John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

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: Ruth Johnson
LDH Undersecretary

RE: Annual Management and Program Analysis Report (AMPAR)

DATE: October 4, 2022

In accordance with Louisiana Revised Statues 36:8, the Louisiana Department of Health is submitting its annual Management and Program Analysis Report (AMPAR) for the 2022 fiscal year. These reports summarize the activities of each 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 Elizabeth Davis at 225-342-5608 (liz.davis@la.gov).

Louisiana Department of Health

09-300	—	Jefferson Parish Human Services Authority
09-301	—	Florida Parishes Human Services Authority
09-302	—	Capital Area Human Services District
09-303	—	Louisiana 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 District
09-320	—	Office of Aging and Adult Services (OAAS)
09-324	—	Louisiana Emergency Response Network
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)
09-375	—	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 2021-2022

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

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Executive Director: **Rosanna DiChiro Derbes, Psy.D**

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

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

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

Accomplishment #1: Implementation of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

A. **What was achieved?**

In Fiscal Year 2021-2022, Jefferson Parish Human Services Authority (JPHSA) began implementation of the Act 421 Children's Medicaid Option (TEFRA) effective at the beginning of 2022. The purpose of this Act is to serve as a pathway for children with disabilities under 19 years of age to receive Medicaid coverage in situations where they would ordinarily not qualify for Medicaid due to parental/caregiver income level. JPHSA works in collaboration with the Louisiana Department of Health to provide Level of Care assessments and assist individuals with the application process.

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

JPHSA's mission is to ensure individuals and families in Jefferson Parish affected by Developmental Disabilities can live full, healthy, independent, and productive lives to the greatest extent possible for available resources. The availability of Medicaid makes it easier and more affordable for children with developmental disabilities to have access to the healthcare services they need.

C. **Who benefits and how?**

Children with developmental disabilities benefit from the availability of Medicaid to ensure they are able to receive services at a more affordable cost or otherwise previously unable to access. The families of children with developmental disabilities benefit from the savings provided by Medicaid to help off-set the significant costs of care for their children.

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

Prior to implementation, representatives from JPHSA participated in workgroup meetings with other stakeholders to create a process for making Level of Care Determinations for applicants. JPHSA performs these determinations for applicants residing in Jefferson Parish. JPHSA assists individuals with completion of all necessary documents for their application. Since its implementation, over 60 children and families have received a Level of Care determination from JPHSA.

Staff in JPHSA's Developmental Disabilities Community Services Division were trained on TEFRA requirements prior to the start date of January 1, 2022. JPHSA additionally enacted a schedule to complete annual Level of Care re-assessment for all eligible individuals.

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

Yes. JPHSA's collaboration with the Louisiana Department of Health for implementation of TEFRA is in furtherance of JPHSA's Mission statement to help Jefferson Parish residents lead full, healthy, independent and productive lives. In doing so, JPHSA was also acting in furtherance of the first goal of its strategic plan, which is to ensure the availability of adequate resources to meet Mission and ultimately achieve Vision while adhering to Board Priorities for the provision of services and supports.

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

Yes. JPHSA worked quickly and collaboratively to ensure preparedness to provide assessments and assistance immediately upon start of the program.

Accomplishment #2: Increased Internal and External Program Awareness through Centralized Care Coordination

A. **What was achieved?**

In Fiscal Year 2021-2022, JPHSA saw a 3.7% increase in referrals from Fiscal Year 2020-2021 following an increased focus on promoting both internal and external awareness of JPHSA programs and services offered through outreach, education, and collaborations.

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

An increase in the referrals to JPHSA demonstrates continued growth and desirability of JPHSA programs and services. This growth is significant especially following challenges for access to services presented by COVID-19 in the previous Fiscal Year as well as challenges from Hurricane Ida early in Fiscal Year 2012-2022.

C. **Who benefits and how?**

All Jefferson Parish residents benefit from the increased access to the programs and services offered by JPHSA. Heightened awareness allows individuals and their families to receive vital services that they may have been waiting to receive elsewhere or did not previously know that these services were available to them.

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

JPHSA's Centralized Care Coordination program provided formal in-service trainings with a number of healthcare organizations, such as Oceans Behavioral Hospital, Ochsner Hospital, and West Jefferson Medical Center. JPHSA also attended community health fairs and provided informal trainings with local psychiatric hospitals and medical facilities. Additionally, the Centralized Care Coordination program began to work in partnership with two newly developed external programs in Family Preservation Court and the Crisis Collaboration Meeting. Internally, Centralized Care Coordination developed a monthly intra-agency service coordination meeting to increase internal collaboration and referrals.

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

Yes. The effort in increasing awareness is example of JPHSA directly acting in furtherance of its Mission statement to help Jefferson Parish residents lead full, healthy, independent and productive lives. In doing so, JPHSA is also acting in furtherance of the first goal of its strategic plan, which is to ensure the availability of adequate resources to meet Mission and ultimately achieve Vision while adhering to Board Priorities for the provision of services and supports.

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

Yes. JPHSA's efforts to increase collaborate with other organizations as well as internally within its own Divisions have been productive and beneficial to the individuals served and their families.

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

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

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

Throughout Fiscal Year 2021-2022 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, even amidst the challenges provided by Hurricane Ida and the ongoing COVID-19 pandemic.

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

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

Goal I: Ensure the availability of adequate resources to meet Mission and ultimately achieve Vision while adhering to Board Priorities for the provision of services and supports.

JPHSA made progress toward reaching this goal in Fiscal Year 2021- 2022. As discussed above, JPHSA continued to expand its service provision and efforts in outreach, especially in its Developmental Disabilities Community Services Division and its Centralized Care Coordination program, in outreach to broaden its reach to as many individuals and families in Jefferson Parish as possible. JPHSA was able to maintain resources and provide services despite continued issues with COVID-19 and closures from Hurricane Ida.

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

JPHSA made progress toward reaching this goal in Fiscal Year 2021-2022. Specifically, JPHSA was able to attract and hire well-qualified candidates despite the disturbances caused by COVID-19 and Hurricane Ida.

Please note in particular:

- Throughout Fiscal Year 2021-2022, JPHSA used brand management as a recruitment tool.

- Throughout Fiscal Year 2021-2022, 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, and collaborating with local colleges and universities.

- Throughout Fiscal Year 2021-2022, JPHSA's Executive Management Team monitored staff member retention rates and ensured all staff members received appropriate monitoring, supervision, and development through an ongoing audit assessing supervisor compliance with JPHSA's Staff Development & Supervision Guidelines.

- Throughout Fiscal Year 2021-2022, JPHSA continued to utilize an intensive first thirty-day orientation for new staff members as a tool to ensure up-front investment and engagement with JPHSA practices and policies.

- **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 submitted its revised Strategic Plan for Fiscal Year 2022-2023 on May 19, 2022. JPHSA plans to continue capitalizing on successes with integration of care and centralized care coordination. Additionally, JPHSA enters this Fiscal Year with a focus on Equity, Diversity, and Inclusion to assess staff and individual experiences and improve as needed.

- **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.

Jefferson Parish Human Services Authority (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 Division and Department Director is required to develop and implement an annual business plan in support of the JPHSA Strategic Plan. Directors provide written reports on progress to the Executive Director on no less than a quarterly basis.

Additionally, the JPHSA PQI Committee works with the Executive Management Team to develop, adopt, and implement cross-divisional PQI Initiatives to further support Mission, Priorities, and achievement of the Strategic Plan. The PQI Committee incorporates input from all levels and areas of the organization through its diverse membership. Every JPHSA staff member is designated as a Full or Ad-Hoc Committee member.

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 Business Plans, and the Annual Performance and Quality Improvement Initiatives. The Executive Director focuses a significant portion of the Executive Management Team members' performance reviews on their contributions to the Strategic Plan and Performance and Quality Improvement Initiatives as well as on their degree of success in accomplishing their Annual Business Plan objectives.

