disaster conditions. By identifying strengths and gaps in surge capacity, the exercise ensures that Louisiana is better prepared for hurricanes, pandemics, mass casualty events, and other large-scale emergencies. It also fulfills federal HPP requirements, strengthening Louisiana’s eligibility for ongoing preparedness funding.

**C. Who benefits and how?**

Patients and communities benefit through improved emergency medical care and quicker, safer access to services during crises. Hospitals and healthcare coalitions gain practical experience in surge operations and patient flow management. First responders and EMS agencies benefit from tested coordination and communication pathways. State and local emergency managers benefit from clear data on capacity gaps and readiness improvements.

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

Coordinated by the Office of the Surgeon General’s Emergency Preparedness team with support from healthcare coalitions. Developed exercise scenarios that reflected real-world threats (e.g., hurricane impact, large-scale casualty incident). Engaged hospitals, EMS agencies, public health officials, and emergency management partners statewide. Conducted structured after-action reviews to capture lessons learned and integrate improvements into surge plans.

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

Yes. The MRSE supports the FY 2024–2028 Strategic Plan by advancing goals tied to healthcare system resilience, surge preparedness, and interagency coordination. It directly aligns with objectives to evaluate readiness, close capability gaps, and enhance healthcare delivery continuity during disasters.

**F. Does this accomplishment or its methodology represent a Best Management Practice?**

Yes. The MRSE process demonstrates best practices in exercise design, execution, and evaluation. Its success highlights: A multi-sector approach to preparedness involving healthcare, EMS, and emergency management. A model for scenario-based surge testing that could be replicated by other state agencies. A proven method for turning after-action data into continuous improvement. This accomplishment is well-suited for sharing with other state agencies and national preparedness forums as a model for coordinated surge testing.

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

realized?

## General Assessment of Overall Timeliness and Progress

The Department is growing in staff rapidly to meet the demands of the strategic plan. This includes a Chief of Staff (hired September 2025) to manage the policy and legislative affairs, a communications staff member dedicated to tracking campaigns and PSAs, and new relationships with University Systems to prioritize our Louisiana students.

The Department's Five-Year Strategic Plan remains **on time and broadly on target**, though significant adjustments have been necessary due to a **31.05% decrease in federal Hospital Preparedness Program (HPP) funding**, from \$3.028 million to \$2.08 million. Despite these constraints, the Department has prioritized sustaining core preparedness infrastructure, maintaining **9 of 10 hospital-based Administrative Regional Disaster Coordinators (ADRCs)**, and enhancing the **statewide hospital situational awareness portal**, which is essential for disaster response coordination.

Anticipated outcomes tied to **system resilience, patient movement coordination, and coalition readiness** are progressing, although reductions in **regional projects and surplus support** have slowed progress in certain areas. Strategies remain largely effective, but future sustainability will require **state funding supplementation of approximately \$1.75 million annually** to preserve ADRCs and the hospital portal in the event of a total federal HPP funding loss.

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

### Where Significant Progress is Being Made

The Department has achieved measurable success in several areas of its strategic plan:

1. **Sustaining Core ADRC Coverage (9 of 10 Regions)**
  - **Attribution of Success:**  
Progress is directly related to **deliberate prioritization and reallocation of reduced resources** to preserve frontline hospital coordination capacity. Without department action, these positions would not have been maintained.
  - **One-Time or Sustainable?**  
This is not a one-time gain. Continued success depends on **ongoing resource reprioritization and potential state funding supplementation**.
2. **Enhancement of the Hospital Situational Awareness Portal**
  - **Attribution of Success:**  
Progress is tied to **strategic investment in technology improvements** and leveraging existing partnerships with healthcare coalitions. Enhancements ensure

more robust patient-tracking, load-balancing, and real-time communication during emergencies.

- **One-Time or Sustainable?**

This is expected to continue, as enhancements are being integrated into daily hospital operations, embedding resilience into the system long term.

### 3. Governance and Planning Improvements

- **Accomplishments such as the Healthcare Coalition Governance Document, Readiness Assessments, and the proposed BP1–BP5 Training & Exercise Plan** are exceeding their planned timelines.

- **Attribution of Success:**

Progress results from **focused planning initiatives, interagency collaboration, and the disciplined use of federal guidance and assessment tools.**

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

## Where Significant Lack of Progress is Being Experienced

### 1. Regional Projects and Surplus Support Initiatives

- **Attribution of Lack of Progress:**

The decline in federal HPP funding directly constrained the Department’s ability to fund regional innovation projects and provide supplemental surge support. This was a **budget-driven constraint** outside the Department’s control.

- **One-Time or Continuing Issue?**

Unless additional state funds are appropriated, this lack of progress will continue and may deepen if federal HPP support is further reduced or eliminated.

### 2. Long-Term Sustainability of ADRCs and Portal System

- **Attribution of Lack of Progress:**

The risk of a **100% loss of HPP funding** poses a significant threat to sustaining the ADRC network and hospital portal beyond the short term. Without state supplementation (\$1.75M annually), this critical infrastructure will be at risk.

- **One-Time or Continuing Issue?**

This is a continuing issue that will require **management intervention and state-level funding solutions** to resolve.

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

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

**Yes.** Adjustments have been made to the Five-Year Strategic Plan in response to reduced HPP funding. These adjustments include:

- **Resource reprioritization:** Maintaining 9 of 10 ADRCs despite cuts.
  - **Technology prioritization:** Enhancing the hospital situational awareness portal while deferring some regional projects.
  - **Sustainability planning:** Preparing for the anticipated 100% loss of HPP funds by identifying a **\$1.75M annual state funding need** to sustain essential hospital coordination infrastructure.
- These adjustments ensure that core preparedness capabilities remain intact while acknowledging budgetary limitations.

No. If not, why not?

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

### Ensuring Coordination and Review of the Strategic Plan

The Department ensures its Five-Year Strategic Plan is **coordinated, regularly reviewed, and integrated into decision-making** through the following mechanisms:

- **Leadership Oversight:** The Office of the Surgeon General's Emergency Preparedness leadership convenes quarterly reviews to assess progress and reallocate resources as needed.
- **Coalition Engagement:** Healthcare coalitions and ADRCs provide ongoing feedback and operational data to measure strategy effectiveness.
- **Performance Monitoring:** After-action reviews from exercises (e.g., MRSE) and real-world events are used to track capability improvements against plan goals.
- **Budget Alignment:** Strategic priorities guide budget allocations, ensuring limited resources are targeted toward high-impact activities.
- **Cross-Agency Coordination:** Partnerships with state and local emergency management, EMS, and healthcare providers align departmental strategies with broader state resilience efforts.

### Summary:

The Department's Strategic Plan is **generally on time and on target**, though constrained by reduced federal funding. Significant progress has been achieved in sustaining ADRCs, enhancing

the hospital situational awareness portal, and completing governance and assessment milestones. However, the lack of federal funding for regional projects and the looming risk of total HPP elimination require proactive state supplementation to sustain core preparedness infrastructure.

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

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

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

## **Problem/Issue 1: Reduced Federal HPP Funding and Resource Constraints**

### **A. Problem/Issue Description**

**1. Nature of the problem or issue:**

The Department experienced a **31.05% reduction in federal Hospital Preparedness Program (HPP) funding**, decreasing from \$3.028 million to \$2.08 million. This reduction necessitated cuts to **regional projects, surplus support, and certain preparedness initiatives**, while attempting to maintain critical core capabilities such as hospital ADRCs and the statewide situational awareness portal.

**2. Is the problem affecting the progress of the strategic plan?**

Yes. The reduction affects strategic plan goals tied to **regional healthcare preparedness, surge support, and innovation projects**, although core objectives (ADRCs and portal functionality) continue to progress due to resource reprioritization.

**3. Organizational unit experiencing the problem:**

The **Emergency Preparedness Office/Office of the Surgeon General** and all statewide **Hospital Preparedness Program initiatives**.

**4. Who else is affected:**

- **Internal:** Department staff managing HPP initiatives, exercise coordination, and coalition engagement.
- **External:** Hospitals, ADRC personnel, healthcare coalitions, EMS, and ultimately patients relying on coordinated disaster response and surge capacity.

5. **Duration of the problem:**

The funding reduction occurred in **FY 2024**, with ongoing effects projected for FY 2025 and potentially beyond.

6. **Causes of the problem:**

- **Federal HPP funding reductions** and anticipated total loss in future fiscal years.
- Constraints in the **state budget** that limit immediate supplementation. These conclusions are based on federal funding notices, budget analysis, and ongoing strategic planning assessments.

7. **Consequences of failure to resolve the problem:**

- Loss or significant reduction of hospital ADRCs and situational awareness portal functionality.
- Compromised statewide patient movement and medical surge capacity during disasters.
- Reduced effectiveness of strategic plan initiatives related to regional healthcare coalition readiness and disaster response.

B. Corrective Actions

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

No. If not, skip questions 2-5 below.

Yes. If so, complete questions 2-5 below.

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

- Secure **state-level supplemental funding** of approximately **\$1.75 million annually** to sustain ADRCs and the hospital portal system.

- Reallocate **remaining federal HPP funds** to prioritize core preparedness infrastructure.

- Implement **efficiency improvements** in portal operations and ADRC coordination to reduce costs without reducing capability.

- Advocate for **policy support and legislative action** to stabilize long-term preparedness funding.

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

4.

This is a new challenge that we were made aware of in June of 2025 with noted expectations of 100% reduction of funding in August of 2025 .

5. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur?
  - How much progress has been made and how much additional progress is needed?
- **Expected timeframe:** Immediate implementation for FY 2026-2027 budget cycle; full stabilization expected within 12–18 months of funding approval.
  - **Progress:**
    - **Reallocation of funds** within FY 2025–2026 budget completed to maintain 9 of 10 ADRCs and enhance portal functionality.
    - **Additional progress needed:** State supplemental funding approval to fully mitigate risk of total HPP loss.
      - b. If not:
        - Why has no action been taken regarding this recommendation?
        - What are the obstacles preventing or delaying corrective actions?
        - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?
6. Do corrective actions carry a cost?
- No. If not, please explain.
- Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)  
Please discuss the following:
- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.  
\$1.75 million annually to sustain ADRCs and portal system for 2026-2027 budget.
  - b. How much has been expended so far?  
Funds being released now at initial \$500k allotment unknown when further allocations will be made likely next 3 months.
  - c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?  
Yes, cuts made for 31.05% to remain solvent for Federal Fiscal year of October 2025 to September 2026
  - d. Will additional personnel or funds be required to implement the recommended actions? If so:  
Yes, for 2026-2027 we will require \$1.75M to support HPP loss of funding. Routing will occur through LHA Contract to ADRC deployment and portal support with no enhancements. Consideration to bring ADRC, in part or in whole

into LDH as Permeant employees long-term.

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

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

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

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

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

- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)**  
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
- In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.
- Benchmarking for Best Management Practices**  
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.
- Performance-based contracting (including contract monitoring)**  
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

A. Did your office complete any management reports or program evaluations during the

fiscal year covered by this report?

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

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

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

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-330 Office of Behavioral Health

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Karen Stubbs, J.D.

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

#### **Accomplishment #1: CCBHC Planning Grant**

- A. **What was achieved?** On December 30, 2024, Louisiana was one of 15 states awarded a 2025 Cooperative Agreement for CCBHC Planning Grants by the Substance Abuse of Mental Health Administration (SAMHSA).
- B. **Why is this success significant?** The Certified Community Behavioral Health Clinic (CCBHC) model provides comprehensive, coordinated community-based care for individuals across the lifespan with and at risk for serious mental illness (SMI), serious emotional disturbance (SED), substance use disorders (SUD), and/or co-occurring mental health and substance use disorders (COD). The model is designed to increase access to an array of outpatient behavioral health services, including crisis services, incorporate evidence-based practices, and establish care coordination as a linchpin for service delivery. CCBHCs serve those most in need of coordinated, integrated, accessible, quality care, with no rejection of services based on a person's ability to pay or place of residence.

Louisiana currently has 6 CCBHCs that are funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Planning Grant that Louisiana was

awarded supports participating states in developing their CCBHC programs and enables them to apply for the CCBHC Demonstration Program. At the end of the planning grant period, participating states are expected to submit their applications to join the CCBHC Demonstration for a four-year period starting on or after July 1, 2026. States selected to participate in the Demonstration will enable state – certified CCBHCs to bill Medicaid under an established Prospective Payment System rate approved by the Centers for Medicare and Medicaid Services (CMS) for behavioral health services provided to individuals eligible for medical assistance under the state Medicaid program.

**C. Who benefits and how?** Many Louisiana citizens that are uninsured, underinsured, or not covered by Medicaid often face barriers to receiving care, but CCBHCs provide services regardless of the ability to pay. The CCBHC model also supports the integration of primary care and behavioral health services. Though Louisiana is early in CCBHC implementation, and does not have complete outcome data for the 6 SAMHSA funded CCBHCs, the National Council for Wellbeing has gathered data on the impact of CCBHCs nationally and have reported the following;

- Expansion of timely access to care - Medicaid funded CCBHCs expanded the number of people served by an average of 33%
- Expansion of access to substance use care - 87% of Medicaid funded CCBHCs and established grantees offer one or more forms of Medication Addiction Treatment compared to 64% of substance use treatment facilities
- Integration of behavioral health and primary care – 76% of CCBHCs reported that referrals to primary care have increased since becoming a CCBHC
- Making crisis services and support available to all – more than 80% of CCBHCs were partnering with 988 call centers as of March of 2024 and 29% of CCBHCs were able to add mobile crisis response as a result of certification
- Improving collaboration with criminal justice agencies – 98% of CCBHCs are actively engaged in one or more innovative activities in partnership with criminal justice agencies

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

OBH formed a CCBHC Planning Grant team and also interviewed several consultants who had previously written CCBHC Expansion Grants, Planning Grants, and Demonstration applications. A small committee along with the OBH Executive Management Team ultimately selected Healthcare Management Associates (HMA) to assist OBH to prepare the Planning Grant Application. A contract was executed and HMA met with various OBH work groups to gather information to respond to the Notice of Funding Opportunity. The OBH CCBHC Planning Grant team reviewed several drafts until the application was finalized and ready for submission. The application submitted by OBH received the highest score of all applications and Louisiana became one of 15 states awarded a CCBHC Planning Grant.

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

This accomplishment contributes to the success of OBH's strategic plan by supporting Goal II which is 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. As indicated above, nationally CCBHCs have expanded the number of people receiving behavioral health services significantly. CCBHCs are required by SAMHSA to provide evidence-informed treatment, peer support and prevention services. The Planning Grant offers Louisiana an opportunity to sustain the existing CCBHCs in the State as to expand the number of CCBHCs offering comprehensive behavioral health services.

This accomplishment also contributes to OBH’s Goal III in the strategic plan which is 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. CCBHCs serve individuals throughout the life span. As of 2024, CCBHCs were providing 3 million people with mental health and substance use treatment and care across the nation. The National Council has documented CCBHC’s ability to improve access to lifesaving substance use treatment, recovery supports, crisis services, integrated care and other services. CCBHCs are eliminating barriers to access in communities and the award of the CCBHC Planning grant is providing Louisiana a possible avenue to sustain and expand CCBHCs in the State.

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

The CCBHC model is a best practice as it provides comprehensive, coordinated community-based care for individuals across the lifespan with serious mental illness (SMI), serious emotional disturbance (SED), substance use disorders (SUD), and/or co-occurring mental health and substance use disorders (COD). The model is designed to increase access to an array of services, including crisis services, incorporates evidence-based practices, care coordination, integrates primary care, and addresses social determinants of health. Entities within LDH that should consider adopting the CCBHC model include the 6 Local Governing Entities (LGEs) that are not currently CCBHCs. In addition, LDH may also want to consider OPH Parish Health Units adopting the CCBHC model to support better integration of behavioral health and primary care.

## **Accomplishment #2: Continued Enhancement of Our Crisis Systems**

- A. **What was achieved?** The Office of Behavioral Health (OBH) continued to expand and refine access to the Louisiana Crisis Response System in FY2024-2025 through the expansion of services to youth, identification of additional adult providers and the implementation of the Louisiana Crisis Hub (LCH).