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 CPS Division audits JPHSA performance using benchmarks set forth in Council on Accreditation standards. Improvement and/or corrective action plans are developed and executed as needed. The Division monitors progress on plan

implementation as well.

Each JPHSA Division establishes an annual business plan containing measurable outcomes in support of the Strategic Plan. Outcomes are tracked and reported on a quarterly basis with Performance and Quality Improvement and/or corrective action initiated as needed. JPHSA's 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 is audited on an annual basis by the Louisiana Legislative Auditor. The Fiscal Year 2021-2022 audit is preparing to start as of the time of this writing. 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 2021-2022 audits were conducted during the Fiscal Year, with JPHSA receiving no findings or recommendations. The peer review, which focused on administrative practices, was done with Metropolitan Human Services District and produced no findings or recommendations.

☒ **Policy, research, planning, and/or quality assurance functions in-house**
JPHSA's Compliance & Performance Support (CPS) Division 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 CPS Division Director, who is also JPHSA's General Counsel, in conjunction with the Compliance Officer, has overall responsibility for ensuring legal and regulatory compliance. The Executive Management Team, under the direction of the Executive Director, is 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 Committee, a chartered committee chaired by the CPS Quality Improvement Specialist, is responsible for the review and update of JPHSA's PQI Plan and for the collaborative development and ongoing monitoring of JPHSA-wide PQI Initiatives. All staff members complete annual PQI training, and each division is required to tackle a division-specific PQI initiative annually. Further, in compliance with Council on Accreditation standards, JPHSA has a plethora of time-limited work groups in place at all times.

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

☒ **Program evaluation by in-house staff**
Program performance is monitored on an ongoing basis utilizing the JPHSA Strategic Plan, Operational Plan, Division-Specific Annual Business Plans, Annual 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.

☐ Program evaluation by contract

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
JPHSA collects data, performs statistical analysis, and reports outcomes/outputs into LaPAS on a quarterly basis. Notes of explanation are provided for positive and negative variances of 5% or more from quarterly Performance Indicator targets. Each note outlines any needed corrective action or process improvement activities. JPHSA also provides data or makes data available to the Louisiana Department of Health (LDH), Office for Citizens with Developmental Disabilities (OCDD), and the Office of Behavioral Health (OBH) on an ongoing basis and as required by contractual agreement. JPHSA is compliant with the LDH Human Services Accountability 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; and ongoing data collection, mining, and analysis for decision support.

The JPHSA PQI Committee meets regularly to discuss progress and any need for Performance and Quality Improvement and/or corrective action. In addition, JeffCare, due to its size and complexity, has a program-specific PQI Committee. Further, the Executive Director meets one-on-one with each member of the Executive Management Team on a quarterly basis for reporting on annual plan progress and any need for Performance and Quality Improvement and/or corrective action. In addition, to underscore accountability at the individual employee level, a "third level" review, i.e. random audit, of rating and planning documents is completed to ensure linkage to job descriptions and ongoing

documented supervision and coaching.

☒ **Benchmarking for Best Management Practices**
In Fiscal Year 2021-2022, JPHSA utilized Netsmart's myAvatar platform as its sole electronic health record for behavioral health, developmental disabilities, and primary care services, as well as data collection and analysis. 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 and through Uniform Data System reporting through the Health Resources Services Administration (HRSA) of the U.S. Department of Health and Human Services. JPHSA's Financial System, Microsoft Dynamics GP, is a highly sophisticated system that allows detailed budget reporting, enabling the measurement of performance against quarterly targets and annual goals as well as identification of trends.

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

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.

☒ **Peer review**
The JPHSA Medical Director facilitates ongoing peer reviews among prescribers (physicians and advanced practice registered nurses) as a routine part of practice. Additionally, he leads comprehensive multi-disciplinary peer review in cases of a service recipient suicide or death not associated with a physical disease or chronic condition. JPHSA participates in the Office of Behavioral Health annual peer review with a sister Local Governing Entity. These reviews alternate focus on program and administrative functions. The peer review for Fiscal Year 2021-2022, with Metropolitan Human Services District, focused on administrative functions and practices. The Office of Behavioral Health and Office for Citizens with Developmental Disabilities also conduct annual on-site reviews with peers from other Local Governing Entities as participants.

☒ **Accreditation review**
JPHSA is fully accredited by the Council on Accreditation (COA). In Fiscal Year 2019-2020, JPHSA was awarded a four-year reaccreditation, the longest COA grants, without any findings or recommendations. JPHSA's next reaccreditation cycle began in Fiscal Year 2021-2022 with a reaccreditation deadline of February 29, 2024.

☒ **Customer/stakeholder feedback**
JPHSA fields the U.S. Health Resources and Services Administration Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Telesage Quality of Care Survey within its Health Centers on an ongoing basis. JPHSA invites confidential feedback on its internet site 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 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 have access to confidential comment boxes in all break rooms and may also provide the staff-led committee, Esprit de Corps, with suggestions for improvement. The Esprit de Corps Chairperson has direct access to the Executive Director and Executive Management Team. The members of the Board of Directors, per the Policy Governance Model, actively engage in "community linkages" and report the outcomes of these community stakeholder interactions during each Board meeting. Additional feedback is obtained through active participation in the monthly Jefferson Parish Behavioral Health Task Force meetings and in the quarterly Regional Advisory Committee meetings for Behavioral Health and Developmental Disabilities. JPHSA also participates on the Jefferson Parish Children and Youth Planning Board. The Executive Director and the Chief Administrative Assistant make regular calls on local and state elected officials as well as community partners.

☐ Other (please specify):

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:

JPHSA monitors and evaluates its operations and programs on an ongoing basis, as described throughout this report. JPHSA has a highly developed decision-support function in place. Data is analyzed and discussions routinely occur in meetings of the Executive Management Team, Performance and Quality Improvement Committee, Safety Committee, and at the individual division and department level. Findings are shared during these meetings as well as during individual and group supervision, as appropriate. Corrective and/or Performance and Quality Improvement plans are developed and implemented as needed. Work Groups and Process Improvement Teams form to support the execution of such plans.

Name: DanMinh Mui
Title: Division Director, Compliance & Performance Support
Agency & Program: Jefferson Parish Human Services Authority
Telephone: 504-838-5716
E-mail: dmui@jphsa.org

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

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

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

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.

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

Accomplishment #1: Increased Telemedicine Options

A. **What was achieved?**
Following the return to "normal" operations after Covid, the agency worked to implement telemedicine as a routine option in the circumstances where it is appropriate.

B. **Why is this success significant?**
It allows for increased access to care which is particularly important when dealing with our population who often have challenges associated with accessing care.

C. **Who benefits and how?**
The clients served by the agency and the community at large due to improved personal and community health outcomes.

D. **How was the accomplishment achieved?**
By utilizing lessons learned during Covid and implementing protocols to support the effort in an organized way, understanding that telemedicine is not the right choice in every situation.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, goal 1 of the strategic plan speaks to improving the quality of life of those the agency serves who have behavioral health conditions.

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: Implemented flexible schedules for staff

A. **What was achieved?**
FPHSA is piloting using flexible schedules for staff to help retain and attract qualified staff during this difficult time. In addition to being a benefit to staff, these changes are allowing the agency to extend hours on certain days without adding additional resources which allows for greater access to care for some of our clients.

B. **Why is this success significant?**
Staff retention and recruiting is a challenge across most of our country at present and holding onto dependable and well trained staff is important. Increasing access to care for our population is also a priority.

C. **Who benefits and how?**
Staff members, clients and their families, citizens of the state.

D. **How was the accomplishment achieved?**
Through an internal process of balancing schedules to accommodate flexibility while ensuring continuity.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, goal 1 of the strategic plan speaks to improving the quality of life of those the agency serves who have behavioral health conditions.