During the reporting period, OBH expanded LA-CRS services to serve youth (20 and younger) through the implementation of Mobile Crisis Response (MCR) and Community Brief Crisis Support (CBCS) for this population. These two services are now available to youth in eight of the ten LDH regions.

OBH continued to identify and train crisis providers of the four LA-CRS services intended for adults (21 and older). Additional providers have been selected through an RFA process and are completing licensing and credentialing to provide the following services for adults:

1. Mobile Crisis Response in three additional regions;
2. Behavioral Health Crisis Care in three additional regions;
3. Community Brief Crisis Support in one additional region;
4. Crisis Stabilization in three additional regions.

Finally, the LCH was implemented in partnership with Carelon. The LCH is a statewide crisis line available to aid callers in navigating to behavioral health services during times of crisis. Through established partnerships with crisis service providers, the LCH seeks to connect those in crisis with alternatives to seeking mental health treatment through Emergency Departments. Mobile Crisis Response (MCR) and Behavioral Health Crisis Centers (BHCC) providers are now part of an online Care Traffic Control platform utilizing person-centered protocols to streamline the triage and mobile dispatch processes. In addition, the Department will benefit from the data collected through the platform. Aggregate data on utilization and outcomes will inform planning for future crisis resources that are reactionary to the needs of Louisiana's citizens.

- B. Why is this success significant?** Louisiana is actively expanding availability and access to the crisis response system to enhance critical mental health and stabilization services throughout the state. Increasing access to the services of the crisis response system, bridges the gaps for both, adults and children, who have historically sought treatment through emergency departments or involved law enforcement.
- C. Who benefits and how?** The LA-CRS focuses on serving adults and children and who are members of the Medicaid program. During the reporting period, funds were also available to cover these services for individuals without Medicaid creating a no wrong door crisis response system.
- D. How was the accomplishment achieved?** OBH continues its partnership with the LSUHSC Center for Evidence to Practice, supporting an RFA process to identify and train potential LA-CRS providers. Once trained these providers execute the proper licensing and contractual agreements with the designated Managed Care Organizations (MCO) to provide these services to communities. The implementation of the LCH in May 2025 expanded the structural partnership of the LA-CRS as crisis providers committed to formal contractual relationships with Carelon, the LCH contractor. Collaboration and consultation continued throughout the year to refine these services and increase utilization.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**

Yes. The expansion of these services and the implementation of the LCH is directly linked to the goal of increasing access to behavioral health resources.

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

No.

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

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

◆ **Please provide a brief analysis of the overall status of your strategic progress.**

What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

The Office of Behavioral Health is currently making progress, and remains on target. OBH is committed to the most effective use of the state’s behavioral health resources to provide for the overall safety and health of the public. The office is continuously developing goals and objectives that prioritize innovative programs to promote and improve the behavioral health of Louisiana residents. In addition, OBH is working eagerly to assess, strategize, develop, and implement additional measures to ensure services are delivered efficiently and effectively, with a strong focus on vulnerable and underserved populations. By emphasizing interagency collaboration and promoting evidence-based best practices, OBH is strengthening access and improving the quality of care for better outcomes statewide.

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

Increased Access to Behavioral Health Services

Louisiana is steadily increasing access to behavioral health services through a multi-layered approach that expands crisis response availability, strengthens community-based care, and prioritizes underserved populations. With the development of Certified Community Behavioral Health Clinics, residents can access comprehensive services regardless of insurance or ability to pay, including 24-hour crisis care and targeted support for high-needs groups. At the same time, the state is broadening its Crisis Response System, bringing mobile crisis teams, crisis walk in centers, and community brief crisis support to more regions across Louisiana. The Office of Behavioral Health continues to make progress by assessing needs, developing strategies, and

implementing evidence-based programs that improve quality of care while ensuring cost-effectiveness. Collectively, these efforts are creating a stronger, more robust and accessible continuum of care for adults and youth in behavioral health crisis.

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

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

Securing the CCBHC Planning Grant from SAMHSA was the direct result of action taken by OBH. A work group was formed and a consultant was identified and a contract executed in order to submit a competitive/responsive grant application to SAMHSA which resulted in an award. The CCBHC Planning Grant is the first phase of a two-phased process. The Planning Grant supports states in developing their CCBHC programs and enables them to apply for the SAMHSA CCBHC Demonstration Program. States selected to participate in the CCBHC Demonstration will enable state-certified CCBHCs to bill Medicaid under an established Prospective Payment System rate approved by the Centers for Medicare and Medicaid Services (CMS) for behavioral health services provided to eligible individuals.

- **Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)**
- **Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?**
- **Other? Please specify.**

As mentioned previously, OBH serves as the convening collaborator for LA-CRS partnerships. In this role, OBH maintains the federal and state policy and fiscal infrastructure to support crisis service delivery while monitoring service utilization, quality and workforce development. The implementation of the LCH was a significant technological advance for the system with the crisis safety platform providing a 24/7 call center platform with air traffic control for assessment, triage and dispatch of mobile crisis services, as well as, a collection point for data related to other crisis services.

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

As indicated above, securing the CCBHC Planning Grant was the first step in the two-phased process. OBH expects to utilize the planning grant year to complete the required planning grant activities which support the development of the CCBHC Program in Louisiana. It is expected that activities continue through April 1, 2026 at which time Louisiana will submit an application to participate in the CCBHC Demonstration Program for a four-year period starting on or after July 2026.

The refinement of the LCH will continue to refine the triage and dispatch functions through the expansion into text and chat episodes, global positioning system (GPS) navigation and dispatch

of mobile crisis teams and bed/service registries as the LA-CRS matures and the demand for crisis services grows.

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

None.

**1. To what do you attribute this lack of progress? For example:**

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

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

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

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

**No. If not, why not?**

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

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

(“Problems or issues” may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. “Problems or issues” may be related to external factors—such as

demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. “Problems or issues” may or may not be related directly to strategic plan lack of progress.)

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

#### A. Problem/Issue Description

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

The complex and time-consuming nature of the contracting process, both within LDH and in conjunction with the Division of Administration's protocols, continues to hinder the timely and efficient implementation of services and initiatives. Although OBH acknowledges the need for thorough review, communication, and approval, these delays highlight inefficiencies and issues with operational coordination and communication throughout the contracting process. The involvement of multiple parties in the development, submission, review, and approval of State contracts—now managed through the Office of Management and Finance’s Contracts and Procurement unit, with the additional requirement for routing to Legal and OSP to occur through OMF—has not led to any noticeable improvements in efficiency. OBH is concerned about the stagnation in modernizing and streamlining the contracting process.

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

The obstacles that OBH encounters in order to secure contracts in a timely manner impacts the ability of OBH to achieve our mission and goals. The contract process is already preceded by the need for receipt of federal grant award notifications, the attainment of Legislative approval for Budget Authority for the receipt of federal funds which may require the submission of a BA-7 that may require approved by the Joint Legislative Committee on the Budget. Interagency Agreements are required between the State (OBH) to simply flow out funds to our regional Local Governing Entities (LGEs), but in order to contract directly with providers, this process is even more tedious. Therefore, the delays in the State’s ability to secure Interagency Transfers (IATs) and contracts in a timely manner, inhibits our ability to promptly initiate the goals and objectives we pursue with the grant funding and Legislatively approved State funding afforded to our Office. In FY25, LDH Legal informed LDH agencies that IATs to LGEs is no longer permitted. The traditionally quicker process of sending an IAT to each LGE for their services must be replaced by the contracting process, which will result in an increased workload for OBH staff and additional delays for the LGEs beginning in mid-FY26 as contracts for FY27 are processed.

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

All units within OBH have been affected by the inefficiencies caused by these obstacles. Administration must prioritize the submission of contracts to OS/OMF, Legal, Civil Service, and the Division of Administration to minimize the impact on individuals requiring behavioral health services. Although direct care often takes precedence, daily requests for prioritization of contracts, amendments, RFIs, RFAs, RFPs, and CEAs are based on current needs and political considerations. This situation complicates the implementation of the goals and objectives outlined in the grants and initiatives supported by OBH.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)  
This issue impacts not only our staff and all of the Louisiana Department of Health staff, but also the recipients of our efforts, the providers of behavioral health services, and our contractors and managed care entities working to provide the essential behavioral healthcare services needed by the residents of Louisiana.
5. How long has the problem or issue existed?  
This impact has been ongoing at a minimum since contract processing was centralized, therefore more than ten years, if not prior. However, it has since been exacerbated with the influx of federal funds and grants requiring more contracting to implement initiatives.
6. What are the causes of the problem or issue? How do you know?  
Inefficient processes compounded by voluminous, outdated and user-unfriendly forms, and overly cumbersome and duplicative routing procedures contribute to the problem. Additionally, there is no comprehensive, transparent tracking system or prioritization methodology across the Department.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?  
Consequences include staff being unable to complete the goals and objectives of initiatives, grants, programs, or strategic plan tasks, and OBH's inability to effectively advance its initiatives and goals.

#### B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?  
 No. If not, skip questions 2-5 below.  
 Yes. If so, complete questions 2-5 below.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue?  
Internally, OBH has been working toward streamlining internal procedures. We have developed new training to help ensure that contract monitors have the tools needed to submit accurate and comprehensive contract packages. We have also developed a tracking system through Monday.com in order to more effectively

and transparently allow for the tracking of our contract documents, internally. OBH continues to expand the capacity and functionality of Monday.com, as well as expanding and revising trainings and templates in order to better meet the needs of staff.

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

Yes, the recommendation was first noted in FY2022 and continues to be a persistent problem despite various corrective actions from OBH, LDH, and the Division of Administration.

4. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur?

Trainings occurred in FY25, and will continue into FY26. We maintain a single entry email for all contract related documents and we have fully implemented the use of monday.com to track all contracts, amendments, CEAs and RFI/A/Ps. We reorganized our shared drive in an effort to increase the ease and completeness of the use and availability of contract documents and training guides necessary for the submission of contracts, amendments, RFIs, RFAs, RFPs and CEAs.

- How much progress has been made and how much additional progress is needed?

The single-entry email and OBH tracking system are both in full implementation. In-person training opportunities continue to be consistently offered not only on contract development, but also on invoicing related to these contracts. In FY25, we continued just-in-time training and Q&A opportunities related to contracting, invoicing and other financial matters via weekly “office hours” sessions which occur every Wednesday, and are open to all staff. The newly revamped shared drive resources are continuously updated in order to account for ongoing modifications to forms and processes.

b. If not:

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

5. Do corrective actions carry a cost?

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital

resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

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

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

The LDH has a designated Audit Coordinator for financial audits. The Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and

operation of state programs and activities.

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

- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
  
- Performance Progress Reports (Louisiana Performance Accountability System)**  
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
  
- In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.
  
- Benchmarking for Best Management Practices**  
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.
  
- Performance-based contracting (including contract monitoring)**  
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a

monitoring plan.

- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

1. Title of Report or Program Evaluation:

**SAMHSA Block Grant Annual Reporting (SUPTRS and CMHS)**

2. Date completed: In Progress

Louisiana's CMHS and SUPTRS Behavioral Grant reports must be submitted to SAMHSA no later than December 1st of each year. Some components of reporting are completed quarterly with an annual review prior to December 1. If OBH misses the statutory date for submitting the reports, it will not receive any federal Block Grant funds for that federal fiscal year.

3. Subject/purpose and reason for initiation of the analysis or evaluation:

Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. 300x-52(a)) requires SAMHSA to determine the extent to which States and Jurisdictions have implemented the State plan for the preceding fiscal year. States and Jurisdictions are required to prepare annual reporting for submission that consists of multiple components which include data submissions, performance indicators and fiscal tables. The annual reporting needs to include the purposes for which the CMHS and SUPTRS funds were expended, recipients of grant funds, authorized activities funded, and services purchased with such funds. CMHS and SUPTRS reports are not combined.

4. Methodology used for analysis or evaluation:

OBH Quality staff work in collaboration with OBH analytics, program and fiscal staff and LGES in the development of the annual reports. Some data is submitted quarterly; annual reporting submissions require several months of preparation and typically begin in September of each year.

OBH Analytics staff collect MH and SUD *Client-level Treatment Episode data* from LGEs on a semi-monthly basis. Collected records are checked for data quality, and findings are shared with the LGEs through Pre-Integration Data Validation Reports every two weeks. Accepted records from the LGE E-HR system and Louisiana Addictive Disorder Data System (LADDS) are processed, stored in the OBH Block Grant Data Warehouse, and submitted to SAMHSA through the Treatment Episode Data Systems (TEDS) portal every quarter. MH-URS (Uniform Reporting System) reports are generated each year, that include all MH records from the LGE E-HR systems, records from Patient Information Portal (PIP, for State Inpatient Psychiatric Hospitals), and Quality of Care Surveys from Telesage Outcome Measurement System (TOMS). Records from the Block Grant Data Warehouse are also used to generate MH and SUD Block Grant Reports, Accountability & Planning Reports, Recurring and Ad-Hoc monitoring reports.

Most components of the December 1 reporting are submitted via SAMHSA's online portal, Web Block Grant Application System (WebBGAS). Other submissions are completed through their respective SAMHSA sponsored online portals.

5. Cost (allocation of in-house resources or purchase price):

There is no cost associated with these reports. These reports are generated in-house; OBH program staff use data from the OBH Data Warehouse to generate client level data based reports.

6. Major Findings and Conclusions:

The primary purpose of the reports is to track and monitor fiscal, program, service and client variables/indicators across time. No major findings/conclusions.

7. Major Recommendations:

No major recommendations.

8. Action taken in response to the report or evaluation:

Data-based decision making relative to programs and services.

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

The data is submitted directly into SAMHSA portals. SAMHSA makes the tables available to the public in PDF format. The Annual Report from SAMHSA's WebBGAS system is distributed via email to the Louisiana Behavioral Health Advisory Council and upon request.

10. Contact Person:

Name: Catherine Peay  
Title: Block Grant State Planner  
Agency & Program: LA Department of Health, Office of Behavioral Health

Telephone: 225.342.7945  
Email: [Catherine.peay@la.gov](mailto:Catherine.peay@la.gov)

1. Title of Report or Program Evaluation:

Prevention Management Information System Reporting on Prevention Services (Quarterly and Annual)

2. Date completed:

July 1, 2024 – June 30, 2025. Data for this report was pulled on July 8, 2025.

3. Subject / purpose and reason for initiation of the analysis or evaluation:

The Office of Behavioral Health (OBH) is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the Substance Abuse, Prevention and Treatment (SAPT) grant, which is the primary funding source for prevention services. It requires 20% of the grant be set aside for primary prevention services. An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report is a continuing process to measure the number of services we provide and the populations that are served.

4. Methodology used for analysis or evaluation:

The data in this report is from the Prevention Management Information System (PMIS), the primary reporting system for the SAPT for prevention services. PMIS reports are generated quarterly and captures demographic information such as age, gender, race and ethnicity. Data and information outlined in this report are also used to meet the requirements for the Prevention National Outcome Measures (NOMS).

5. Cost (allocation of in-house resources or purchase price):

There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from PMIS to generate this document. Data is entered into PMIS by the Local Governing Entity (LGE) prevention staff, their contract providers statewide and OBH staff.

6. Major Findings and Conclusions:

During FY 2025, Prevention Services provided evidence-based services to 73,269 enrollees. In addition, during FY 2025, block grant funded one-time services were provided to the general population and reached 5.24 million people. This number

reflects the number of individuals reached through rallies, speaking engagements, health fairs, and conferences. In addition, this number reflects the number of individuals impacted by PSAs, print, digital and electronic billboard messaging; newspaper, radio, movie theater ads, television commercials, and social media posts (e.g. Facebook, Instagram, Twitter, Snapchat, TikTok, etc.). This number included the combined services provided by LGE Prevention Staff and Prevention Contract Providers.

7. Major Recommendations:

The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.

8. Action taken in response to the report or evaluation:

No actions other than the recommended (above) were pertinent.

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

The report is distributed via e-mail and is available by hard copy upon request.