F. **Does this accomplishment or its methodology represent a Best Management**

Practice that should be shared with other executive branch departments or agencies?
Yes

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

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

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized? Our strategic plan was updated in 2022 and we continue to make significant progress with the goals subject to the limitations listed below.

- **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:

  We continue to make significant progress with regard to our goals due to a committed and well trained workforce and an engaged leadership team. Stability of finding this over recent years has also helped focus on improvement rather than survival of programs.

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

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

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

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

None.

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

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

The updated strategic plan appropriately reflects the direction the agency is, and should be, headed.

- **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.

This is accomplished through the leadership structure by ensuring that agency goals are known throughout the agency and that all efforts undertaken across the agency are meant to further those 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?
   Staffing continues to be difficult across almost all position titles.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   Yes, it impacts how many individuals can be served on any given day.

3. What organizational unit in the department is experiencing the problem or issue?
   All organization units, primarily the behavioral health outpatient clinics.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Anyone relying on our agency for services may be impacted by longer waits for new appointments or return appointments which can lead to poor outcomes.

5. How long has the problem or issue existed?
   It has been difficult for many years due to compensation issues but has worsened as the problem has impacted most of our country over the past year.

6. What are the causes of the problem or issue? How do you know?
   Compensation may be a factor but this appears to be a nationwide trend.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   Poorer outcomes in health treatment can be expected when treatment is impacted by availability of health care workers.

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?
   Internal options using flexible scheduling and Civil Services approved pay

options has been somewhat helpful. Further actions through Civil Service to address market pay inequities would help even more.

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? Working on internal options and working with Civil Service on external options.
      - What are the obstacles preventing or delaying corrective actions? Funding and Civil Service regulations.
      - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

   Yes, Flexible scheduling options have been used to recruit and retain as well as some pay options approved by Civil Service. It is unlikely that any of these actions will fix the problem alone but each one helps some.

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.

         The costs are impossible to determine based on pay options as it will depend on Civil Service and individual actions for any retention offer or recruitment offer. Some options, such as flexible scheduling do not carry any cost at all.

      b. How much has been expended so far?
         None, so far, but a request before Civil Service for premium pay for certain jobs would cost approximately $120,000 annually.

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 or no?

   Yes, as of this time we expect to be able to cover these costs within the existing budget.

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 will not be required to implement the recommended actions.

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**

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)**

Civil Service, Office of Risk Management, LDH, Office of the Legislative Auditor and the Healthy Louisiana plans conduct audits and reviews of FPHSA's processes, procedures and services. Corrective actions are devised and implemented in response to deficiencies. (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)**
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. FHPHA conducts monthly expenditure analysis to manage efforts towards compliance.

☒ **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. FPHSA conducts periodic and routine reviews intended to evaluate our performance and to support continued accountability and improvement 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. FPHSA's goals are to meet and exceed benchmarks by setting performance goals at or above benchmarks.

☒ **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. FPHSA monitors internally and is monitored by LDH for compliance with contract statement of work. Internally, contract monitors in partnership with the fiscal grants management team conduct routine monitoring meetings.

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

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

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

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

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

Report #1:

1. Title of Report or Program Evaluation:
   Administrative Independent Peer Review FFY 2022

2. Date completed:
   March 10, 2022

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   IPRs are a learning opportunity for participants. The review encourages and allows staff from FPHSA and SCLHSA to interact with one another and to gather suggestions and/or insight regarding such issues as: improving services, programmatic and fiscal operations, business practices that assist with increasing efficiency and effectiveness, ways to enhance revenue, etc.

4. Methodology used for analysis or evaluation:
   LGE's are paired for reciprocal reviews. The Independent Peer Review Form was used in the 2022 review to assist the provider to identify program strengths and challenges. Teams from respective LGEs were made up of content experts. The IPR is not strictly a monitoring, licensing, or auditing process. It is a method to

continuously improve quality, performance, and provide credibility where administrative functions within the State System are concerned.

5. Cost (allocation of in-house resources or purchase price)
   No cost.

6. Major Findings and Conclusions:
   South Central Louisiana Human Services Authority was FPHSA's peer reviewer. There were no findings or recommendations.

7. Major Recommendations:
   NA

8. Action taken in response to the report or evaluation:
   Continued operations as normal.

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

10. Contact person for more information:
    Name: Richard Kramer
    Title: Executive Director
    Agency & Program: FPHSA
    Telephone: (985) 543-4333
    E-mail: Richard.Kramer@fphsa.org

Report #2:

1. Title of Report or Program Evaluation:
   ORM Compliance Review

2. Date completed:
   March 28, 2022

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   To evaluate compliance with safety and risk guidelines and to mitigate hazards that may compromise safety and promote risk for staff, persons served, and visitors to FPHSA.

4. Methodology used for analysis or evaluation:
   Onsite inspection and review of all written reports used to document compliance with safety standards.

5. Cost (allocation of in-house resources or purchase price)
   No cost assigned.

6. Major Findings and Conclusions:
   FPHSA was rated 95.67% compliance.

7. Major Recommendations:
   None.
8. Action taken in response to the report or evaluation:
   There were recommendations and these recommendations were put into corrective action.

9. Availability (hard copy, electronic file, website):
   The report is available in hard copy and e-file.

10. Contact person for more information:
    Name: Richard Kramer
    Title: Executive Director
    Agency & Program: FPHSA
    Telephone: (985) 543-4333
    E-mail: Richard.Kramer@fphsa.org

Report #3:

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

2. Date completed:
   11/5/21 (11/1/21 through 11/5/21)

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

5. Cost (allocation of in-house resources or purchase price)
   No cost.

6. Major Findings and Conclusions:
   A couple documentation issues were identified related to testing, resulting, and subsequent counseling for treatment recipients of SUD services. Charts were flagged for corrective action for all deficiencies identified, as possible.

7. Major Recommendations:
   NA

8. Action taken in response to the report or evaluation:
   Corrective Action Plans were submitted and accepted as written and have been implemented. Results were reviewed with leadership and staff. Corrective actions were implemented.

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

10. Contact person for more information:
    Name: Richard Kramer
    Title: Executive Director
    Agency & Program: FPHSA
    Telephone: (985) 543-4333
    E-mail: Richard.Kramer@fphsa.org

Report #4:

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

2. Date completed:
   4/29/22 (4/12/22 through 4/29/22)

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

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

6. Major Findings and Conclusions:
   A couple documentation issues were identified related to the waitlist as well as to required testing, resulting, and subsequent counseling for treatment recipients of SUD services.

7. Major Recommendations:
   None noted.

8. Action taken in response to the report or evaluation:
   FPHSA reviewed reports with leadership and staff and a corrective action plan (for implementation region wide) was implemented immediately. Charts were flagged so that all deficiencies could be addressed.

9. Availability (hard copy, electronic file, website):
   Available in e-file or hard copy.

10. Contact person for more information:
    Name: Richard Kramer
    Title: Executive Director
    Agency & Program: FPHSA
    Telephone: (985) 543-4333
    E-mail: Richard.Kramer@fphsa.org

Report #5:

1. Title of Report or Program Evaluation:
   Accountability Plan: Developmental and Disability Services

2. Dates completed:
   November 2021; February 2022; March 2022; May 2022

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. FPHSA Developmental and Disability Services (DDS) conducts internal audits that help to identify potential gaps and deficiencies and therefore support compliance with the accountability plan.

4. Methodology used for analysis or evaluation:
   Reviews conducted by State Office and guided by AP workbook.

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

6. Major Findings and Conclusions:
   DDS performance consistently received high scores for compliance and CAPS are immediately submitted and implemented to address any identified areas that help with performance improvement.