10. Contact Person:

Name: Dr. Leslie Brougham Freeman

Title: Director of Prevention, Wellness and Workplace Development

Agency & Program: LA Department of Health, Office of Behavioral Health

Telephone: 225.342.5705

Email: [Leslie.BroughamFreeman@la.gov](mailto:Leslie.BroughamFreeman@la.gov)

1. Title of Report or Program Evaluation:

Synar Report: Youth Access to Tobacco in Louisiana

2. Date Completed: December 27, 2024

3. Subject / purpose and reason for initiation of the analysis or evaluation:

The Office of Behavioral Health (OBH) conducts this annual Synar Report to examine the current level of accessibility of tobacco products to minors as pursuant to Federal Government guidelines. SAMHSA is the enforcing agency. An amended Synar Regulation, issued by SAMHSA in January 1996, requires each state receiving federal grant funding to conduct annual random, unannounced inspections of retail outlets to assess the extent of tobacco sales to minors.

4. Methodology used for analysis or evaluation:

The study design is a cross-sectional survey of compliance, with compliance defined as the refusal to sell tobacco to minors and the prevention of entry of a minor to outlets

restricted to youth. A stratified random sample of outlets are identified and surveyed by a team of one youth operative and two adult agents Office of Alcohol and Tobacco Control (OATC). The youth operative attempts to purchase tobacco from unrestricted outlets and tests the access of restricted outlets. The adult agents record characteristics of outlets, inspection events, and outcomes, and cite non-compliant outlets and clerks. Information about outlets, inspectors, and the inspection event are entered into an electronic data system via laptop at the time of inspection.

5. Cost (allocation of in-house resources or purchase price):

OBH contracted with OATC to conduct the random, unannounced inspections of tobacco outlets identified by the random sample at a cost of \$72,300.00 (\$100.00 per compliance check x 723 checks). The total cost to prepare and complete the Annual Synar Report was \$97,331.00.

6. Major Findings and Conclusions:

The objective of this study was to estimate the non-compliance rate for tobacco sales in Louisiana among youth under age 21. Annual targets were established to decrease the state's non-compliance rate to 20% by FFY 2002. However, Louisiana achieved 20.3% non-compliance in FFY 1999, only two years after the start of the Louisiana Synar Initiative, and three years ahead of the scheduled target date. The current rate of tobacco sales to minors in FFY 2025 is 5.9%.

7. Major Recommendations:

OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2025 report and will adhere to any future recommendations, as warranted.

8. Action taken in response to the report or evaluation:

An annual report is generated by SAMHSA including a Table listing the Synar Retailer Violations (RVRs). According to the most recent FFY 2018 on file, Louisiana was below the national average in regards to compliance. The SAMHSA report can be viewed at [https://www.samhsa.gov/sites/default/files/synar\\_program\\_rvr\\_table\\_1997-2018\\_dec\\_11\\_2018.pdf](https://www.samhsa.gov/sites/default/files/synar_program_rvr_table_1997-2018_dec_11_2018.pdf). Our goal is to continue implementing current strategies since they've proven to be successful.

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

The FFY 2025 Annual Synar Report is available by hardcopy, and may be accessed online at <https://www.ldh.la.gov/news/7451>

10. Contact Person:

Name: Dr. Leslie Brougham Freeman

Title: Director of Prevention, Wellness and Workplace Development

Agency & Program: LA Department of Health, Office of Behavioral Health

Telephone: 225.342.5705

Email: [Leslie.BroughamFreeman@la.gov](mailto:Leslie.BroughamFreeman@la.gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

<b>Department:</b>	Louisiana Department of Health (LDH) 09-340 Office for Citizens with Developmental Disabilities
<b>Department Head:</b>	Bruce D. Greenstein LDH Secretary
<b>Undersecretary:</b>	Drew Maranto
<b>Assistant Secretary:</b>	Julie Foster Hagan

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

#### Accomplishment #1: Completion of Support Coordination Value Based Payment Project to Enhance Person Centered Practices

##### A. What was achieved?

The Office for Citizens with Developmental Disabilities (OCDD) implemented a support coordination Value Based Payment (VBP) initiative through a collaboration between OCDD clinical services, waiver services and the My Place program. The goal of this initiative was to improve person-centered practices aimed at positive recipient outcomes for Louisiana OCDD Home- and Community-Based Service (HCBS) recipients by providing incentives for investment by support coordination agencies. The intent was for each agency to build sustainable in-house capacity for training and certification of support coordinators, and for supervisors to effectively use person-centered tools to develop:

- person focused and driven plans of support to increase independence and autonomy,
- engagement with meaningful work/day activities, and
- Relationship/connections with the local community.

There were four phases associated with four incentives that the agencies could earn. The four phases were:

**Phase 1:** Set percentage of each agency's support coordinators (SCs) must achieve

certification in person centered tools completion and one supervisor achieving certification in person centered tools review.

**Phase 2:** Set percentage of each agency's SCs must achieve certification in person centered plan development completion plus one supervisor achieving certification in person centered plan review.

**Phase 3:** Eighty percent (80%) of each agency's SC supervisors must achieve certification in both person-centered tools and plan review.

**Phase 4:** Each agency must develop a proposal and receive OCDD approval of the proposal to implement the following:

- Person centered training modules as part of new SC orientation,
- Set timeframes and process for person centered tools and plan certification for new SCs within 1 year of employment,
- Supervisor person centered tools and plan development review training built into new supervisor orientation, and
- Set timeframes and processes for supervisor certification within 1 year of promotion.

Five support coordination agencies participated in the VBP project; four of the five successfully completed the project. Participating agencies included Easterseals Louisiana, Medical Resources and Guidance, Qualify Support Coordination, and Blossom Support Coordination. Together they serve over two-thirds of OCDD's waiver recipients. Each of these agencies has OCDD verified certification of selected SCs and at least 80% of their supervisors in these initial basic practices with reviewed and approved in house proposals to continue training and certification on these basic principles in each agency. The agency that did not complete the project fully did complete phase 1. However, this agency only serves 1% of the waiver population so there is limited impact, and OCDD can address this in further efforts to expand these practices beyond the VBP project.

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

This project resulted in a measurable increase in defined skills and ability to use core person-centered tools and practices consistent with the best practice standards for support coordination agencies that serve over two-thirds of all waiver recipients. The design of the project also ensures in-house capacity in each agency to continue training and certification for all new support coordinators and supervisors. It further provides a process for addressing these practices in any new support coordination agencies and the remaining existing agencies.

**C. Who benefits and how?**

OCDD participants, families, SCs, and direct support professionals could all potentially benefit from the appropriate use of person centered tools and practices. The use of these tools and practices are associated with improved access to appropriately matched services and improved outcomes for individuals with IDD with a specific focus on greater independence. Addressing fundamental person-centered needs around meaningful work/day activities, personal goals and autonomy, and health and wellbeing

leads to increased independence, more naturally occurring relationships and connections, fewer medical and mental health symptoms and decreased need for higher cost emergency or institutional services.

D. How was the accomplishment achieved?

OCDD used Money Follows the Person (MFP) funds to incentivize existing support coordination agencies to participate in the project. The project included four phases with a fiscal incentive for each phase. OCDD linked the incentives to the number of recipients supported by the agency with larger agencies able to earn higher incentives. Similarly, criteria for larger agencies were more intensive.

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

Yes. Agency Goal II reflects OCDD's responsibility "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 focused on the person's goals and desires and addresses quality of life."

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

Yes. The person-centered tools and practices are consistent with the demonstrating competency in four of the five domains of competency via the National Center for Advancing Person Centered Practices. Domain 5 is not focused on plan discovery/assessment or development, which was the focus of this initial project.

Accomplishment #2: HCBS Settings Rule Compliance:

A. What was achieved?

Centers for Medicare and Medicaid (CMS) issued the Settings Rule, which became effective March 17, 2014. The purpose of the rule was to ensure that individuals receive Medicaid HCBS services in integrated settings, and that provide full access to the greater community. The requirements maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting and protects individual choice.

B. Why is this success significant?

OCDD supported providers to make the necessary changes to their settings and to ensure services would be individualized and integrated in the community. Initially CMS issued a deadline of March 17, 2019; however, they granted several extensions over the course of the last 10 years. In December 2022, CMS allowed states to request a Corrective Action Plan based on the lingering effects from the Public Health Emergency. Louisiana requested to go into a Corrective Action Plan that would end on 12/31/2024. On May 29, 2025, Louisiana received notification from CMS that Louisiana is in compliance because we have completed the Corrective Action Plan.

C. Who benefits and how?

The completion of the settings rule ensures the waiver program supports individuals

(New Opportunities Waiver, Residential Options Waiver, Supports Waiver and Children's Choice) to receive services and supports that are individualized and integrated in the community. Additionally individuals have choice in the services and supports they receive and who provides them.

D. How was the accomplishment achieved?

The OCDD provided education and training on the HCBS Settings Rule to individuals, families, the Local Governing Entities, Support Coordination Agencies and stakeholders. OCDD enlisted the help of the LGEs to provide ongoing training, technical assistance and guidance, and monitoring through onsite visits to the waiver providers. These visits ensured that providers understood requirements and expectations of the HCBS Settings Rule and that they must deliver services in compliance with the regulations. OCDD also implemented new community-based day services and a new individual supported employment service array to ensure that individuals had a choice of services in the community and to ensure that those services integrated individuals in their community.

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

Yes, this accomplishment directly contributes to the success of our strategic plan. OCDD is focused on providing a person-centered system to support individuals, and we seek to increase opportunities for people to live, work, and learn in integrated community settings. This accomplishment directly impacts both of those goals.

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

Yes, this accomplishment represents a Best Management Practice. OCDD reached compliance with the HCBS Settings rule by following CMS guidance. It is a best practice to make changes and adjustments to services and service delivery to ensure that individuals have a choice of services that are individualized and integrated in the community.

Accomplishment 3: Enhanced Training for Community Professionals and Providers through Strategic Partnerships

A. What was achieved?

The OCDD Clinical Services Leadership and Resource Center staff initiated strategic partnerships across multiple organizations to expand OCDD's ability to reach more community professionals and providers. These efforts expand the OCDD's ability to use the professional expertise of its Clinical and Resource Center staff to develop and conduct training and technical assistance activities with community providers and professionals. This allows us to enhance the ability of these providers and professionals to support individuals with complex medical and behavioral support needs. OCDD developed strategic partnerships with:

- The Provider Network (TPN) and five (5) of the six (6) currently contracted Managed Care Organizations (MCOs),
- the Office of Behavioral Health (OBH) and LSU Health Sciences Center

(LSUHSC),

- the National Association of State Developmental Directors of Disability Services (NASDDDS),
  - the Arc of Louisiana, and
  - Louisiana licensing boards for each allied health profession in addition to its core continuing education and training activities.
1. In partnership with five of the six MCOs and TPN, an increased number of professionals are receiving training in understanding intellectual and developmental disabilities (IDD) and MH needs via a curriculum developed and delivered by OCDD's Clinical Director. Prior to this, no consistent training was available to community behavioral health professionals. Now four modules are available for licensed clinicians with two of the four modules also applicable to unlicensed clinicians practicing under the supervision of licensed clinicians. In the year and half since the modules have been available, 267 behavioral health clinicians in Louisiana have completed at least one module, with 123 of these completing all four modules. The modules are competency-based so all clinicians successfully completing modules were able to demonstrate an ability to apply modifications to successfully provide assessment and treatment for behavioral health needs in people with IDD. Evaluation information of the modules indicates that 99-100% of all participants learned an average to above average amount in each module (with 86% learning above average or a great deal). The modules continue to be available on the TPN platform for ongoing access for additional community professionals and they offer the modules at no cost to all participating clinicians. The sixth MCO chose to offer the curriculum via an alternate platform. Of note, the TPN curriculum is available nationally, an additional 262 clinicians across 46 other states and DC have completed at least one module, and 136 of them have completed all modules. Louisiana is affecting clinician education nationally through this partnership.
  2. OCDD collaborated with the OBH and LSUHSC to develop and implement training for crisis providers to meet the needs of individuals with IDD in crisis and ensure access to the services now implemented across the state. To date, 21 individuals from nine agencies completed the two-module series with over 90% indicating that the training was helpful and challenged their previous knowledge on the topic. The training also provides linkage to the local OCDD Resource Center behavioral health clinician for each crisis provider to ensure collaboration and consultation as needed. The modules continue to be available virtually for ongoing training for crisis provider staff as needed. Connection to national experts for a new training series for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) providers also occurred this fiscal year with contracts in process for this training in the coming fiscal year. OCDD Clinical Services also provided a series of IDD and behavioral health trainings to OBH staff to support continued in-house collaboration.
  3. Louisiana's Clinical Services leadership team collaborated with the Arc of Louisiana and the Office of Behavioral Health to develop a Clinician's Guide to Accessible Treatment for Individuals with IDD and an Individual and Family Guide to

- Navigating the Service Systems. The National Link Center website, as well as the Arc of Louisiana website, features the Clinician Guide as a model. OCDD has distributed the guide to all MCOs to share with their networks, and it is a companion tool for all OCDD clinical and resource center training on IDD and behavioral health. OCDD's Assistant Secretary and Clinical Director, along with the Arc of Louisiana Program Manager, presented on this partnership at the National HCBS conference in August 2024, and the NASDDDS Annual Conference in November 2024. Using the Individual and Family Guide, the Arc of Louisiana is now able to conduct more effective training and education sessions for individuals with IDD and their families. Last fiscal year we provided eight training sessions across the state. Feedback from participants indicate that the training increased their knowledge of services available across systems and provided detailed information and resources to help with access to services.
4. Louisiana's Clinical Services Leadership team collaborated with Missouri's IDD team and NASDDDS to record mini-training modules for clinicians for easier access and training. Modules for Cognitive Behavior Therapy and Dialectical Behavior Therapy are now available on the National Link Center and NASDDDS websites. These modules have also been highlighted in presentations at national HCBS and NASDDDS conferences. These modules are easy to access and provide reference as needed modifications for clinicians. The OCDD Clinical and Resource Center staff use these as companion tools and resources for behavioral health related trainings that they offer.
  5. This fiscal year, the OCDD Clinical Services Director also collaborated with the Arc of Louisiana on a broader Wellness Initiative. Five adults with disabilities who are members of the Arc of St. Charles People First chapter and five parents of youth with IDD from different age and developmental ranges completed a pilot. Following a 2-hour education and mentoring session, each participant was able to develop their own wellness guide (or one for their child) which focuses on important individualized strategies to promote positive interaction and emotion regulation and decrease challenging emotional and behavioral symptoms. All participants reported improvements in emotion monitoring, fewer behavioral and emotional challenges, and support that is more effective from paid supporters. Peer-led trainings are in process and planned for FY 25-26 to expand the progress from the pilot. The initial focus is on adults with IDD and partners with the Arc of St. Charles People First chapter. Initial trainings with other Arc chapters are planned for early FY 25-26, along with presentations at the Governor's Office of Disability Affairs conference, the Louisiana American Association on Intellectual and Developmental Disabilities (AAIDD) conference, and the National Association for the Dually Diagnosed (NADD) national conference.
  6. The OCDD Resource Center also continued core continuing education and training activities with expanded strategies. Resource Center nurses are now routinely completing outreach to all waiver provider nurses with an additional 10% increase in contacts this fiscal year from 5,626 to 6,412. These outreach efforts can have an increased impact as OCDD waiver services implements the new nurse services. General provider training included Certified Medication Assistance certifications,

which increased by 15% from 588 to 674 this FY. We continue to offer professional continuing education to psychologists, nurses and BCBAs directly through OCDD. Partnerships with the Licensing boards for Physical Therapists, Occupational Therapists and Speech-Language Pathologists resulted in expanding the number and type of continuing education offerings OCDD's Resource Center can provide. The ability to offer virtual trainings when appropriate for the content also expands the number of clinicians who can access these opportunities.

A. Why is this success significant?

Individuals with IDD are more likely to experience behavioral health distress and co-occurring behavioral health conditions compared to their peers who do not experience IDD. Individuals with IDD and behavioral health needs when compared to individuals with either disability condition alone are:

- Less likely to access appropriate services when experiencing a mental health crisis,
- More likely to be institutionalized, and
- Remain in institutional settings for longer "because they cannot access the services they need to live in the community."

Individuals with IDD are significantly more likely to experience trauma than individuals without IDD. In addition to greater likelihood of experiencing more commonly recognized trauma events (i.e., adverse childhood events), individuals with IDD are also more likely to experience frequent smaller trauma events such as bullying and isolation. Despite the increased frequency of trauma events, individuals with IDD are less likely to receive access to counseling or therapy post trauma.