7. Major Recommendations:
   None noted.

8. Action taken in response to the report or evaluation:
   FPHSA DDS reviewed reports with leadership and staff and corrective action plans are developed and implemented immediately and as indicated.

9. Availability (hard copy, electronic file, website):
   Available in e-file or hard copy.

10. Contact person for more information:
    Name: Richard Kramer
    Title: Executive Director
    Agency & Program: FPHSA
    Telephone: (985) 543-4333
    E-mail: Richard.Kramer@fphsa.org

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department:	**Louisiana Department of Health (LDH)** 09-302 Capital Area Human Services District
Department Head:	**Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Executive Director:	**Janzlean Laughinghouse, PhD, 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.

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

Accomplishment #1: CAHSD Earns Three-Year CARF Re-Accreditation

A. **What was achieved?**
The Commission on Accreditation of Rehabilitation Facilities (CARF International) has issued a three-year re-accreditation to Capital Area Human Services District (CAHSD) in the areas of mental health and substance use treatment through November 30, 2024.

B. **Why is this success significant?**
This is the fourth consecutive three-year accreditation that CARF International has issued to CAHSD 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).

C. **Who benefits and how?**
Persons served benefit by receiving quality services that meet international accreditation standards in addition to state licensing standards.

D. **How was the accomplishment achieved?**
"*This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served*," wrote CARF President/CEO Brian Boon, PhD in the April 7, 2022, letter to CAHSD Program Manager Karen Pino, LCSW-BACS, LAC, who coordinated CAHSD's reaccreditation efforts.

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

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

Accomplishment #2: CAHSD Quickly Resumes Operations Following Hurricane Ida's Impact

A. **What was achieved?**
Although state offices remained closed, CAHSD's Baton Rouge Behavioral Health facility quickly resumed operations following the impact of Hurricane Ida and reopened on Wednesday, 9/1/2021, with small teams from other CAHSD locations available as well to address the needs of persons usually served at clinics that were still closed such as Ascension Behavioral Health which had water leaking into the lobby. North Baton Rouge Behavioral Health, CAHSD Developmental Disabilities Services, and CAHSD Administration were not able to access their office buildings that were closed for the remainder of the week by the owners for storm-related repairs and safety inspections. In addition, from Thursday, 9/2/2021, through Friday, 9/17/2021, CAHSD met its contractual obligation to LDH and helped staff the state-operated Medical Special Needs

Shelter in Baton Rouge which was one of three such shelters that received a combined total of 843 patients. CAHSD Program Manager John Nosacka, LCSW-BACS, MSHCM served as the Incident Commander for CAHSD staff at the shelter.

B. **Why is this success significant?**
Hurricane Ida was a dangerous Category 4 hurricane with 150 mph winds (Category 5 hurricane winds are 157+ mph) that began in the Caribbean, made landfall near Port Fourchon, Louisiana on Sunday, 8/29/2021, the 16th anniversary of Hurricane Katrina, and caused 30 deaths as well as $18 billion dollars of damage in Louisiana alone before moving northeast (https://gov.louisiana.gov/index.cfm/newsroom/detail/3371). On 8/30/2021, state offices were closed in 25 parishes including the seven served by CAHSD. Many people, as well as persons served by CAHSD and staff, were without power/running water/cell service/internet, gas stations ran out of fuel, grocery stores ran out of bottled water/bread/diapers, and main roads were blocked by fallen trees/downed power lines/storm debris. Power restoration, fuel resupply, and grocery restocking took more than two weeks in heavily damaged areas. Meanwhile, CAHSD staff, including those from severely affected areas, continued to report to work.

C. **Who benefits and how?**
Persons served benefitted from CAHSD's quick reopening and continuity of operations to provide access to much-needed services including medication refills and therapy.

D. **How was the accomplishment achieved?**
Staffing schedules were split between the Medical Special Needs Shelter and the CAHSD divisions, with staff working 12-hour shelter shifts in addition to their usual work hours. By Monday 9/20/2021, all CAHSD locations and services were open with a return to usual staffing patterns that continued to incorporate COVID-19 mitigation strategies (e.g., telehealth and telework)

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes. All divisions managed by CAHSD, including Administration, Developmental Disabilities Services, Nurse-Family Partnership, Children's Behavioral Health Services, Adult Behavioral Health Services, and Prevention & Primary Care, followed CAHSD's continuity of operations plan and quickly resumed operations in order to meet the ongoing needs of persons served.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes. Lessons learned from past hurricane events and advance planning made it possible for CAHSD to return to business as usual in less than a month.

Accomplishment #3: CAHSD Provides School Based Behavioral Health Enrichment Camps

A. **What was achieved?**
Capital Area Human Services District (CAHSD) provided School Based Behavioral Health Summer 2021 Enrichment Camps for 172 children with behavioral health challenges at ten schools across five parishes.

B. **Why is this success significant?**
Camp participants were from households that are at or below area median income and were able to attend camp sessions at no cost within their parish of residence.

C. **Who benefits and how?**
School aged children with behavioral health challenges, who were served by the CAHSD School Based Behavioral Health program during the school year, benefitted from the summer enrichment camps. Through adventure-based indoor and outdoor therapeutic activities, participants were taught important life skills including showing kindness, problem solving, effective communications with others, and coping with feelings. During individual and group sessions, participants also learned about impulse control, bullying prevention, mindfulness-based stress reduction, and building positive self-esteem.

D. **How was the accomplishment achieved?**
The summer enrichment camps were staffed by therapists from the CAHSD School Based Behavioral Health program who provided psychiatric support and treatment services to participants.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes. The summer enrichment camps are an innovative way to engage CAHSD School Based Behavioral Health clients during the summer months and provide them with opportunities to practice learned life skills in fun and exciting ways, so that progress continues even when school is out.

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: Clinicians trained by National Center for Mind-Body Medicine

A. **What was achieved?**
Two School Based Behavioral Health Clinicians participated in the CMBM (National Center for Mind-Body Medicine) trainings. The CMBM curriculum provides tools to clinicians that promote healing and processing of emotions via the mind-body connection. In the initial CMBM training clinicians participated as future clients would. This allowed clinicians to get a feel for how to create and promote an ideal setting to allow

for vulnerability and self-exploration as well as community development. It also provided the clinicians a chance to practice the skills that they would be teaching and leading in the future. In the advanced training, the clinicians gained further skills by practicing facilitating a group and learning from and watching others do the same.

B. **Why is this success significant?**
Completing this training is significant because it further equips clinicians in the agency in effective interventions to help clients experiencing stress and trauma in our populations served. It is a great step toward creating trauma-informed environments and care in the many settings for which social workers are practicing throughout the community.

C. **Who benefits and how?**
Our populations served, as well as clinicians themselves, benefit from this work by integrating mind-body skills into daily practice. These skills aid in reducing stress and provide alternative positive ways of coping. These practices further promote a positive, healthy environment for employees and clients to thrive.

D. **How was the accomplishment achieved?**
The School-Based Behavioral Health Clinicians volunteered to participate in the program in the hopes of bringing an additional modality of treatment to populations served. SBBH plans to implement these practices into group therapy setting within the schools served starting in Fall 2022, as well as promote mind-body skills throughout the school year to support staff and students alike.

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

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes. Anyone can benefit from skills learned in CMBM training.

<u>Accomplishment #5: Prevention Services</u>

A. **What was achieved?**
Capital Area Human Services hosted "Driving Into Recovery with Capital Area" events that allowed staff to educate the community on opioid misuse, prevention and share recovery resources. The four (4) events were held throughout the fiscal year in Baker, Donaldsonville, Plaquemine, and Port Allen. The four (4) events combined reached over 400 individuals.

B. **Why is this success significant?**
The increased misuse of opioids is continuing and CAHSD was able to provide education to the community on avoiding misuse and resources for those seeking recovery.

C. **Who benefits and how?**
The entire community benefited from these events.

D. **How was the accomplishment achieved?**
Each event was held in one of the seven (7) parishes serviced by CAHSD. The CAHSD staff partnered with City Officials and other vendors to create a drive thru experience for attendees. Vendors would walk up to vehicles and engage with the individuals and offer them resources. Some of the resources we were able to provide attendees were: Food boxes, COVID-19 vaccines/boosters, Narcan kits, list of services provided by CAHSD, hot food, diapers, information on Medicaid/Medicare services

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: Transition to new EHR (CareLogic)

A. What was achieved?
CAHSD was able to design and implement a new electronic health record, Carelogic; that will be in use in behavioral health and developmental disability settings.

B. Why is this success significant?
The project required the design of new clinical interfaces and a billing system. Then all behavioral health and developmental disability staff were trained prior to the Go-Live date of 12/1/2021. Months of additional troubleshooting, redesign, and retraining followed.

C. Who benefits and how?
CAHSD will benefit in a number of ways:
1) Clinicians have a more customized interface.
2) Billing and reporting tools are more robust
3) Developmental Disabilities will have an online depository for document storage and record keeping, a first for that division.
4) The system downtime that users previously experienced has been substantially reduced.

D. How was the accomplishment achieved?
Clinical and Billing Project Managers were assigned to collaborate with stakeholders to design and implement the new system.

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

Yes. The reporting requirements of third party payers and managed care organizations (MCOs) have grown in number and specificity with each contract cycle. We could not create our own data fields that could be queried. Our new EHR provides this capability and access to pay-for-performance arrangements that we could not access before.

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

The accomplishment followed common practices for design and implementation, including needs assessment, procurement, planning, design, training, implementation, and evaluation phases.

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

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

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

  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 part of the Louisiana Department of Health, participate in the state-wide LaPAS Performance Based Budgeting and Planning process which establishes common goals and objectives 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:

CAHSD has continued to make significant progress with opioid-specific outreach. Our opioid-specific initiatives include the *Be Safe* opioid mobile unit, which distributes Narcan and provides recovery coaching and referral to treatment in high impact areas; *Drive Into Recovery* outreach events, during which we provide Narcan, food, and resources to residents in the CAHSD catchment area; *Recovery Sundays*, an initiative that provides a toolkit and support for communities of faith that would like to educate their congregants on opioid misuse and provide treatment resources, Grief recovery groups for friends and loved ones of individuals who died from opioid overdose; Comprehensive Opioid Stimulant and Substance Abuse Program (COSSAP) formerly the Comprehensive Opioid Abuse Program (COAP) at the EBR Parish prison, which consists of peer support, screening, and referral to treatment; Narcan training for first responders and community providers, which includes supplying them with 10 Narcan Kits; homeless outreach teams (HOT) comprised of certified peer support specialists who work with BRPD to enter homeless encampments to distribute Narcan, provide recovery coaching, and referral to community resources.

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.

The success of the opioid-specific outreach can largely be attributed to two reasons: 1) pursuit of initiatives based on recommendations from the *Community-Wide Response to the Opioid Epidemic*, a plan based on expert presentations provided at the Capital Region Behavioral Health Collaborative meetings and 2) funding for these initiatives, through the Office of Behavioral Health (OBH).

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

CAHSD expects to continue to see this progress given the agency's focus on specific initiatives and continued funding from OBH.

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

None.

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

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

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

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

The current plan has not been revised yet; however, revisions are due during this fiscal year. Proposed revisions will include changes based on feedback from client surveys, the CAHSD Spring 2022 Listening Tour (employee feedback) and data from the quality improvement committee.

- **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?

Staff recruitment and retention is an ongoing problem that has been exacerbated exponentially by the effects of the pandemic and the "Great Resignation", wherein employees are leaving their jobs to seek better wages. While the issue is agency-wide, nurses and licensed mental health professionals continue to be most difficult positions to fill. The issues with recruitment and retention continue to create issues because understaffed clinics must utilize existing employees to handle the workload, which increases the risk of employee burnout. Also, client wait times are longer because there are not enough qualified providers to see them for appointments. The pay disparity between private sector and civil servants is the answer most often cited when individuals decline job offers or tender their resignations.

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?

CAHSD has begun to implement non-wage related benefits such as telework (for

certain positions) and flex schedules as recruitment tools.

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?

   The Civil Service Commission has increased pay for nurses and CAHSD is hopeful that the trend to increase salaries will continue.

   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?

   The correction actions implemented by CAHSD are non-wage related and therefore carry no cost.

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 of 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, including:
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

Report #1

1. **Title of Report or Program Evaluation**:
   Louisiana Performance Accountability System (LaPAS)

2. **Date completed:**
   Quarterly from July 1, 2020 through June 30, 2021.

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

4. **Methodology used for analysis or evaluation**:
   Standard methodology required by DOA; performance indicators developed in conjunction with program offices and approved by DOA.

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

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):**
   https://www.doa.la.gov/Pages/opb/lapas/login.aspx

10. **Contact person for more information**:
    Name: Janzlean Laughinghouse, PhD, LCSW-BACS, LAC
    Title: Executive Director
    Agency & Program: Capital Area Human Services District
    Telephone: (225) 922-2700
    E-mail: Janzlean.Laughinghouse@la.gov

    Name: Karen Thomas
    Title: Accountant Administrator
    Agency & Program: Capital Area Human Services District
    Telephone: (225) 922-0004
    E-mail: Karen.Thomas@la.gov

Report #2

1. **Title of Report or Program Evaluation**:
   Commission for the Accreditation of Rehabilitation Facilities (CARF International) Survey.

2. **Date completed**:
   January 22-24, 2022

3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   To accredit CAHSD 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).

4. **Methodology used for analysis or evaluation**:
   Examination of organization compliance with CARF standards

5. **Cost (allocation of in-house resources or purchase price):**
   $14,265.00

6. **Major Findings and Conclusions**:
   CAHSD accredited through November 2024

7. **Major Recommendations**:
   1) Add overdose to written procedures on critical incidents 2) Conduct annual test of organization's procedures for business continuity/disaster recovery 3) Implement policy for clinical supervision 4) Utilize standardized tool to assess

for suicide risk for individuals 12 and older 5) Standardized safety plan on assessments 6) Revise treatment plans to include transition plans 7) Provide a homelike setting in residential program.

8. **Action taken in response to the report or evaluation**:
   Comprehensive corrective action plan submitted to address recommendations. Plans will be reviewed during next survey.

9. **Availability (hard copy, electronic file, website):**
   Report available as hard copy or 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

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

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

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Executive Director: **Amy Deaville**

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

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

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

Accomplishment #1: 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 community-based services for individuals with developmental disabilities and the impact of educational policies and practices on students with disabilities.

Through the Council's technical assistance provided to the grassroots Louisiana Council's Advocacy Network (LaCAN), numerous policies were changed to improve

and/or increase community services. Significant policy and practice changes influenced by LaCAN and Council advocacy related to community-based services included: successfully advocating for an additional $500,000 for Families Helping Families Resource Centers; successfully advocating for a deadline for schools to create and implement a policy on cameras in special education self-contained classrooms as well as receiving $8 million to fund those cameras; and successfully advocating $1 million and the creation of an advisory council to help create more Post-Secondary Inclusive Education Programs within Louisiana.

B. Why is this success significant?

Families Helping Families Resource Centers provide information and referrals, educational programs and training and peer to peer support to families of persons with developmental disabilities. They received a one year increase from the legislature last year and were able to secure another year of the same increased funding.

There is a need for cameras in special education self-contained classrooms to help protect students that are not able to communicate issues that arise. Although the original bill that paved the way for cameras in these classrooms passed in the 2021 legislative session, most school districts did not move on creating the necessary policies to make the installation of these cameras possible upon parent request. The legislation in 2022 added a necessary deadline for school districts to apply as well as adding funding to make it more feasible.