Individuals with IDD are also more likely to experience co-occurring medical conditions, which also place them at greater risk for medical complications and emergencies, hospitalizations, and early mortality. Many medical conditions also impact an individual's physical and nutritional status and their day to day support needs in these areas.

B. Who benefits and how?

These activities can improve access to needed services and associated outcomes for individuals with IDD and co-occurring behavioral health and medical needs and their families. Providers and community professionals across systems also benefit through increased training and education to expand their ability to provide needed behavioral health and medical services to individuals with IDD. Access to needed community-based (outpatient) behavioral health and medical services is also more cost effective as it decreases the need for other higher cost emergency and institutional services.

C. How was the accomplishment achieved?

OCDD employs clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral and medical support needs. The strategic partnerships with both internal and external collaborators has allowed for a greater reach for these activities.

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

Yes. Agency Goal III focuses on increasing the “capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings” with a specific Resource Center Goal “to increase capacity of the Developmental Disabilities Services System to support people with complex behavioral, mental health, and/or medical needs in all service settings.”

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

Training methods and outreach are consistent with professional best practice standards. The training curricula/content is consistent with best practice standards for each content area, are reviewed prior to the offering of continuing education credits, and are recognized nationally. The Wellness initiative is consistent with best practices in supporting wellness. The specifics of these initiatives are focused on individuals with IDD, so each executive branch or agency would need to determine relevant standards.

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

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

- ◆ **Please provide a brief analysis of the overall status of your strategic progress.**

What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

OCDD is making timely progress in its current five-year Strategic Plan, particularly with those initiatives that support the following strategic plan goals:

- 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;
- 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;
- To increase the capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings;
- 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;
- To implement an integrated, full-scale data-driven quality enhancement

system; and

- To rebalance the Developmental Disabilities Services System in an efficient and equitable manner such that we allocate resources to enable people to live in the most integrated setting appropriate to their needs.

These initiatives also support OCDD's priorities, which relate to system transformation, as well as effective and efficient service delivery. OCDD's effective use of available American Rescue Plan Act (ARPA) funding allowed OCDD's progress on objectives to remain steady despite setbacks posed by the COVID-19 Public Health Emergency. The Centers for Medicare and Medicaid Services (CMS) has granted OCDD an extension to September 30, 2026 to expend the ARPA funding. OCDD continues to build on successes in the areas of customer responsiveness, waiver reform, person-centered thinking, early intervention, and supports for people with complex behavioral needs, and employment. The success of these initiatives in FY 2024-2025, and the continued success in 2025-2026 will help move OCDD toward the goals and objectives outlined in OCDD's Strategic Plan.

- ♦ **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
  1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
    - Other? Please specify.
  2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

### **Supporting Individuals with Complex Behavioral Health Needs to Live in their Community**

The OCDD Resource Center has continued to support individuals with the most complex behavioral needs, and currently acts as a service of last resort. The primary reason(s) for high-cost institutionalization within the OCDD system are the presentation of behavioral health needs and/or legal involvement. OCDD's Strategic and Operational Plan include a performance indicator (#24259) to monitor the success of this initiative. This year the OCDD Resource Center Behavioral Health staff provided consultation or direct services as last resort to 385-574 individuals each

month across the state including continued operation both in person and virtually of a medical psych clinic for individuals unable to secure a prescriber for psychotropic medications. This support resulted in more than 98% of the individuals maintaining community living. These results represent significant positive outcomes for these individuals, and speak to the success and importance of this OCDD effort.

1. To what do you attribute this success?

The OCDD Resource Center employs clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral/ medical support needs. The OCDD Resource Center uses a multi-disciplinary approach to providing consultation, training, and services that improves the ability of caregivers and providers to achieve positive outcomes for persons with complex needs.

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

OCDD expects progress to continue. The Resource Center staff continues to implement triage initiatives, and they have been able to provide responsive consultative services to individuals and provider agencies who may be in an urgent situation regarding ability to continue to live and receive services in their home and community. Resource Center professionals, in collaboration with the Local Governing Entities (LGEs), have implemented crisis/diversion initiatives, and can initiate a consultation prior to escalation of a crisis to ensure one's community connection is maintained, or within a timeframe that increases the likelihood of diversion to the most integrated setting. The Resource Center staff have also continued formal liaison partnerships with all Managed Care Organizations and the two State Operated Psychiatric Hospitals to ensure collaboration and access to appropriate services.

### **Progress Note Monitoring**

In response to a Louisiana Legislative Auditor's finding of inadequate documentation by service providers, OCDD developed a Corrective Action Plan that consisted of the following elements:

- Development/Finalization of a standardized note that all personal care type providers will use,
- Training/Implementation of the standardized progress note, and
- Development/Implementation of a monitoring process to review provider records/notes.

All activities completed on schedule as outlined in the Corrective Action Plan developed. OCDD implemented the monitoring process in July 2025 with plans to monitor all personal care providers by June 2026.

1. To what do you attribute this success?

OCDD is committed to ensuring that individuals are receiving the appropriate supports to meet their needs and that the documentation reflects the work that

all partners in the service delivery system are contributing. Results achieved are a reflection of cross section coordination/collaboration to develop and implement necessary processes in this area as well as allocating resources to address this area.

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

This initiative is progressing as expected. OCDD intends to integrate this process into regular business practice with a monitoring cycle occurring annually with personal care providers. The monitoring cycle will occur on a fiscal year cycle.

### **OCDD Value Based Payment (VBP) Model**

OCDD implemented a CMS approved value based payment model. The model includes nine incentives by which OCDD can pay providers based on meeting the predetermined performance measures.

1. To what do you attribute this success?

We attribute OCDD's success to our work with various stakeholder groups. The state distributed information to stakeholders through various communication channels and in-person/virtual meetings/webinars. Communication channels included email blasts, social media platforms, newsletters, and provider relations distribution lists. OCDD held in-person and virtual meetings to discuss the model. In addition, the department established a VBP ad hoc committee with representatives from the provider, self-advocate/family and advocacy communities to provide feedback and input on all nine incentives, as well as distribute information. OCDD will continue to distribute information via the established channels described above, as well as add VBP information in the provider enrollment process to educate new providers, Medicaid DD Provider Waiver Manual, and request ongoing feedback via surveys and continued engagement with the VBP committee.

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

The above progress is expected to continue at an accelerated pace. OCDD has received approval from CMS for the operation of this value-based program. This approval allows us to implement, evaluate and incentivize providers for the proposed measures.

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

1. To what do you attribute this lack of progress? For example:
  - Is the lack of progress related to a management decision (perhaps

temporary) to pursue excellence in one area at the expense of progress in another area?

- Is the lack of progress due to budget or other constraint?
  - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
  - Other? Please specify.
2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

**Development of an Integrated, Full-Scale Data-Driven Process**

1. To what do you attribute this lack of progress?

OCDD is in the process of obtaining a full-scale data-driven quality database because it lacks the internal resources to develop a process. OCDD must resolve many issues before the database is complete. However, LDH has been able to secure funding through the American Rescue Plan Act (ARPA) for possible system upgrades and the opportunity for OCDD to obtain the desired system. The plan also presents a funding opportunity to secure additional resources to support the one available programmer who, to this point, has had the full time responsibility for modernizing all of OCDD's databases. OCDD is currently in the pilot and testing phase of finalizing the electronic Individual Support Plan (eISP), which will be key to the effectiveness and operability of any system OCDD will use.

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

The lack of progress on a quality-integrated database was due to a lack of resources, both in terms of funding to create the singular data system and infrastructure (i.e. concerns for server space, web-based capabilities) and adequate personnel to develop and administer the system. In addition to the barriers, modernization of all IT infrastructure has had a significant impact on progress. However, OCDD has completed the initial phases of the system's upgrades.

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

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

No. If not, why not?

Yes. OCDD has updated its Strategic Plan for FY 2025 through 2030. Updates included revisions to office goals, program objectives, strategies and indicators to reflect OCDD direction, to build on successes, to provide strategies in areas where success has not been as substantial or where changes in program direction indicate such, and to improve performance assessment.

- ♦ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department,**

**regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

The LDH Division of Planning and Budget coordinates performance-based budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) on a department-wide level. This section reviews objectives, performance indicators, and strategies for programs within the Office of the Secretary, other LDH agencies, and for some LGEs. Each agency and LGE, with input from executive management, develops its own operational plan and strategic plan. Individual offices submit plans to the Office of the Secretary for review and feedback. If the Office of the Secretary requires modifications or additions, it will make recommendation directly to the assistant secretaries or the secretary. In addition, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year to determine if they should use information from this review to improve strategic and operational planning, or program management operations.

OCDD assigns objectives to specific staff members who are responsible for management and oversight of the accomplishment of each objective and related performance indicators. OCDD uses a variety of management tools (i.e., databases, project charters, etc.) and initiative-specific workgroups/committees to track, review, and provide feedback for use in decision-making and resource allocation. OCDD staff report progress, or lack of progress, (along with support/resources needed to achieve assigned objective) to OCDD Executive Management. OCDD reports performance data in Louisiana Performance Accountability System (LaPAS), which is available for both management and stakeholder review.

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

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

**Community settings continue to have limited trained professionals and direct support staff to deliver needed (1) behavioral services, and (2) services and supports, including skilled nursing service and community nursing service, to individuals who are medically fragile**

A. Problem/Issue Description

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

There continues to be a limited number of adequately trained professionals and direct support staff to deliver needed behavioral and medical/nursing services to individuals with complex needs in community settings. There is a shortage of trained staff to provide services and supports for individuals with significant medical needs, including a shortage in skilled nursing services, and a shortage of trained nurses who work either full

time, part time, and contract for the agency/provider for individuals who are medically fragile and reside in community settings.

Adequate behavioral health supports can be very effective in improving quality of life and reducing behavioral symptoms/challenges for individuals with intellectual/developmental disabilities. Complex medical support needs, particularly those requiring nursing supports throughout significant periods of the day, can be managed in community settings; however, it is difficult to locate and secure trained staff to meet these needs. Continued challenges in this area contribute to institutional admissions, hospital admissions, emergency room use, increased illnesses, increased medication usage and costs, and other negative health outcomes.

There have been specific departmental and OCDD initiatives introduced during this fiscal year to continue addressing this barrier—and there have been some areas of improvement—however, the general problem still exists. A multi-faceted and multi-year approach is likely required to resolve the problem.

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

Yes. Limited access to professional supports in community settings continues to be the primary contributor to admissions to the supports and service center and other more restrictive settings. Requests for admissions happen when community providers are unable to meet behavioral and psychiatric needs of people whom they are serving in community settings and (in smaller numbers) those with complex medical needs. These challenges hamper the continued movement from Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) settings to community-based living arrangements due to the challenges in securing needed behavioral and medical/nursing supports for individuals with complex needs.

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

The lack of professional support in the community affects OCDD and the Local Governing Entities. These impacts have continued for years. The Office of Behavioral Health (OBH) and Medicaid are also experiencing some impact due to this problem.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
  - This problem affects individuals supported and their families, support coordinators, and private providers who serve persons with intellectual/developmental disabilities in community homes, family homes, and supported independent living settings.
  - This problem affects hospitals when individuals with co-occurring needs present at the emergency room due to difficulty accessing

other needed services.

- This problem affects behavioral health professionals and agencies because they are now receiving referrals for individuals with co-occurring needs for whom they may not feel adequately trained to deliver treatment.
- This problem affects managed care organizations due to expectations related to developing a network of providers for the provision of needed health and behavioral health services in an environment where access to needed specialized training is a challenge.

5. How long has the problem or issue existed?

The problem has been longstanding over many years.

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

Many factors contribute to the problem, beginning with a historic lack of training of persons equipped to deliver these services. Most professional training programs offer no training in intellectual/developmental disabilities. National reports continue to indicate that there is a general shortage of behavioral health professionals in many areas of the country, with access for those with co-occurring developmental disabilities and behavioral health needs even more challenging. The cost of providing nursing services in individual settings—and challenges in terms of isolation in these arrangements—negatively affect the access to needed medical/nursing supports. Both the increasing number of persons with intellectual/developmental disabilities now being served in the community, and the downsizing of institutional services (generally considered to be positive and progressive developments in developmental disabilities services) have contributed to an increased need for medical/nursing and behavioral/psychiatric supports in the community. In addition, private Supported Independent Living (SIL) providers serving persons in waiver settings and private community home providers generally do not conduct, and are not required to conduct, training with direct support staff on behavioral health and medical/nursing needs.

Factors linked to impacts of the pandemic, additional major hurricanes disrupting services in the State, and historically significant workforce challenges Louisiana and the nation have faced further affect this challenge. These public health disasters and workforce challenges continue to affect the provision of community-based services. Many entry-level jobs are reimbursing new hires at rates significantly higher than DSPs. Therefore, we may have a shrinking workforce of qualified DSPs to support people in the community, resulting in increased utilization of more restrictive, high-cost alternative.

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

## Consequences include:

- a significant number of people with intellectual/developmental disabilities having unmet needs,
- a continued need for costly institutional admissions to the higher treatment cost supports and service center,
- continued high utilization of high-cost acute services, and
- an inadequate number of practitioners to positively impact the developmental trajectories of children with IDD and other behavioral challenges and/or complex medical needs leading to increasing service costs over the course of their lifespan.

## B. Corrective Actions

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

No. If not, skip questions 2-5 below.

Yes. If so, complete questions 2-5 below.

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

The following are new recommendations to alleviate the problem:

- Initiate contract with The Center for START Services to develop professional learning communities, and evaluate program design and cost options for a START Team pilot.
- In collaboration with OBH and LSUHSC, implement the upcoming trauma focused training series for TF-CBT and EMDR clinicians.
- Implement updated Wellness Guide with additional focus on training for individuals with IDD and their families.
- In collaboration with OBH, complete actions related to specialized PRTF services for youth with IDD and co-occurring behavioral health needs.
- Implement through the OCDD waivers the newly funded nurse consultation service.

The following are actions OCDD recommends continue to alleviate the problem:

- Continue implementation of opportunities for collaborating with university programs that provide training, as well as individual clinicians, resulting in additional needed professionals and growing the service provider pool.
- Continue OCDD developed and sponsored professional continuing education opportunities.
- Continue partnerships with the Arc of Louisiana and TPN regarding clinician and individual/family education and training.
- Continue to evaluate other state's practices, which may offer opportunities

for new and expanded services.

- Continue and enhance nursing and dental outreach efforts to improve outcomes for individuals with complex medical/dental needs.
- Implement other activities of the study groups in HCRs passed in FY 22, including implementation of the nursing consultation service and the payment for support coordinators for work done from linkage to certification in the waiver.

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

Yes. A recommendation has been included in this annual report since FY 2007-2008. OCDD has implemented some recommendations, and new recommendations are included. Many of these recommendations require sustained implementation over time to affect needed systems issues and improve outcomes, and the extent of the factors affecting the issue cannot all be addressed all at once.

4. Are corrective actions underway?

Yes. The following actions are underway:

- OCDD continues implementation of the complex care supplemental option within the waiver services and implementation of an Emotional Wellness Guide in its HCBS program. In the last fiscal year, OCDD initiated a partnership with the Arc of Louisiana and started wellness education and training directly with adults with IDD and their supporters with new actions noted above.
- OCDD has developed and deployed core training for DSPs on supporting emotional wellness and meeting complex medical needs. We continue to offer these trainings on a revolving schedule.
- OCDD continues its statewide offering of Medical/Nursing DSP training via the Money Follows the Person (MFP) Rebalancing Demonstration.
- OCDD has continued professional continuing education across disciplinary areas.
- OCDD continues to provide consultation and technical assistance via the OCDD Resource Center.
- OCDD has implemented routine outreach to full time, part time, and contract nurses for HCBS providers via the OCDD Resource Center.
- OCDD is working with Medicaid to support Applied Behavior Analysis (ABA) services via the State Plan and has increased routine coordination with the Office of Behavioral Health (OBH) related to mental health needs for individuals with intellectual/developmental disabilities.
- OCDD continues to collaborate with the statewide Dental Taskforce, and passage of funding to provide dental coverage has occurred in the last two fiscal years.