Post-Secondary Inclusive Education Programs are very important for students with developmental disabilities that want the opportunity to experience college life and learn more independent living skills while also learning and gaining job skills. The existing programs in our state have been very successful at helping students achieve competitive employment after completion of these programs. Starting new Post-Secondary Inclusive Education Programs is expensive and time consuming. Even when a college or university has the desire to start one, the lack of funding can be a deterrent. This funding should be help expand the existence of these programs across our state.

C. Who benefits and how?

People with developmental disabilities and their family members benefit the most directly. However, teachers could also benefit from having cameras in the classroom to be able to show what is happening in their classroom when questions are being asked.

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 and providers, including the Louisiana Association of Post-Secondary Inclusive Education.

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 regarding stakeholder input to create a consumer-directed, consumer-driven service delivery system. These strategies have been shared to build the capacity of other agencies to improve services.

Accomplishment #2: Capacity Building through Training and Technical Assistance

A. What was achieved?

The Council provided support to multiple capacity building initiatives. A series of activities, including multi-day, intensive training sessions coupled with on-going technical assistance in the area of customized employment has improved the awareness and skill sets of employment support providers in effective approaches, strategies and techniques to develop customized employment opportunities for individuals with the most significant support needs. This activity has been conducted over multiple years in the Council's Five-Year plan and has resulted in professionals becoming certified and qualified to provide this employment service through Louisiana Rehabilitation Services.

In an effort to increase the number of opportunities for individuals with developmental disabilities to participate in inclusive post-secondary education programs throughout the state of Louisiana, the Council established an Alliance tasked with this responsibility. This Alliance has helped two more higher education institutions begin the process of creating these inclusive programs to be offered on their campuses.

Partners in Policymaking®, a leadership training program for individuals with developmental disabilities and parents of young children with DD, builds the capacity of these individuals to be leaders in systems change advocacy. This is typically a six-month long training program conducted by the Council every year from January to June. Due to COVID-19, classes were held virtually.

In light of the number of emergencies within our state, the DD Council has provided financial support for emergency management practice training held within our state. We have also provided financial support for training first responders in the best ways to identify and work with people with developmental disabilities.

B. Why is this success significant?

The success of building the capacity of providers, post-secondary education programs,

and community members improves the quality of services delivered, improved 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?

People with developmental disabilities will benefit from the improved quality of services delivered, emergency plans that take their needs into account, and increased options for employment.

D. How was the accomplishment achieved?

These accomplishments were achieved 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 executive branch departments have been heavily involved with implementation of these capacity building initiatives.

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

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

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

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

incredibly effective with ensuring policy-makers have first-hand perspectives of the impact of their decisions on the citizens they represent.

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

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

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

  While many of the successes in policy and practice changes were a result of collaborations with other agencies, the successes realized are a direct result of targeted educational campaigns to policy makers, advocates and the general public conducted by the Council. The vast majority, if not all, of these changes would not have occurred without the specific actions taken by the Council. The Council has expanded its repertoire of strategies and tools to connect with the public and policy makers and has 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 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.

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 Coronavirus global pandemic continued to prevent a few of the Council's in-person activities/programs from being fully conducted or implemented. Where appropriate and when possible, virtual activities were conducted; however, the cessation of certain activities/programs impeded expected outcomes from being achieved for those initiatives. However, The Council has seen better outcomes over the last year as everyone had mostly been able to adapt to operating differently due to the pandemic. The Council's contractual activities for 2022 were required to provide contingences which allowed for opportunities for virtual access until Louisiana was no longer under a governor-declared State of Emergency in response to COVID-19.

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

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

The Council just completed the revision 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.

- **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 Deputy Director supervises the Strategic Plan, and directly coordinates with the Department's Planning staff to ensure the plan is effective and efficiently implemented.

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

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

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

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

There are no significant department management or operational problems/issues that exist. All Council activities are dependent on federal and state appropriations. The Council consistently takes all actions possible to ensure continuation of allocations.

A. Problem/Issue Description

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

B. Corrective Actions

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

department?

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

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

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

5. Do corrective actions carry a cost?

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

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

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

☒ **Internal audit**
The 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; 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 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, including:
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

As required by federal law, the Council submitted a Program Performance Report (PPR) to the federal Department of Health and Human Services, Office on Intellectual and Developmental Disabilities in March 2022 on its performance in compliance with the federal Developmental Disabilities Assistance and Bill of Rights Act.

This report is based on the federal fiscal year – October 1, 2020 to September 30, 2021, and therefore covered the first quarter of state fiscal year 2021-2022. A report covering the remainder of the 2022 state fiscal year (October 1 to June 30) is scheduled to be submitted to the federal government in January 2023.

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

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

For more information contact:
Amy Deaville
Executive Director
Developmental Disabilities Council
(225) 342-6804 (phone)
(225) 342-1970 (fax)
Amy.Deaville@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department:	**Louisiana Department of Health (LDH)** 09-304 Metropolitan Human Services District
Department Head:	**Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Executive Director:	**Rochelle Head-Dunham, M.D.**

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

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

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

Accomplishment #1: Continued Enhancements to Telemedicine Service Delivery

A. **What was achieved?**

Metropolitan Human Services District (MHSD) continuously seeks to identify and implement approaches that increase access to care for individuals needing mental health or addictive disorders services. During 2019, MHSD elected to implement Telemedicine as a service delivery modality. Telemedicine is the remote diagnosis and treatment of persons by means of telecommunications technology. The decision to build the technology infrastructure needed and to provide Telemedicine in 2019 positioned MHSD

to be able to rapidly respond to the COVID-19 pandemic by preventing a disruption in services for person served.

In 2021-2022, MHSD enhanced its Telemedicine service delivery. The MHSD IT Division made improvements to the Telemedicine software. Also, MHSD has expanded Telehealth training options for staff and persons served.

B. **Why is this success significant**?
These initiatives reduce the barriers that may hinder persons from being seen by clinicians. Increasing access to care goes to the heart of MHSD's mission of ensuring person-centered support and services are available and provided to eligible individuals in the tri-parish area.

C. **Who benefits and how?**
The enhancement of MHSD's telemedicine service delivery is beneficial for both Persons Served and MHSD providers. Individuals seeking mental health, substance use and intellectual/developmental disability services are able to access services in a timely manner. Telemedicine service delivery eliminates barriers such as transportation, childcare, and travel time. Additionally, persons who are at higher risk of infection, especially those with either chronic, autoimmune, or immunosuppressant diseases or elderly are able to prevent/minimize the exposure to risk factors by engaging in telemedicine.

D. **How was the accomplishment achieved?**
Success was achieved by having agency wide support for the initiative. By planning and coordination of efforts with clinic management and staff, the MHSD Care/Call Center, the Mental Health and Addictive Disorders programs and the Executive Leadership Team. Importantly, MHSD's Executive Director and the agency's Leadership Team recognized the importance of rapid transition to Telehealth. This recognition was crucial to enable MHSD's IT, Fiscal and QDM department to rapidly activate telemedicine services.

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

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

<u>Accomplishment #2: Data Performance Initiative and continued use of MHSD Dashboards</u>

A. **What was achieved?**

The continued development of divisional and staff Key Performance Indicators (KPI's) and the accompanying reporting dashboards (to support staff productivity).

B. **Why is this success significant?**
Dashboards and KPIs assist leadership and supervisory staff with supporting the overall goals of the agency. Dashboards allow leadership and supervisory staff to monitor and evaluate program and staff performance. Thus, allowing leadership and supervisory staff to be aware of successes and areas needing improvements, both of which ultimately inform decision making. This, in turn, promotes the transparency promised by the organization in terms of tracking and measuring performance.

C. **Who benefits and how?**
MHSD's Leadership, Board, staff, persons served and the public benefits. Information gleaned from the dashboards will facilitate program managers, clinicians, and administrative staff in evidence-based decision-making and planning, which will positively impact clinical care and outcomes.

D. **How was the accomplishment achieved?**
The utilization of electronic data sources, as well as, information sharing with MHSD Mental Health, Addiction and Intellectual/Developmental Disabilities Divisions, allows the MHSD Division of Quality and Data Management to produce the monthly dashboard. Across programs, dashboards are created which give even greater specificity to provider performance and productivity.

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

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

<u>Accomplishment #3: MHSD's Continued Embracement of Diversity, Equity and Inclusion</u>

A. **What was achieved?**
MHSD's continued embracement of the principles of diversity, equity and inclusion within the agency and within the communities we serve.

As part of this embracement MHSD's Human Resource Department created a DEI Cultural Celebrations committee that hosts, "DEI Monthly Cultural Celebrations" that included the following **actions/activities** by respective staff:

- **Monthly Introductory Email Communication** to all MHSD staff announcing the cultural group of focus for the month based upon the national calendar of celebrations.

- Committee staff research and develop **"Did You Know"** facts about the celebrated group which will be shared during the monthly virtual gathering.
- Monthly Virtual Gathering – **"Cultural Mixer"** all staff are invited to attend and participate in discussions.

B. **Why is this success significant?**
It is well documented that biases in the workplace with regard to differences in people and biases in the community with regard to behavioral health issues can harm the wellbeing of individuals. Educating the workforce and the community in this regard makes for a healthier environment for all.

C. **Who benefits and how?**
Employees and the people that we serve benefit from Equity and Diversity Training. The community benefits from education about erasing the stigma associated with behavioral health issues.

D. **How was the accomplishment achieved?**
By Executive Leadership prioritizing educating and training around diversity and inclusion.

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

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

<u>Accomplishment #4: Continued MHSD COVID Vaccination Efforts</u>

A. **What was achieved?**
MHSD developed various strategic community-based marketing efforts to educate and encourage community members to receive the COVID-19 vaccine. Advertisements within the community (commercials, flyers, PSAs, forums) encouraged community members to get vaccinated. Additionally, providers at MHSD were encouraged to speak to each person served regarding obtaining the Covid-19 vaccination.

Additionally, MHSD established a COVID vaccination clinic that from February 2021 through June 2021. Staff members at MHSD Central City Clinic, in conjunction with Genoa pharmacy, coordinated at least thrice weekly vaccination clinics. The opportunity for vaccination was extended to all of our external partners including Odyssey House, Bridge House/Grace House, and Oxford House. Included were persons served in the DD community, as well as their caregivers. Staff members who did not receive a COVID vaccination from an outside agency were vaccinated here, as well as their family members.

B. **Why is this success significant?**
These efforts allowed access to education and care that protects the persons that MHSD serves. This is significant because enough staff members at MHSD were vaccinated to achieve herd immunity. Community members were provided the convenience of receiving a vaccination easily within their community at an accessible location. We simplified the process of obtaining the 2-step vaccination by allowing persons served or their caregivers/family members to make their appointment over the phone.

C. **Who benefits and how?**
MHSD staff and the local community benefit. Family members of vaccinated staff and community members.

D. **How was the accomplishment achieved?**
MHSD implemented the "Protect Your Neighbor, Get Vaccinated" campaign to educate the community about the COVID Vaccine. MHSD created postcards with the "Top 10 reasons to get vaccinated" and distributed the postcards via outreach efforts.
The MHSD's Executive Director, Dr. Dunham, partnered with local television station, WWL Channel 4, for live interviews about the importance of receiving the COVID Vaccine. MHSD also shared videos and images of agency staff getting vaccinated via the agency website

Staff members at MHSD Central City Clinic, in conjunction with Genoa pharmacy, coordinated at least thrice weekly vaccination clinics. Additionally, providers at MHSD were encouraged to speak to each person served regarding obtaining the COVID-19 Vaccination.

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

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

<u>Accomplishment #5: Mental Health First Aid (MHFA)</u>

A. **What was achieved?**
In FY22, MHSD has partnered with the Louisiana Public Health Institute (LPHI) and the National Association of Mental Illness (NAMI) to pool and expand trainer resources for community-wide trainings on MHFA, equipping the many to care for themselves and others thereby increasing overall population health.

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?**
This was achieved through continuous community outreach efforts.

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: Intellectual Developmental Disabilities (IDD) Division Implements Paperless Documentation

A. **What was achieved?**
The Intellectual Developmental Disabilities (IDD) filing system chronicles decades of services and supports to persons with disabilities, in an offsite warehouse, for the required years of retention. Paper storage is costly, inefficiently, and unreliably retrievable, risking disruptions in services due to the probability of lost or misplaced documents. To integrate disability information into the MHSD filing system, an electronic filing system will be implemented for scanning and filing individual records, easing access and shared data-entry between all staff.

B. **Why is this success significant?**
This accomplishment is an example of efficiency and innovation in the agency.

C. **Who benefits and how?**
MHSD's workforce and the persons they serve.

D. **How was the accomplishment achieved?**
The MHSD IDD Division, under the guidance of the MHSD Executive Leadership, successfully identified and rolled-out the software.

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: Team Based Care

A. **What was achieved?**
Metropolitan Human Services District (MHSD) is committed to an interdisciplinary team-based care approach to persons served. The interdisciplinary team coordinates care for persons served through a plan of care constructed by an interdisciplinary team of providers, to meet the stated goals and interests of persons served.

B. **Why is this success significant?**
Based on the needs of persons served, MHSD outpatient programs employ a variety of service modalities that are designed to assist persons served to achieve their goals related to mental health, psychological, social, and occupational functioning. The behavioral health goals of persons served are the focus of the team-based care approach.

C. **Who benefits and how?**
Benefits individual with behavioral health conditions, but it also benefits providers via collaborative learning experiences.

D. **How was the accomplishment achieved?**
Planning and execution by MHSD executive leadership and program 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.

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

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

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

MHSD has made significant progress towards the accomplishment of the goals outlined in its five-year (2020-2025) strategic plan. Strategies, as measured by performance indicators, have generally been shown to be effective. Performance measurement, data analysis and other information indicate a positive ROI (Return on Investment) when monitoring the linkage between performance and district budgeting.

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

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

  MHSD has made significant progress towards its initiatives related to establishing a quality Tele-behavioral Health Program, Data-based Staff Performance Initiative, Mental Health First Aid training, and DEI programing. Success is attributed to MHSD Executive Leadership's early allocation of resources to this initiative. Progress is related to agency-wide efforts with the intention to increase access to and efficiency of care.

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

  Progress is expected to continue at an accelerated pace. Although fully implemented, MHSD is continuing to identify and address areas for improved efficiency and are responding to administrative and clinical needs.

- **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.

Slow progress was seen in the area of outreach and prevention, although some improvements have been made when compared to FY20-21. Due to COVID-19 social distances guidelines, outreach events and one-on-one prevention activities with at-risk substance use populations were impacted in FY22. Innovative and alternative methods to connect with the community have been and are being implemented.

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?

   Lack of progress is due to a set of circumstances related to COVID-19. Outreach programs related to substance use have begun using virtual events to communicate information and messaging in MHSD communities. Following COVID-19 guidelines and precautions, outreach providers will continue to conduct their outreach activities. MHSD will continue to closely monitor progress with this program in FY23.

- **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?

  After careful review and consideration of our successes, the current strategic plan adequately represents the agency. Adjustments were not needed.