- OCDD continues collaborating with OBH, the Coordinated System of Care (CSoC), and Managed Care Organizations (MCOs) to address the co-occurring IDD and behavioral health needs of recipients who access services across systems. MCO contracts have specific network adequacy and training requirements for meeting the needs of individuals with IDD and co-occurring behavioral health needs.
- OCDD Resource Center staff continues implementation of a liaison program with the two state operated psychiatric facilities and each MCO.
- OCDD continues to work in collaboration with NASDDDS and other states to develop additional training and educational materials for clinicians.
- OCDD is part of the Arc of Louisiana’s dual diagnosis grant workgroup and has worked collaboratively with the group to develop a Clinicians Guide to Accessible Behavioral Health Treatment for individuals with IDD and co-occurring behavioral health needs.

5. Do corrective actions carry a cost?

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Most of these actions do not carry a cost. The Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana) Operational Protocol funds the approved training and capacity building efforts with federal demonstration dollars. As we recruit additional clinicians and/or technical assistance staff into state service systems, they do not carry a cost because most new positions in OCDD are existing positions diverted from institutional services. They do not incur a cost when the focus is on community, non-public capacity building. Costs are associated with new services such as ABA, START and enhanced waiver services. However, those costs are likely offset by the cost of failure to implement corrective actions such as:

- Failure to intervene at the community level can result in extensive additional institutional treatment costs,
- Failure to intervene with persons with autism at an early age results in extensive lifelong service costs estimated at over \$1 million per person, and
- Families and taxpayers incur these costs.

Additionally, the funding for the START contract will occur through federal ARPA dollars.

### **Information Technology (IT) Upgrades/Modernization Project**

#### A. Problem/Issue Description

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

OCDD's information technology (IT) software and equipment are out-of-date and need a system upgrade and modernization. Many applications and databases need a redesign or major revisions, and OCDD needs to update equipment. Modernization is necessary to allow for automation of processes requiring access by multiple internal and external users. The lack of up-to-date IT equipment and programming hampers OCDD's system transformation efforts.

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

Yes. In some way, OCDD's outdated IT system negatively affects all six goals because OCDD needs better resources to make improvements. This problem directly impedes Goal V (To implement an integrated, full-scale data-driven quality enhancement system).

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

This problem affects all OCDD units to varying degrees. IT upgrades and modernization would improve the efficiency of all work units within OCDD.

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

The people supported by OCDD and their families, providers, support coordination agencies, and other stakeholders are indirectly affected. OCDD is unable to implement an updated person-centered planning process without the ability to allow for multiple users and storage for automated assessments and plans of support.

5. How long has the problem or issue existed?

The problem has existed for a number of years, but has exacerbated in the past year due to the need for higher system requirements to accomplish major initiatives.

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

The lack of funding has significantly hampered the OCDD IT Upgrades/Modernization project. Although OCDD requested funding during the state budgeting process, LDH chose not to fund the project.

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

Development and implementation of person-centered software such as OCDD's electronic Individual Support Plan (eISP) and OCDD's Quality Enhancement system remain priorities and are critical to the next steps in system transformation. This will delay the project, and will significantly affect progress in meeting established OCDD goals and objectives absent additional funding.

## B. Corrective Actions

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

No. If not, skip questions 2-5 below.

Yes. If so, complete questions 2-5 below.

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

OCDD needs funding to implement, test, correct, and maintain the data infrastructure necessary to implement the eISP; build a proposed electronic developmental disability health record; and redesign the current quality enhancement integrated database. OCDD needs a full-time programmer and additional funding to replace older equipment. OCDD needs funding to address larger systemic issues to implement major initiatives related to the planning process for individuals with developmental disabilities served by HCBS waivers.

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

Yes, this issue was identified in previous management and program analysis reports, and has remained in the report since at least 2017.

4. Are corrective actions underway?

OCDD requested funding in the FY 2024-2025 budget. LDH has allocated money from the American Rescue Plan Act (ARPA) to provide OCDD with necessary resources to begin the process of building or obtaining the desired system and technology. OCDD might also need resources to help make the move to new systematic program coding to make existing systems compatible with the new IT system upgrades.

5. Do corrective actions carry a cost?

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Yes. To resolve the issue, OCDD must have funding for a salary for another full-time programmer. Funding for equipment upgrades and system modernization are also required. This cannot be managed with the current TO and budget.

### **Ongoing cost associated with facilities that have been closed, vacated, or privatized**

#### A. Problem/Issue Description

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

Over the last 19 years, eight former state-operated supports and services centers for people with developmental disabilities have either privatized their operations or closed in ongoing efforts to serve people in the least restrictive settings in their communities. OCDD continues to bear responsibility for the ongoing costs associated with four of these eight facilities. These costs generally include:

- acquisitions and major repairs,
- the payment of risk management premiums,
- building and grounds maintenance, utilities, and/or loss prevention/ security, and
- ongoing (or legacy costs) including the employer share of group insurance benefits for retirees.

As of FY 2025, these expenditures require a state general fund appropriation to the OCDD budget to maintain.

2. Is the problem or issue affecting the progress of your strategic plan?

No, OCDD noted the direct impact to the strategic plan to the extent these costs are billed at the appropriated level. Should billing exceed the amount set aside for these costs, services would be impacted if funds had to be moved from other areas to meet the mandated costs.

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

Not applicable.

4. Who else is affected by the problem?

The OCDD budget is impacted.

5. How long has the problem or issue existed?

OCDD identified this issue in 2010.

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

The issue results from the mandatory expenditures mainly associated with duties and costs for state-owned property insured by the Office of Risk Management (ORM) and mandated group insurance costs for retirees from now closed institutions.

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

The consequence of this issue is the continued expenditure of funds to maintain properties that OCDD no longer uses. These expenditures may cause cash flow shortfalls in future fiscal years to the extent that billing for these costs exceeds the appropriated funding.

B. Corrective Actions

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

No. If not, skip questions 2-5 below.

Yes. If so, complete questions 2-5 below.

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

LDH should pursue an alternative use for the facilities, such as:

- the transfer of state-owned property to other state, parish, or local governing departments/offices for an alternative public good, and/or
- the usage of state-owned property as revenue generating property.

If not, the state can propose to sell the properties, however sections of all facilities contain asbestos that will require abatement. All corrective actions listed above may require an amendment to rule or law.

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

Yes. OCDD has made the same recommendations in this report since FY 2009-2010.

4. Are corrective actions underway?

Yes. Corrective actions are underway.

For closed facilities costs, OCDD is working to identify potential alternate uses for all properties that are unoccupied (or will be unoccupied due to downsizing) in accordance with ORM guidance. The Opelousas property is in process of sale. The Arc of Acadiana property is in process of surplus. LDH demolished the Hammond/North Lake property following major repairs associated with Hurricane Ida.

For legacy costs associated with mandated group insurance premiums for employees who retired from now closed institutions, Act 119 of the 2021 Regular Session appropriated less than full funding from the State General Fund, placing a greater burden the revenue stream at the state-operated facilities.

5. Do corrective actions carry a cost?

No. If not, please explain.

No. There are no anticipated direct costs related to researching. Existing staff would develop amendments to existing legislation. Failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings and facilities. Additional resources are necessary to the extent that the revenue stream at Pinecrest is unable to fund the costs over and above the State General Fund appropriation.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
- b. How much has been expended so far?
- c. Can this investment be managed within your existing budget? If so,

does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

- d. Will additional personnel or funds be required to implement the recommended actions? If so:
- Provide specific figures, including proposed means of financing for any additional funds.
  - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

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

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

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

- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)**  
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
- In-house performance accountability system or process**  
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.
- Benchmarking for Best Management Practices**  
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.
- Performance-based contracting (including contract monitoring)**  
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

- Yes. Proceed to Section C below.

No Skip Section C below.

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

1. Title of the Report or Program Evaluation:

*National Core Indicators Survey.* NASDDDS and the Human Services Research Institute (HSRI) co-sponsor the National Core Indicators (NCI) project. Forty-eight states and the District of Columbia contribute survey data on individualized cycles for each NCI annual survey period. The NCI surveys focus on core indicators, which are standardized measures used to assess outcomes in key areas like employment, rights, service planning, community inclusion, health and safety and choice for individuals with intellectual and developmental disabilities.

2. Date completed: August 12, 2025

HSRI and NASDDDS will make the final reports for the survey cycle that ended on June 30, 2025 available to Louisiana in January 2026.

During the survey cycle FY 24/25, OCDD had a contractor to complete two surveys: the Child Family Survey and the Adult in Person Survey. In addition, OCDD participated in the NCI State of the Workforce Survey.

**Child Family Survey Process:**

Beginning March 2025, the OCDD contractor mailed more than 5,000 Child Family Survey packets to the families of children from birth to 18 years for the parents or guardian to complete.

**Adult In-Person Survey Process:**

The contractor contacted adults 18 and older and asked if they would like to participate in the NCI In-Person Survey from the survey sample population.

**State of the Workforce Survey Process:**

OCDD sent electronic invitations via the NCI portal to provider agencies for the NCI Workforce Survey (previously called the Staff Stability Survey) in February 2025. NCI also extended the final response entries for the State of the Workforce Survey from June 30, 2025 to July 31, 2025.

3. Subject or purpose and reason for initiation of the analysis or evaluation:

NCI uses standardized surveys to assess the quality of services for participants with intellectual and developmental disabilities. Surveys were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. The surveys gather information on various aspects of the lives of the participants served by the states developmental disabilities system. Analyses compared Louisiana statewide results with results of other states participating in the NCI project. During the 2024-2025 survey cycle, OCDD chose to conduct the Child Family survey in which the contractor was able to complete 355 surveys. OCDD also completed the NCI In-Person Survey in which we

completed 457 surveys.

In addition, OCDD participated in the NCI State of the Workforce Survey. 176 State of the Workforce Surveys were completed. All the information from these three surveys will be included in the NCI national data. OCDD has participated in the NCI State of the Workforce Survey for eight consecutive years. NCI instituted this survey to address the concerns that surfaced in HSRI and NASDDDS about the instability of the direct care service workforce across the United States. Concerns center on wages, benefits, career opportunities, work environment, and educational opportunities for the workforce of caregivers. The NCI State of the Workforce Survey is an online survey through an NCI portal that is accessed by licensed service provider administrators of agencies supporting adults with I/DD in residential, employment, day services, and other in-home or community inclusion programs. The survey captures information about wages, benefits, and turnover of the direct support staff hired by the agencies. The survey is voluntary, but OCDD strongly encourages providers to complete the survey in order to obtain the most comprehensive data about the conditions that exist in Louisiana. OCDD only has access to the aggregate data collected and reported by NCI.

4. Methodology used for analysis or evaluation:

Previous year's data, as current data year's data will not be available until January 2026.

The public can access the results for the Louisiana Child Family Survey Report for 23/24 at <https://idd.nationalcoreindicators.org/wp-content/uploads/2025/07/LA-23-24-CFS-Report.pdf>.

This report provides an aggregated summary of the survey results. It was mailed to families of children living and receiving developmental disability services in the family home, and provides comparisons between Louisiana and the national average of other participating states.

OCDD did not participate in the in-person year for the previous year's survey cycle; therefore, the data is not available.

The public can access the Louisiana State of the Workforce Report at [https://idd.nationalcoreindicators.org/wp-content/uploads/2024/11/2023-NCI-IDD-SoTW\\_241126\\_FINAL.pdf](https://idd.nationalcoreindicators.org/wp-content/uploads/2024/11/2023-NCI-IDD-SoTW_241126_FINAL.pdf). Louisiana data was included in the NCI national report. This report helps state developmental disabilities systems examine workforce challenges; identify areas of further investigation; provide opportunities for states to benchmark their data; and make improvements to policies and practices. This survey collects data about wages, turnover, recruitment/retention, and benefits.

The OCDD Quality Section is continuing to explore ways to increase the online participation rate for NCI surveys.

5. Cost (allocation of in-house resources or purchase price):

The OCDD contractor completed the Child Family and the In Person Survey.

The total amount paid to the contractor was \$228,893.65. NCI emailed a link to providers to complete the survey online, so there were no additional costs for the NCI-Workforce survey.

6. Major Findings and Conclusions:

The preliminary review of the 2024-2025 Family Survey suggests feedback from family members of service participants still reflects the challenges that families face finding and keeping direct care staff. The 2024-2025 NCI Survey cycle findings will be available in January 2026.

7. Major Recommendations:

OCDD should formulate strategies to promote online participation in the Family Surveys for the 2025-2026 survey cycle by offering families additional support to use the technology. OCDD can offer that support through phone contact, a dedicated email site, and web-based tutorials. The OCDD Quality section is currently exploring different potential resources for compiling the provider list. The list of invitees is extremely important in order to reach the correct target audience, minimize redundancy, and allow for a strong base in which to calculate the statistically significant return rate of = or <5%. OCDD should also consider continuing to offer incentives for providers to complete the State of the Workforce Survey. This last survey cycle was the highest number of providers to complete the State of the Workforce Survey.

8. Action taken in response to the report or evaluation:

OCDD matched survey information with CMS measures in the HCBS Settings Rule. The rule addresses community participation and employment goals for persons with developmental disabilities receiving HCBS.

OCDD reviews NCI data along with other sources, like regional performance indicators from the Human Services Accountability Plan and data from EarlySteps and HCBS waiver performance indicators, as part of its quality improvement process. A workgroup of OCDD Quality staff examines the data to identify trends. OCDD develops and implements quality improvement projects when OCDD identifies trends or patterns.

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

<https://www.nationalcoreindicators.org/>

10. Contact person for more information:

Name: Pam Sund

Title: Program Manager 3

Agency & Program: OCDD Quality Section

Telephone: 225-342-5646

E-mail: [Pam.Sund@la.gov](mailto:Pam.Sund@la.gov)

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-350 (Agency 350 & Office on Women’s Health and Community Health - OWHCH)

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Deputy Assistant Secretary:** **Courtney A. Highshaw**

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

#### Accomplishment #1: Publication of the Women’s Health Resource Map

- A. What was achieved?  
Publication of the Women’s Health Resource Map
- B. Why is this success significant?  
The publication is significant because it centralizes access to services, empowers women with information and strengthens care coordination across the state.
- C. Who benefits and how?  
The priority is for the resources to be leveraged as a guide to serve as support tailored to meet the needs of women across the state of Louisiana. Also understanding that supporting women includes allies and support across gender lines which would include all constituents of Louisiana. In return the Interactive Resource Map is used to support all constituents in Louisiana and to better assist women in access resources.
- D. How was the accomplishment achieved?  
By creating a list of resources available throughout the state and working with the data analysis team in creating the map but also partnering with The Office of Behavioral Health (OBH) and BFH (Bureau of Family Health/OPH) to keep the list the most up to date. The resource map serves as an interactive tool that allows users to filter resources

shown by category and provides contact information for each facility listed.

- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)  
Yes
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?  
Yes

### Accomplishment #2: Maternal Mental Health

- A. What was achieved?  
Maternal Mental Health Awareness Week Proclamation
- B. Why is this success significant?  
The constituents of Louisiana are informed on the importance of Maternal Mental Health Awareness Week, with data, Louisiana's rank as it pertains to maternal mortality as well as the leading causes of death of postpartum death.
- C. Who benefits and how?  
The constituents of Louisiana specifically women, men and advocates supporting causes towards researching and implementing strategies on how to reduce preventable maternal deaths.
- D. How was the accomplishment achieved?  
Through requesting the governor to designate a specific day in May for Maternal Mental Health Awareness Day in Louisiana and recognize the commitment of Woman's Hospital to provide mental health services to pregnant and postpartum women in Louisiana.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)  
Yes
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?  
Yes

## **II. Is your department Five-Year Strategic Plan on time and on target for**

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

- ◆ **Please provide a brief analysis of the overall status of your strategic progress.** The strategic plan identified an approach that allows OWHCH to set clear goals as it pertains to empowerment, collaboration, integrity and compassion. The Office on Women’s Health and Community Health (OWHCH) is dedicating to creating a healthcare landscape where every woman can access the care, support, and education that women need to thrive. The effectiveness of the strategies are aligned with the office’s approach.
- ◆ **Where are you making significant progress?**
  - **Program A: Administration and Support**
    - Maintain accurate and transparent financial processes to support budget management, timely procurement, and compliance with state and federal regulations.  
Progress: On Track
    - Facilitate timely communication and logistical support for stakeholder meetings, legislative updates, and community education.  
Progress: On Track
    - Deliver accessible education on key women’s health topics, including chronic disease prevention, mental wellness and nutrition.  
Progress: On Track
    - Collaborate with local health providers, schools, faith based-groups, and organizations to expand reach.  
Progress: On Track
    - If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
      1. To what do you attribute this success? For example:
        - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
          - No, for the goals to be on track, intentional actions were required to accomplish the goals. Strategic planning, trackers to identify and track milestones, and quality checks to measure effectiveness.
        - Is progress directly related to specific department actions?

- Collaboration with Well Ahead/Well Woman/BFH/LaPQC/Medicaid have been instrumental in continued collaboration and support.
      - Financial resources have been allocated to improve maternal health outcomes through, Remote Patient Monitoring, Identifying Birthing Places, and Alliance for Innovation on Maternal Health (AIM) Patient Bundles. Working with the data technology team to establish a value based payment system as well as a system similar to an HIE (Health Information Exchange) system.
    - Facilitate timely communication, logistical support, accessible education and collaboration with local health providers and organizations to expand reach as it pertains to community education.
      - Communication education through the Maternal Wellness Days for rural communities (R1 and R8). To stand up the community events it required community partnerships (therapists, yoga enthusiasts, nutritionist), effective communication for social media blast with BMAC/Graphics (agenda and flyers), and logistical efforts to ensure seamless transitions from location to location.
    - Advance and align women's health policy initiatives by providing administrative support and coordination to ensure departmental consistency.
      - Participating on Women's Policy and Research Commission and Children's Cabinet Advisory Board Meeting to make recommendations as it pertains to recommendations on policies to be submitted to legislative members.
- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
  - The progress is related to multi department collaboration. As the project director it's extremely imperative to leverage departments that have systems in place to support the various initiations. For the OWHCH to act solely it would require re-inventing the wheel versus collaborating to reduce duplicative efforts.
  - Facilitate timely communication, logistical support, accessible education and collaboration with local health providers and organizations to expand reach as it pertains to community education.

- Well Ahead/BFH/LaPQC/Medicaid have been instrumental in ensuring that resources are deployed. The department's contribution solely provided the logistic and direction to execute multi events conducted statewide.

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

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

1. To what do you attribute this lack of progress? None

For example:

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

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

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

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

No. If not, why not? Changes are not needed at this time.

- ♦ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Each member of the OWHCH team plays a role in the efficiencies and

effectiveness of the deliverables of the office. The strategic plan is not just a document but a living, operational tool that guides discussion during our 1:1's and allows our initiatives to be lead with the overall goal and strategy in mind. With the strategic plan being an operational tool it also assists with communication, continuous improvement and the team's alignment.

### III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend? None

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

#### A. Problem/Issue Description

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

#### B. Corrective Actions

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

No. If not, skip questions 2-5 below.

Yes. If so, complete questions 2-5 below. Do not delete any questions.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
  - a. If so:
    - What is the expected time frame for corrective actions to be implemented and improvements to occur?
    - How much progress has been made and how much additional progress is needed?

b. If not:

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

5. Do corrective actions carry a cost?

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

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

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

A. Check all that apply. Add comments to explain each methodology utilized. Some examples have been provided.

**Internal audit**

**The LDH Office on Women’s Health and Community Health ensures ongoing monitoring and administrative functions.**

**The Office on Women’s Health and Community Health**

**1. Financial Audits: Working with Budget and Fiscal Teams:**

- a. Auditing travel reimbursements, P-Card Purchases/Receipts.
- b. Matching budget allocations to actual spending for variances

**2. Operational Efficiency Audits**

- a. Assessing staffing and workload distribution

**3. Performance & Outcome Audits**

- a. Checking alignment between strategic plan goals vs. actual performance.
- 4. Payroll & Time Keeping (Prevention of Payroll Fraud)**
  - a. Verifying accuracy of entered records in payroll system.
  - b. Evaluating employee leave balance and proper use of leave codes.
- 5. Grants Management Audit**
  - a. Reviewing drawdowns and funds usage
  - b. Checking documentation for deliverables, reporting timelines and spending accuracy.

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

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

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

- Policy, research, planning, and/or quality assurance functions in-house
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)**  
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.
- In-house performance accountability system or process**

The 5 year strategic plan is leveraged by translating long-term goals into annual priorities, aligning budgets and staffing around priorities. Monday.com, 1:1's annual reviews and team meetings ensure the plan drives weekly decision making. Each year, OWHCH's goals are reviewed along with the 5-year strategic plan to ensure goals are met. This process ensure the 5-year plan remains actionable, adaptive and the foundation of our operational and budget decisions. Also, realizing that there may come a time where the 5 year strategic plan may need to be adjusted due to the direction of the LDH.

**Benchmarking for Best Management Practices**

The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

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

LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

Peer review

Accreditation review

Customer/stakeholder feedback

Other (please specify):

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

Yes. Proceed to Section C below.

No Skip Section C below.

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

For each report, please discuss and explain each item below.

Please type your answer **below** or **next to** the stated question; do NOT delete any of the questions.

1. Title of Report or Program Evaluation:

2. Date completed:

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

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-375 (Imperial Calcasieu Human Services Authority)

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Assistant Secretary/Executive Director:** Tanya McGee

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

#### Accomplishment #1: SWLA Behavioral Health Pipeline

- A. What was achieved?  
ImCal HSA, in partnership with McNeese State University, manages the Southwest Louisiana (SWLA) Behavioral Health Pipeline Program. This initiative provides stipends to master's-level students in McNeese's *Master of Science in Clinical Mental Health Counseling* program during their practicum and internship placements. Participating behavioral health providers also receive stipends for offering clinical supervision, ensuring quality training while reducing financial burden for both students and providers.
- B. Why is this success significant?  
Southwest Louisiana faces a critical shortage of behavioral health professionals, creating barriers to care across the region. This program directly addresses the shortage by increasing the number of students able to complete their clinical training and graduate with a master's degree in counseling. The program has expanded rapidly, growing from 10 interns to 26 interns and 4 provider sites to 15 sites in just 3 years, with continued growth expected.
- C. Who benefits and how?  
Students benefit through financial support that makes it more feasible to participate in

the unpaid internships required for graduation.

Provider agencies benefit from stipends that incentivize supervision, strengthen their role in workforce development, and create a direct pipeline of trained professionals to meet staffing needs.

The broader SWLA community benefits from an expanded pool of qualified behavioral health professionals, improving access to timely, high-quality care.

D. How was the accomplishment achieved?

ImCal HSA identified grant opportunities, supported McNeese State University Foundation in securing funding, and coordinated with local behavioral health providers to build and sustain program partnerships.

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

Yes. Addressing workforce shortages is a core priority of our strategic plan. By expanding the pipeline of licensed and unlicensed therapists, this program directly supports long-term goals to strengthen behavioral health staffing capacity in Southwest Louisiana.

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

Yes. The program demonstrates the value of building strong partnerships with local colleges and universities to develop a steady pipeline of professional-level staff. In addition, proactively identifying and leveraging funding streams is a replicable strategy that ensures sustainability and maximizes community impact.

## Accomplishment #2: LA Bridge Program Expansion

A. What was achieved?

ImCal's LA Bridge program, launched in 2021, aims to provide accessible, evidence-based addiction treatment in emergency departments. LA Bridge is currently operational in Calcasieu and Jefferson Davis parishes and focuses on three main components:

- Rapid buprenorphine initiation for opioid use disorder in the emergency department.
- Creating a harm-reduction overdose prevention, stigma-free culture in the emergency department.
- Linking patients to ongoing medication assisted treatment (MAT) through trained Substance Use Navigators (SUNs) who have lived experience.

In FY 24-25, the LA Bridge program assisted individuals with substance use disorders, successfully linking 73% to outpatient care. In its year of inception, LA Bridge served 34 individuals in hospital emergency departments. In under 3 years, the program expanded from one hospital to 5 hospitals and served 457 individuals in 2024, with projection to serve 576 in 2025. Beyond assisting with opioid use disorders, the SUNs offer care navigation to all individuals seeking abstinence from all substance use. The LA Bridge team has developed relationships with treatment providers across SWLA and statewide to offer the best fit for the person served. In FY24-25, LA Bridge began focusing efforts to maternal health and ensuring pregnant women and women 12

months post-partum get access to MAT services which is in alignment with LDH's Project MOM initiative. The success of ImCal's LA Bridge program has piqued interest across Louisiana and statewide expansion efforts are underway.

B. Why is this success significant?

In Calcasieu Parish, deaths due to overdose decreased by 47% from 2021 to 2024. This is a direct result of the successful implementation of LA Bridge in 5 local hospitals.

C. Who benefits and how?

Individuals with substance use disorders who are at risk for overdose.

D. How was the accomplishment achieved?

ImCal partnered with the Region V Office of Public Health, SWLA Area Health Education Center, Lake Charles Memorial Hospital, CHRISTUS-Oschner Lake Area Hospital, West Calcasieu Cameron Hospital, Oschner Jennings American Legion Hospital, the Partnership for a Healthier SWLA, and recently the LA Perinatal Quality Collaborative and the Region V Department of Children and Family Services to develop and implement strategies to address Substance Use Disorder (SUD) in high risk populations.

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

Yes. Expansion of Behavioral Health services, particularly relating to SUD

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

Yes. LA Bridge is modeled after the National Bridge program and has been implemented across the country in several states.

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

Imperial Calcasieu Human Service Authority (ImCal HSA) is on time and on target to meet the goals and objectives set within our 5-year strategic plan. The mission of ImCal HSA is that citizens with mental health, addictions, and developmental challenges residing in the parishes of Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis are empowered, and self-determination is valued such that individuals live a satisfying, hopeful, and contributing life. This mission is accomplished through ImCal's Administrative, Behavioral Health and Developmental Disability Activities. ImCal HSA makes use of best practices in implementing, evaluating, monitoring, modifying existing services so that quality is assured; services meet the needs of those served; and the variety of services available

adequately address the range of behavioral health issues identified and are further developed to address service gaps.

**Imcal Agency Goals:**

- I. Increase public awareness and to provide access to care for individuals and their families who are in need of behavioral health and developmental disabilities services.
  - II. To ensure that services provided are responsive to client needs, based on evidence-based best practices, and that programs afford the client a continuum of care taking into consideration cultural diversity and abide by all State and Federal guidelines.
  - III. To promote healthy, safe lives for people by providing leadership in educating the community on the importance of prevention, early detection and intervention, and by facilitating coalition building to address localized community problems.
- ♦ **Where are you making significant progress?** If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department’s contribution to the joint success?
    - Other? Please specify.
  2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

ImCal HSA continues to make steady progress in all three Program Activity areas. Outside of the three accomplishments described in Section I. above, while ImCal has not significantly exceeded any stated objectives and strategies, we have made steady and efficient progress in all objectives and strategies as indicated in our 5-year plan. This becomes more and more difficult to accomplish with the increase in need for services within the community and lack of licensed professionals to fill the need.

- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state “None.” However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall

significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

1. To what do you attribute this lack of progress? For example:
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
    - Is the lack of progress due to budget or other constraint?
    - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
    - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?  
None
- ♦ **Has your department revised its strategic plan to build on your successes and address shortfalls?**
- Yes. If so, what adjustments have been made and how will they address the situation?
- No. If not, why not?
- ♦ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

ImCal HSA ensures its strategic plan is coordinated, reviewed, and utilized across all organizational levels through a comprehensive Performance Improvement Program led by the Executive Management Team (EMT). This program integrates ongoing data collection, stakeholder feedback, and community collaboration to assess service effectiveness, resource allocation, and operational performance. Strategic goals from the 5-year Strategic Plan and Annual Operational Plans guide the development of annual Business Plans, which are implemented across all divisions through targeted activities and continuous quality improvement efforts. Data is collected and analyzed on a quarterly basis to support decision-making and future planning. Findings are shared with internal and external stakeholders through reports, surveys, and public forums, ensuring transparency, accountability, and alignment with ImCal's mission and values.

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

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

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

#### A. Problem/Issue Description #1: **Recruitment and retention of licensed, billable professionals.**

1. What is the nature of the problem or issue?  
Persistent shortages of licensed counseling professionals have significantly impacted ImCal’s ability to recruit and retain qualified staff. Limited budgetary resources make it difficult to offer competitive salaries compared to the private sector. Insufficient licensed staff not only reduces the scope of services available to the community but also prevents ImCal from maximizing self-generated revenue, which is an important financial safeguard during periods of budgetary constraint.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)  
Not at this time
3. What organizational unit in the department is experiencing the problem or issue?  
All clinics within the Behavioral Health Division.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)  
Low-income individuals, including Medicaid members and uninsured or indigent individuals supported by state general funds or federal block grants, are most affected by shortages of qualified providers. Rural residents are also disproportionately impacted, as they already face limited access to behavioral health services.
5. How long has the problem or issue existed?  
This is a longstanding issue that has intensified over the past several years, with further strain following Hurricanes Laura and Delta in 2020.
6. What are the causes of the problem or issue? How do you know?  
National data confirm that fewer individuals are entering lower-paying helping professions such as counseling. Locally, ImCal has experienced direct challenges recruiting licensed professionals despite consistent efforts to fill vacancies.

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

Without resolution, ImCal's ability to meet its mission of ensuring a comprehensive continuum of care will be compromised. Service capacity could be negatively impacted, revenue potential reduced, and the region's critical shortage of behavioral health providers perpetuated..

#### B. Corrective Actions

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

No. If not, skip questions 2-5 below.

Yes. If so, complete questions 2-5 below..

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

ImCal has hired provisionally licensed providers through job appointments, allowing us to sustain services despite staffing shortages. While unlicensed providers are now billable, reimbursement rates remain significantly lower than those of fully licensed staff. To remain competitive in a BH Managed Care environment, ImCal must be able to recruit and retain fully licensed professionals who can maximize revenue and stabilize service delivery.

The SWLA Behavioral Health Pipeline Program has also been leveraged as part of the solution, supporting graduate students through internships and creating a feeder system into the local workforce. While this expands the pool of future professionals, competitive salaries and stable positions are still required to retain them once licensed.

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

Yes. Staffing challenges including recruitment, retention, limited TO, Civil Service constraints, and non-competitive pay have been documented in every annual report.

4. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur?
- How much progress has been made and how much additional progress is needed?

b. If not:

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

Hiring unlicensed professionals has eased staffing shortages and allowed ImCal to

maintain service delivery, but it has also reduced revenue since reimbursement rates are lower than for fully licensed providers. While these staff strengthen the workforce pipeline and are progressing toward full licensure, long-term improvements depend on converting job appointments into permanent positions and securing funding for competitive salaries to ensure retention once licensure is achieved.

5. Do corrective actions carry a cost?

Yes. While unlicensed providers help sustain services, they generate lower revenue, and retention becomes a challenge once they achieve full licensure. If ImCal cannot offer competitive salaries or permanent TO positions, the investment in their training and professional development may be lost.

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)

Please discuss the following:

a) What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.

Salary and benefits for the unlicensed professionals

b) How much has been expended so far?

FY24 \$326,149

c) Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

Yes

d) Will additional personnel or funds be required to implement the recommended actions? If so:

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

No.

A. Problem/Issue Description #2: Continued displacement of Administrative and Developmental Disabilities offices due to Hurricane Laura in 2020.

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

Hurricane Laura destroyed the building which housed the Administrative and Developmental Disabilities office. Temporary space was acquired with the expectation that our building would be repaired within 18-24 months which continued to be extended until finally it was revealed that the building would be condemned and destroyed. The building was demolished in September of 2024. The temporary space is very small and most employees are still working from home, despite the need for some to return to an in person setting. There is no

conference or meeting space. Records had to be moved to the Region V Public Health Unit. This requires staff to travel from home, office and the health unit to complete their work which is not efficient and taking its toll on staff burnout. Cost per square foot of a new location exceeds previous rental by annual cost of \$436,000.

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

No

3. What organizational unit in the department is experiencing the problem or issue? Administration and Developmental Disabilities.

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

Individuals served in our DD Division. There is limited space at the DD office to see individuals who are accessing services. Visits must be scheduled around one small screening room. ImCal Board of Directors are unable to meet at Admin office due to lack of space. Moved Board meetings to OPH Regional Office. ImCal leadership has no private meeting areas therefore is using a group therapy room at our Lake Charles BH clinic for most meetings. We have not had the option to bring staff back to in-person work after the pandemic ended due to continued displacement.