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

  MHSD's Executive Leadership and Management team conducts weekly staff meetings where roundtable discussions are held on current projects and timelines. During these meetings, leaders from respective areas within the organization are able to provide input, communicate roadblocks and determine execution of various initiatives. The Executive

Director also meets individually on a weekly basis with Division Directors from Fiscal, Legal/Compliance, Quality, Adult, Children's and I/DD to obtain status reports. On a quarterly basis, Division Directors report on strategic plan indicators for which their divisions are responsible, and monthly the Executive Director meets with the Board of Directors and provides a status report on key performance indicators for the organization.

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

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

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

A. Problem/Issue Description

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

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

B. Corrective Actions

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

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

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

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

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

5. Do corrective actions carry a cost?

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

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

A. Check all that apply.

☒ **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 c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

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

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive 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):

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, including:
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

Report #1:

1. **Title of Report**:
   AP/Accountability Plan

2. **Date Complete**:
   12/12/2021

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 used for analysis or evaluation**:
   Site monitoring consisted of a joint OBH and OCDD Review team to include data reviews, chart audits, and interviews with staff.

5. **Cost**:
   In-house. 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

Report #2:

1. **Title of Report**:
   Independent Financial Audit

2. **Date Completed**:
   Expected completion August 2022

3. **Subject/Purpose**:
   Full independent audit of MHSD as an independent fiscal entity

4. **Methodology used for analysis or evaluation**:
   External audit firm selected by LLA and used standard audit approach including A-133 single audit

5. **Cost**:
   None

6. **Major Findings**:
   No findings – unqualified audit

7. **Major Recommendations**:
   No recommendations for MHSD

8. **Action**:
   MHSD has shared report with its Board and Leadership staff.

9. **Availability**:
   Hardcopy and electronic format

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

Report #3:

1. **Title of Report or Program Evaluation**:
   MHSD Operations Risk Management Audit

2. **Date completed**:
   March 2022

3. **Subject or purpose:**
   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:**
   N/A

6. **Major Findings and Conclusions**:
   Status: compliant

7. **Major Recommendations**:
   Blood Borne Pathogens: Conduct documented employee training on BBP (including the agency's policy) for all high-risk employees annually after initial orientation training.

8. **Action taken in response to the report or evaluation**:
   Blood borne Pathogens: Due to Insurance information notice 2020-5, COVID-19 waiver, the high-risk BBP training was not conducted during this audit year.

9. **Availability:**
   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

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department: **Louisiana Department of Health (LDH)**
09-305 Medical Vendor Administration
09-306 Medical Vendor Payments

Department Head: **Dr. Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Assistant Secretary: **Tara A. LeBlanc**
Medicaid Executive Director

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

Accomplishment #1: Act 421/TEFRA

A. What was achieved?
The Act 421/TEFRA program was launched on January 1, 2022.

B. Why is this success significant?
This program provides a pathway for Medicaid eligibility to children with complex medical conditions who wouldn't otherwise qualify for Medicaid due to their family's income and/or resources.

C. Who benefits and how?
Children with disabilities and complex health conditions who were previously ineligible for Medicaid will now receive Medicaid eligibility. Medicaid eligibility provides children with access to Medicaid State Plan services including the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit that ensures children have access to all medically necessary services. In addition, Medicaid coverage helps children gain access to additional services which are not always covered under private insurance plans.

D. How was the accomplishment achieved?

Act 421 of the 2019 Regular Legislative Session tasked the Louisiana Department of Health with establishing a TEFRA program. A State Plan Amendment (SPA) was submitted to CMS to create the program. CMS approved the SPA in December 2021 and on January 1, 2022 Medicaid began accepting applications for this program. Medicaid and the Office for Citizens with Developmental Disabilities (OCDD) established a workgroup to plan for and implement the TEFRA program and this workgroup continues to oversee and monitor the program.

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

Yes, implementation of the Act 421 program contributed to the success of the state fiscal year 2022 LDH Business Plan. Specifically, the creation of the Act 421 program served as one of the goals of the larger initiative to increase and strengthen service delivery for vulnerable residents. By providing a new Medicaid eligibility pathway for children with disabilities and complex medical conditions, eligible children will now have access to additional services which will allow them to be better supported in their home while reducing some of the financial burden placed on these 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, cross-agency collaboration between Medicaid and the Office for Citizens with Developmental Disabilities throughout the planning stages was a key driver towards the successful implementation of this program. Also, routine stakeholder engagement allowed for stakeholders to provide input early into the planning stages of the program and LDH was able to incorporate much of the feedback it received into the final design of the program. The Department also rolled out a robust communications plan ahead of implementation to increase awareness of this new program among families, medical practitioners, and other stakeholders.

Accomplishment #2: Public University Partnership Program (PUPP)

A. What was achieved?

Medicaid implemented the Public University Partnership Program (PUPP) as a cost sharing partnership to fund research applications of Louisiana Public Universities which focus on improvement opportunities within the Medicaid priorities. In this initial year, university research at Louisiana State University Health Sciences Center and Pennington Biomedical Research Center received funding to address opioid use, health policy review, maternal and newborn outcomes and improvements in diabetes care.

B. Why is this success significant?

This program signals the beginning of partnerships to collaboratively work with university researchers to shape public policy and implement innovative approaches that address the many challenges facing Medicaid programs today.

Findings from the research projects will guide policy-making and promote new

approaches to address Medicaid priorities. These priorities include improving maternal and neonatal outcomes, improving early childhood health and development, reducing deaths and illness with a focus on preventive care, improving mental health and substance use outcomes, and improving health equity.

C. Who benefits and how?

Medicaid participants overall benefit as they will be the recipients of program innovation identified by the research projects. The Agency benefits by leveraging the expertise of public universities and colleges to inform Louisiana Medicaid policy and program. The public universities benefit from this partnership to create or expand research through additional federal funding which can provide new opportunities for students and junior researchers working with experienced research Principal Investigators.
Lastly, the Agency will be provided with actionable data to improve Medicaid program covered services and benefits administration.

D. How was the accomplishment achieved?

The program was championed by the Medicaid Deputy Director and the Chief Medical Officer after meeting with the Kentucky's State Medicaid who have operated their university partnership program since 2018. The proposal was reviewed with the Undersecretary, the Bureau of Legal Services, and the Medicaid Executive Management Team for approval to proceed.

The Agency sought Prior Approval with CMS for 42 CFR 433.51 for Public Funds as the State share of financial participation and received approval in November 2020. The Universities' CPE qualify for up to 50% federal matching funds, creating a funding pass-through for the State Medicaid Plan.

After the implementation process was developed, program deliverables were summarized in the NOFO and released in July 2021. Subsequently, the Agency had informal sessions with internal and external stakeholders for feedback and held a more formal Q&A session with interested universities in August 2021.

Applications from the four university submissions were screened and reviewed with the Medicaid CMO, before final review by the Bureau of Legal Services and the Quality Section Chief for approval. All four University applicants were awarded funding notification in November 2021 with the expected start date as 1st Quarter 2022. Learnings from this process will be used to refine program operations for subsequent NOFO cycles.

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

Strategic partnerships with Louisiana's public universities and colleges will help LDH make data-driven decisions and improve the quality of services provided to the public. This program was included in the LDH Business Plan as an initiative under Commitment 3 "Enhance Customer Service, Partnerships and Community Relations."

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

This exact funding program cannot be replicated with other Agencies due to the unique funding source from the Social Security Act [Section1903 (a) (7)] for the proper and efficient administration of the Medicaid State Plan. However, the partnerships with universities for consultative purposes should be expanded.

Accomplishment #3: Comprehensive Dental Coverage

A. What was achieved?

Medicaid successfully Implemented comprehensive dental coverage for adults over age 21 enrolled in an Intellectual/Developmental Disabilities (I/DD) Waiver. Benefits include diagnostic services, preventive services, restorative services, endodontics, periodontics, prosthodontics, oral