5. How long has the problem or issue existed?

Hurricane Laura, 08/26/2020

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

Destruction of office building, limited options and increased cost for rental space.

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

Staff burnout, inefficient work processes and procedures due to multiple work areas in various buildings across town.

## B. Corrective Actions

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

No. If not, skip questions 2-5 below.

Yes. If so, complete questions 2-5 below.

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

ImCal HSA has purchased a plot of land on which to build a new office, large enough to house our DD and Admin offices and went out on bid for construction of new building. Before bid was awarded, an opportunity to purchase a historic building in downtown Lake Charles was made available. With the opportunity to receive, and in-turn sell, historic tax credits, the purchase and renovations to this building is a substantially lower cost than new building construction.

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

This issue has been on our plan since 2020. ImCal has had to change and adapt strategies on an ongoing basis as options change.

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

ImCal purchased the building in March 2025 and is currently awaiting approval from the Calcasieu Parish Police Jury to utilize the Calcasieu Parish Trust Authority as the venue to secure revenue bonds to fund the renovation.

4. Do corrective actions carry a cost? Yes, corrective actions would carry a cost.

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue?

(For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.  
The cost to purchase and renovate the Housing Authority Building is estimated at \$8,794,287
- b. How much has been expended so far?  
none
- c. Can this investment be managed within your existing budget?  
No, this investment can't be managed.  
If so, does this require reallocation of existing resources?  
If so, how will this reallocation affect other department efforts?
- d. Will additional personnel or funds be required to implement the recommended actions? If so:
  - Provide specific figures, including proposed means of financing for any additional funds.  
Additional increase of \$436,000 from SGF
  - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?  
Yes, it was requested in FY25 and \$192,000 was awarded. An additional \$221,000 is being requested for FY27.

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

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

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

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

**Performance Progress Reports (Louisiana Performance Accountability System)**

The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis

for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

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

Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

**Benchmarking for Best Management Practices**

The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

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

LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

Peer review

Accreditation review

Customer/stakeholder feedback

Other (please specify):

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

Yes. Proceed to Section C below.

No Skip Section C below.

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

1. Title of Report or Program Evaluation: ORM Audit
2. Date completed: 02/18/2025
3. Subject or purpose and reason for initiation of the analysis or evaluation:  
Annual audit by Office of Risk Management
4. Methodology used for analysis or evaluation: onsite visit
5. Cost (allocation of in-house resources or purchase price): 0
6. Major Findings and Conclusions: none
7. Major Recommendations: none
8. Action taken in response to the report or evaluation: none
9. Availability (hard copy, electronic file, website):
10. Contact person for more information:  
Name & Title: Tanya McGee  
Agency & Program:  
Telephone:  
E-mail:

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

**Department:** Louisiana Department of Health (LDH)  
09-376 Central Louisiana Human Services District

**Department Head:** Bruce D. Greenstein  
LDH Secretary

**Undersecretary:** Drew Maranto

**Executive Director:** Rebecca Craig

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

#### Accomplishment #1: Full Implementation of TANF-Funded Residential Treatment Program for Women and Children:

**A. What was achieved?**

In fiscal year (FY) 25, Central Louisiana Human Services District (CLHSD) launched a new Temporary Assistance for Needy Families (TANF)-funded residential treatment program for pregnant and parenting women with substance use disorders and their dependent children. The program offers 24/7 residential treatment, trauma-informed care, evidence-based interventions, and wraparound supports to promote family recovery and stability. In its first six months, the program served 44 unduplicated individuals (23 children and 21 adults).

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

This marks the first time a residential treatment program of this nature has operated in the CLHSD region with a dedicated focus on women and children since May 2019. It fills a major service gap, provides whole-family care, and integrates health, housing, education, and recovery resources into one setting.

**C. Who benefits and how?**

Women participating in the program receive individualized treatment planning,

therapeutic services, case coordination, and direct connections to housing, education, and employment opportunities, helping them rebuild stability and independence. Children benefit from comprehensive developmental assessments, therapy groups, and tailored care plans designed to address their unique needs.

Early program outcomes demonstrate a clear positive impact: all women discharged between April and May were employed or enrolled in school one month later, and the majority (83%) reported a reduction in the frequency of primary drug use. Among children served, 60% of those ages 0–5 showed improved developmental assessment scores, while 65% of those ages 6–18 demonstrated improved problem scores during treatment. These results highlight the program’s effectiveness in supporting both immediate recovery goals and longer-term family well-being.

The broader community also benefits as the program supports family reunification, reduces foster care placements, and decreases reliance on emergency services. By addressing the root causes of instability for women and children, the program promotes safer, healthier neighborhoods and reduces the long-term social and economic costs associated with untreated substance use disorders.

- D. How was the accomplishment achieved?  
CLHSD developed and executed a contract with Louisiana Health and Rehab Center, Inc., supported licensing and accreditation, and oversaw phased implementation (facility readiness, staffing, admissions, and service delivery). The district also provided ongoing technical assistance and monitoring to ensure contract compliance.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)  
Yes, it supports Behavioral Health Goal 1 by improving access to comprehensive, family-focused behavioral health services, and strengthens prevention and early intervention for at-risk families.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?  
Yes, CLHSD’s integration of TANF funding into a holistic, family-centered residential program is a replicable model for other LGEs seeking to address intergenerational impacts of substance use.

### Accomplishment #2: Transition to CareLogic EHR and New Billing Vendor:

- A. What was achieved?  
In FY25, CLHSD transitioned from ICANotes to CareLogic as its primary electronic health record (EHR) and implemented a new billing vendor aligned with the system. This upgrade addressed long-standing technical issues, streamlined workflows, and improved compatibility between clinical documentation and billing functions.
- B. Why is this success significant?

The prior EHR system experienced frequent performance problems that impacted staff productivity and delayed administrative processes. The move to CareLogic, paired with a compatible billing vendor, modernized the agency's infrastructure and reduced reliance on manual workarounds.

C. Who benefits and how?

Clinical staff benefit from a more reliable and user-friendly documentation platform. Fiscal and compliance teams have better system integration between documentation and billing processes, supporting oversight and reducing the potential for errors. Clients benefit indirectly through improved continuity of care when administrative processes run more smoothly.

D. How was the accomplishment achieved?

CLHSD leadership coordinated a phased implementation plan, provided staff training, migrated records, and monitored early system performance to identify and resolve issues quickly. The billing transition was synchronized with the EHR go-live to ensure minimal disruption.

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

Yes, it supports Strategic Objective 2.0 by enhancing technology to improve access, efficiency, and outcomes, and aligns with administrative goals for operational modernization and quality improvement.

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

Yes

### Accomplishment #3: Strengthened Opioid Response:

A. What was achieved?

In FY25, CLHSD expanded its opioid response through continued Narcan distribution, peer navigation in emergency settings, and growth of its medication-assisted treatment (MAT) program. CLHSD distributed 1,677 doses of Narcan—972 through Prevention and 705 through the Louisiana State Opioid Response (LaSOR) Mobile Crisis Team. The Mobile Crisis Team served 385 individuals, including 96 following an overdose, and provided 1,502 one-to-one peer follow-ups. As a result, 266 individuals entered residential or outpatient treatment services after crisis contact. The team also conducted 22 outreach events and 27 speaking engagements to raise awareness of crisis services and opioid recovery resources across Central Louisiana. MAT services grew significantly, with enrollment increasing by 35% from FY24 to FY25.

B. Why is this success significant?

Opioid overdoses remain a critical public health challenge. Expanded access to Narcan saved lives, peer navigation in emergency rooms connected individuals directly to treatment, and MAT expansion provided sustainable recovery options. Together, these

efforts reduced overdose risk, strengthened recovery supports, and improved public health outcomes.

C. Who benefits and how?

Individuals at risk of overdose benefit from immediate access to Narcan and supportive peer engagement that connects them with recovery services. Families and communities benefit from reduced overdose risk, stronger prevention networks, and improved coordination among hospitals, emergency responders, and treatment providers.

D. How was the accomplishment achieved?

CLHSD collaborated with local hospitals, emergency responders, prevention coalitions, and state initiatives such as LaSOR to expand Narcan distribution and strengthen peer navigation in emergency rooms. MAT services were expanded through clinical training, integration into Caring Choices clinics, and improved referral pathways from crisis services to treatment.

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

Yes. It advances behavioral health goals by improving access to treatment, expanding prevention strategies, and reducing the harms of substance use disorders.

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

Yes

#### Accomplishment #4: Expansion of Evidence-Based Practices (EBPs) in Caring Choices Clinics:

A. What was achieved?

In FY25, CLHSD expanded the implementation of evidence-based practices (EBPs) across its Caring Choices clinics. While a number of EBPs were already in use, the district provided additional training opportunities to strengthen fidelity and expand staff competency. The range of EBPs delivered included trauma-focused and manualized therapies such as Eye Movement Desensitization and Reprocessing (EMDR), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Dialectical Behavior Therapy (DBT), Trust-Based Relational Intervention (TBRI), and Acceptance and Commitment Therapy (ACT). Services for substance use disorders were also expanded through Medication-Assisted Treatment (MAT), Motivational Interviewing (MI), Motivational Enhancement Therapy (MET), Contingency Management (CM), and Relapse Prevention approaches. In addition, Peer Support Services and prevention programs were further integrated into clinic operations, both of which are recognized as EBPs due to their demonstrated outcomes in improving recovery and community health.

B. Why is this success significant?

The expansion ensures that clients across all four clinics have access to interventions that are nationally recognized, research-driven, and proven to improve outcomes in

trauma recovery, substance use treatment, and mental health care. By increasing the breadth of EBPs, CLHSD strengthened its capacity to provide individualized, effective care that meets diverse client needs.

C. Who benefits and how?

Clients benefit from access to therapies with demonstrated effectiveness in addressing trauma, emotional regulation, substance use, and family systems challenges. Staff benefit from additional training opportunities that strengthen their clinical skills, enhance job satisfaction, and improve treatment fidelity.

D. How was the accomplishment achieved?

CLHSD invested in training and clinical supervision for staff, integrated EBPs into treatment planning processes within the CareLogic EHR, and reinforced fidelity to EBPs through compliance reviews and peer supervision.

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

Yes, it directly supports Behavioral Health strategic goals by improving treatment quality, increasing recovery outcomes, and aligning clinical care with best practice standards.

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

Yes, systematic expansion and monitoring of EBPs enhances treatment effectiveness and can be replicated by other local governing entities (LGEs) or agencies seeking to improve care quality.

### Accomplishment #5: Completion of Developmental Disabilities Records

#### Digitization:

A. What was achieved?

In FY25, CLHSD completed a multi-year initiative to digitize all central records in the Developmental Disabilities division, converting paper files into electronic format.

B. Why is this success significant?

Digitization modernized records management, improved efficiency, reduced the risk of lost or damaged files, and enhanced staff capacity to quickly access and share records in support of eligibility determinations, waiver monitoring, and family support services. It also reduced reliance on paper and ink, lowering long-term administrative costs and supporting environmental sustainability.

C. Who benefits and how?

Individuals and families benefit from faster, more coordinated services. Staff benefit from streamlined workflows and improved record accuracy.

D. How was the accomplishment achieved?

CLHSD reallocated resources to support staff training and file conversion, prioritized DD record modernization within its strategic goals, and completed conversion in FY25.

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

Yes, it supports Administrative and Developmental Disabilities strategic goals by improving efficiency, sustainability, and service coordination.

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

Yes. Systematic digitization of legacy records is a best practice that enhances efficiency and can be replicated by other agencies.

**II. Is your department Five-Year Strategic Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

CLHSD is generally on target with the 2023–2028 Strategic Plan. While the CareLogic EHR transition ran behind schedule, it was successfully completed in FY25, strengthening technology infrastructure. Additional milestones included the launch of the TANF residential treatment program for women and children, the full digitization of developmental disabilities records, and expanded DD outreach that increased eligibility inquiries. Prevention coalitions remained active across all eight parishes, supporting more than 200 outreach events. Administrative strategies focused on compliance, workforce support, and succession planning to maintain operational stability. Strategies emphasizing collaboration, stakeholder engagement, and data-informed planning have been effective, and returns on investment are beginning to be realized through improved systems, expanded service access, and stronger community engagement.

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

CLHSD made notable progress in implementing new residential treatment services for women and children, completing a multi-year records digitization effort in developmental disabilities, transitioning to a new EHR system, and expanding prevention outreach across all parishes.

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

Progress in FY25 is primarily attributed to deliberate department action, careful oversight, and strong community partnerships. The successful launch of the TANF residential program was achieved through targeted contract management, facility readiness oversight, and technical assistance provided to the contractor. Completion of the developmental disabilities records digitization was the result of a multi-year modernization initiative in which resources were reallocated to support staff training and file conversion. Although the CareLogic EHR transition experienced delays, the accomplishment reflects leadership's decision to replace an underperforming system and to implement a phased rollout supported by intensive staff training. Prevention outreach gains were driven by close coordination with parish-level coalitions and strengthened partnerships with schools, healthcare organizations, and community stakeholders. Together, these efforts demonstrate that the progress realized this year is the direct result of intentional department action, collaboration, and data-informed planning rather than external factors alone.

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

Some of the progress achieved in FY25 represents one-time gains, while other areas are expected to continue building momentum in future years. The digitization of developmental disabilities records was a multi-year initiative that has now been completed; while the work itself will not be repeated, the efficiencies gained will provide lasting benefits in record management and service coordination. The TANF residential program, by contrast, is expected to show continued growth as it stabilizes operations, maintains strong utilization, and produces additional client outcomes in FY26. The transition to the CareLogic EHR was a major milestone, but progress in this area is ongoing as staff become more proficient, reporting functions are refined, and billing processes are fully optimized. Prevention outreach is also positioned for sustained advancement, as parish coalitions are well-established and partnerships with schools, healthcare providers, and community stakeholders are expected to support continued outreach at or above current levels. Overall, while some accomplishments represent completed milestones, most are expected to yield continued progress

and long-term impact.

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

CLHSD continues to face challenges recruiting and retaining administrative coordinator staff in its clinics. These positions are essential to daily operations, and vacancies have created ongoing staffing pressures despite active recruitment efforts. Progress is expected with continued focus on recruitment and retention strategies.

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

The difficulty in recruiting and retaining administrative staff is primarily due to external factors, particularly regional workforce shortages and competition for qualified candidates. These positions are essential to clinic operations, yet applicant pools remain limited, and turnover continues to affect stability. This challenge is not the result of internal management decisions or budget restrictions but reflects broader workforce shortages that are being experienced across the region.

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

This is not a one-time event but an ongoing challenge. Without continued intervention, staffing pressures are likely to persist. CLHSD is actively addressing this through civil service postings, outreach, and retention strategies, and while progress is expected, additional focus will be required in FY26 to strengthen workforce stability.

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

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

CLHSD updated its strategic plan in FY25. The new 2025–2030 plan

closely aligns with the 2023–2028 plan, continuing core priorities such as prevention coalitions, developmental disabilities outreach, workforce development, and technology modernization. While largely an update, the plan reflects both the successes achieved and the ongoing challenges that remain, particularly in workforce recruitment and retention, optimization of electronic health records, and improving access in rural parishes. This ensures that accomplishments are sustained, and areas of shortfall remain active priorities for the years ahead.

No. If not, why not?

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

CLHSD coordinates its strategic plan across all levels of the organization through regular communication between the Executive Management Team, clinic managers, supervisors, and the Board of Directors. The plan is reviewed through quarterly EMT and quality improvement meetings, with progress assessed and strategies adjusted as needed. It is also used to guide budgeting, contract management, and resource allocation to ensure priorities align with identified goals. Performance indicators tied to the plan are tracked through internal monitoring, compliance reviews, and Louisiana Performance Accountability System (LaPAS) reporting, providing data to support management decisions. The adoption of the 2025–2030 Strategic Plan reflects this ongoing process, carrying forward priorities while refining objectives to address workforce, technology, and access challenges.

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

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

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

#### A. Problem/Issue Description

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

CLHSD has continued difficulty recruiting and retaining administrative staff, including administrative assistants and fee assessors, at its clinics. These positions are critical to front-end operations, client flow, and billing processes.

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

Yes. Workforce stability is an administrative priority in the strategic plan, and vacancies in administrative roles affect efficiency and timely service delivery.

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

The problem affects Caring Choices clinics across the district, particularly in locations with higher turnover or fewer qualified applicants.

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

Staff and clinicians are impacted because administrative gaps increase workload and create delays. Clients are indirectly affected through longer wait times and reduced efficiency in scheduling, intake, and billing.

5. How long has the problem or issue existed?

This has been a persistent issue, though it was more pronounced in FY25 due to multiple vacancies and turnover.

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

The issue is primarily caused by regional workforce shortages, civil service pay scales that are less competitive with other employers, and the limited applicant pool in rural parishes. Vacancy postings consistently draw few applicants, and turnover data show higher attrition in administrative roles compared to other positions.

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

Without stable administrative support staffing, clinics face reduced efficiency, delays in processing client information, and added burden on clinical staff. Over time, this could impact client satisfaction, billing timeliness, and progress toward workforce development goals.

## B. Corrective Actions

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

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

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

CLHSD recommends continued use of multiple recruitment channels (civil service postings, social media, employee referrals) and strengthening retention through employee engagement, supervisor support, and workload adjustments. Longer-term strategies may include evaluating compensation and career advancement pathways to make administrative support roles more competitive.

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

4.

Yes. Workforce recruitment and retention have been noted in prior management and performance analysis reports for several years, but the emphasis has typically been on clinical positions. FY25 highlighted administrative support roles as an area of particular concern.

5. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur?
- How much progress has been made and how much additional progress is needed?

b. If not:

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

Corrective actions are currently underway. Recruitment postings and outreach are active, and retention supports have been implemented. To further strengthen these efforts, CLHSD extended its Premium Pay Policy to include Administrative Coordinators, providing an added incentive for recruitment and retention. Improvements are expected to occur gradually over the next 12–18 months as positions are filled and turnover stabilizes. Progress has been made in raising visibility of vacancies, though continued effort is needed to attract larger applicant pools and reduce turnover.

6. Do corrective actions carry a cost?

- No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.

The primary cost is associated with extending the Premium Pay Policy to Administrative Coordinators to support recruitment and retention. The total cost for FY25 was \$3,329.80.

- b. How much has been expended so far?

In FY25, \$3,329.80 was expended.

- c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

Yes. The cost was absorbed within the existing personnel budget and did not require reallocation of resources. No reductions to program services were necessary.

- d. Will additional personnel or funds be required to implement the recommended actions? If so:

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

No additional personnel or funds are anticipated at this time. If workforce challenges persist, CLHSD may consider further adjustments in future budget cycles, but no additional funds have been requested in the current budget.

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

A. Check all that apply.

**Internal audit**

The Compliance Office conducts internal audits, including chart reviews, billing audits, and contract monitoring, to identify issues, ensure compliance, and implement corrective actions.

- External audits (Example: audits by the Office of the Legislative Auditor)**  
Oversight is provided through audits by the Louisiana Legislative Auditor, LDH program monitors, Office of Risk Management, accreditation bodies, and insurance carriers. These reviews validate fiscal integrity, compliance, and service efficiency.
- Policy, research, planning, and/or quality assurance functions in-house  
CLHSD maintains in-house quality assurance through the Executive Management Team, compliance staff, and the Performance Improvement (PI) Committee, which develop policies, monitor outcomes, and align operations with strategic goals.
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff  
Quarterly reports, contract monitoring, and PI reviews are conducted by staff to evaluate outcomes, identify areas for improvement, and guide resource allocation.
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)**  
Performance indicators are reported quarterly through LaPAS, reviewed by management, and used to track efficiency, effectiveness, and progress toward strategic objectives.
- In-house performance accountability system or process**  
An internal PI process monitors indicators quarterly, reviews results at Executive Management Team and PI Committee meetings, and guides changes to improve effectiveness.
- Benchmarking for Best Management Practices**  
CLHSD benchmarks against Commission on Accreditation of Rehabilitation Facilities (CARF) standards, state and federal guidelines, National Outcome Measures, and best practices from other LGEs to strengthen efficiency and service quality.
- Performance-based contracting (including contract monitoring)**  
All CLHSD contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan. Monthly invoice reviews and quarterly evaluations ensure accountability.
- Peer review

CLHSD conducts internal clinical peer reviews and also participates in an annual cross-agency peer review with another LGE, providing external perspective and accountability.

- Accreditation review  
CARF accreditation provides an external review of business and service standards, confirming efficiency, compliance, and quality improvement.
- Customer/stakeholder feedback  
Feedback is collected through Telesage Outcome Measures (TOMS) and C'est Bon surveys, grievance reviews, suggestion boxes, QR code-based surveys, and community coalition meetings. An employee survey is also in development to strengthen staff engagement and identify internal improvement opportunities.
- Other (please specify):

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

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

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

1. Title of Report or Program Evaluation:  
FY25 Annual Performance Analysis
2. Date completed:  
June 30, 2025
3. Subject or purpose and reason for initiation of the analysis or evaluation:  
To evaluate progress toward CLHSD's strategic plan goals, review organizational performance across administrative and program areas, and identify areas for improvement. Required as part of annual PI process.
4. Methodology used for analysis or evaluation:  
Review of PI indicators, LaPAS measures, compliance monitoring, financial analysis, workforce reports, and stakeholder feedback.
5. Cost (allocation of in-house resources or purchase price):  
Completed in-house by compliance staff as part of ongoing PI responsibilities.  
No additional cost.

6. Major Findings and Conclusions:  
Progress achieved in EHR transition, Developmental Disability record digitization, and program expansion (TANF residential). Ongoing challenges remain in workforce recruitment and retention, billing stabilization, and clinic space limitations.
7. Major Recommendations:  
Continue workforce recruitment/retention initiatives, monitor billing processes under new vendor, and explore options for expanded clinic capacity.
8. Action taken in response to the report or evaluation:  
Corrective actions initiated for staffing and billing issues; workforce and compliance oversight remain priorities for FY26.
9. Availability (hard copy, electronic file, website):  
Electronic copy available on request.
10. Contact person for more information:  
Name & Title: Rebecca Craig, Executive Director  
Agency & Program: CLHSD  
Telephone: 318-487-5191  
E-mail: rebecca.craig@clahsd.org

1. Title of Report or Program Evaluation:  
Office of Risk Management (ORM) Compliance Review
2. Date completed:  
February 27, 2025
3. Subject or purpose and reason for initiation of the analysis or evaluation:  
State-required annual audit to assess compliance with ORM risk management standards, safety protocols, and employee training requirements.
4. Methodology used for analysis or evaluation:  
Review of safety records, staff training compliance, incident reporting, and risk management policies. On-site and document-based review conducted by ORM auditors.
5. Cost (allocation of in-house resources or purchase price):  
Completed as part of routine state ORM oversight. No additional costs beyond in-house staff time.
6. Major Findings and Conclusions:  
CLHSD received a compliance score of 95.63, with six recommendations noted.

Recommendations included improvements to safety meeting documentation, accident reporting, and defensive driving/BBP training schedules.

7. Major Recommendations:  
Strengthen monitoring of required trainings, reinforce documentation procedures, and implement a backup process for defensive driving and return-to-work policy training.
  8. Action taken in response to the report or evaluation:  
Corrective actions were implemented by March 2025. All identified training and documentation issues were addressed and brought into compliance.
  9. Availability (hard copy, electronic file, website):  
Electronic copy available on request; maintained by the Compliance Department.
  10. Contact person for more information:  
Name & Title: Rebecca Craig, Executive Director  
Agency & Program: CLHSD  
Telephone: 318-487-5191  
E-mail: rebecca.craig@clahsd.org
1. Title of Report or Program Evaluation:  
Developmental Disabilities (DD) Quality Enhancement Monitoring Report – FY25
  2. Date completed:  
July 30, 2025
  3. Subject or purpose and reason for initiation of the analysis or evaluation:  
To monitor and evaluate outcome measures for the Office for Citizens with Developmental Disabilities (OCDD), including Flexible Family Fund (FFF), Individual and Family Support (FS), Waiver, and EarlySteps services. Required as part of statewide quality enhancement monitoring.
  4. Methodology used for analysis or evaluation:  
Quarterly and annual performance data were collected across 29 outcome measures, including community integration, compliance with policies, waiver record management, timeliness of approvals, and family support plan implementation.
  5. Cost (allocation of in-house resources or purchase price):  
Completed by in-house compliance staff and submitted to OCDD. No additional costs incurred beyond regular reporting responsibilities.
  6. Major Findings and Conclusions:

CLHSD met or exceeded standards on most measures, including 100% community retention for Flexible Family Fund and Individual & Family Support participants, and 100% compliance with waiver approvals and records management. Areas of improvement included one quarter where Flexible Family Fund eligibility determinations fell below target (80%), community-based employment rates (averaging 55–59%, below the 20% standard but reflecting limited sample size), and timely closure of some Critical Incident Reports (72% in Q1, improved to 88–95% in later quarters).

7. Major Recommendations:

Continue performance on core measures while focusing on ensuring consistency in eligibility determinations for Flexible Family Fund, expanding outreach and support for community-based employment opportunities, and improving timeliness and documentation of Critical Incident Report follow-ups.

8. Action taken in response to the report or evaluation:

Monitoring of CIR documentation was strengthened through compliance reviews. Employment outcomes continue to be an area for statewide collaboration and local outreach.

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

Electronic copy available on request; maintained by the Compliance Department.

10. Contact person for more information:

Name & Title: Rebecca Craig, Executive Director

Agency & Program: CLHSD

Telephone: 318-487-5191

E-mail: [rebecca.craig@clahsd.org](mailto:rebecca.craig@clahsd.org)

1. Title of Report or Program Evaluation:

Behavioral Health Accountability Plan (AP) Monitoring Results

2. Dates completed:

September 5, 2025 and September 6, 2025 & February 10, 2025 and February 11, 2025

3. Subject or purpose and reason for initiation of the analysis or evaluation:

The Accountability Plan (AP), established under Louisiana R.S. 28:918, is the statewide human services plan that sets criteria, processes, and performance measures for service delivery. AP monitoring ensures that districts comply with these standards and that state and federal funds are used effectively to support behavioral health services.

4. Methodology used for analysis or evaluation:

LDH conducted monitoring of CLHSD's programs, including review of clinical

and administrative documentation, fiscal oversight, and assessment of performance measures and compliance with state and federal requirements.

5. Cost (allocation of in-house resources or purchase price):  
No additional cost; monitoring is conducted by LDH as part of statewide oversight, with in-house staff support for preparation and follow-up.
6. Major Findings and Conclusions:  
All CLHSD Caring Choices clinics performed at or above compliance thresholds. Jonesville and Marksville scored 100%, Alexandria scored 98%, and Leesville scored 99%. A minor deficiency related to documentation of tuberculosis (TB) and human immunodeficiency virus (HIV) testing was identified.
7. Major Recommendations:  
Maintain strong compliance practices and continue reinforcing documentation standards for health screenings.
8. Action taken in response to the report or evaluation:  
An in-service training was completed for clinic staff regarding TB and HIV testing documentation, ensuring corrective action and compliance moving forward.
9. Availability (hard copy, electronic file, website):  
Electronic copy available on request.
10. Contact person for more information:  
Name & Title: Rebecca Craig, Executive Director  
Agency & Program: CLHSD  
Telephone: 318-487-5191  
E-mail: [rebecca.craig@clahsd.org](mailto:rebecca.craig@clahsd.org)

# Annual Management and Program Analysis Report

## Fiscal Year 2024-2025

Department: Louisiana Department of Health (LDH)  
09-377 Northwest Louisiana Human Services District

Department Head: Bruce D. Greenstein  
LDH Secretary

Undersecretary: Drew Maranto

Executive Director: Doug Efferson

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

#### Accomplishment #1: Forensic Psychiatry Training Program:

- A. What was achieved? Established an agreement with the Louisiana State University Health Sciences Center in Shreveport to have a Forensic Psychiatry Training Program in our Shreveport Behavioral Health Clinic.
- B. Why is this success significant? Having residents of the local psychiatry training program include our clinic in their residency assignments gives us the opportunity to evaluate and possibly hire physicians as part of our succession plan for providers. It also gives residents the opportunity to see and serve our unique client population since we are the only local behavioral health provider with 80% uninsured or underinsured (Medicaid).
- C. Who benefits and how? Our clinic gets the immediate benefit of having additional providers in-house. A longer term benefit is the opportunity to recruit residents as they complete their residency training. The residents get the immediate benefit of experiencing how a state-subsidized, safety-net service provider operates. A longer term benefit is the opportunity to do a “test run” with our clinic as a possible employment opportunity. Our clients also benefit from the additional providers in-house and the professionalism of a teaching environment.
- D. How was the accomplishment achieved? Our in-house psychiatrist also works at the Louisiana State University Health Services Center in Shreveport Louisiana. She helped

establish the agreement and agreed to be responsible for the education and supervision of the residents.

- E. Does this accomplishment contribute to the success of your strategic plan? Yes. Hiring prescribing providers has always been a challenge. This residency training program gives us the opportunity to evaluate and possibly hire physicians as part of our succession plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. The partnership of Local Governing Entities with psychiatric residency training programs may help in maintaining a prescribing provider workforce.

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

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

Yes.

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

Clinical staff vacancies has been difficult to fill in recent years despite improved pay grades and our premium pay policy. We addressed this chronic issue by purchasing 12months of paid advertising through the Louisiana Association of Substance Abuse Counselors (LASAC) and the National Association of Social Workers (NASW). We hope this paid advertising will bring more attention to our posted clinical vacancies and help fill them. Also, our district has been instrumental in supporting the awareness and use of 988 through participation in our local Crisis Response Coalition and the Shreveport Police Department Chief's Advisory Council. One outcome of these community efforts has been the establishment of a Memorandum of Understanding (MOU) between our local Crisis Service provider and the two largest 911 call centers in our service area. Caddo and Bossier Parish have agreed to work closely with 988 and our local Crisis Service provider to address behavioral health calls to 911. All of these efforts are helping us keep on track in achieving our five-year strategic plan goals and objectives.

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

1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
    - Other? Please specify.
  2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?
- ◆ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:  
**None.**
1. To what do you attribute this lack of progress? For example:
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
    - Is the lack of progress due to budget or other constraint?
    - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
    - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?
- ◆ **Has your department revised its strategic plan to build on your successes and address shortfalls?**

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

No adjustment was needed this year. There were no significant successes or shortfalls to address and the strategic plan remains relevant in its' current form.

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

The areas of focus for the strategic plan were based on stakeholder input and the District's End Statement developed by the Northwest Louisiana Human Services District (NLHSD) Board of Directors. The NLHSD Senior Leadership Team then adjusted the goals and objectives of the plan based on input from management staff. The final draft has been disseminated to staff via e-mail and posted on the NLHSD shared folder for all staff to reference when needed. Review of the plan is set to occur twice a year with a summary report to the Board of Directors for their review and input.

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

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

**None.**

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

#### A. Problem/Issue Description

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

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

## B. Corrective Actions

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

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

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

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

4. Are corrective actions underway?

a. If so:

- What is the expected time frame for corrective actions to be implemented and improvements to occur?
- How much progress has been made and how much additional progress is needed?

b. If not:

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

5. Do corrective actions carry a cost?

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

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

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

A. Check all that apply.

**Internal audit**

The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

**External audits (Example: audits by the Office of the Legislative Auditor)**

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

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

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

**Performance Progress Reports (LaGov System)**

The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

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

Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

**Benchmarking for Best Management Practices**

The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

**Performance-based contracting (including contract monitoring)**  
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

Peer review

**Accreditation review**  
Northwest Louisiana Human Services District (NLHSD) currently operates under a 3-Year CARF (Commission on Accreditation of Rehabilitation Facilities) Accreditation. This accreditation includes an annual conformance review process.

**Customer/stakeholder feedback**  
Northwest Louisiana Human Services District (NLHSD) solicits input from LaPAS and C'est Bon surveys, comments on the NLHSD website, verbal and written comments during public forums, and stakeholder surveys distributed during the NLHSD Board's annual strategic planning process

Other (please specify):

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

Yes. Proceed to Section C below.

No. Skip Section C below.

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

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

Telephone:

E-mail: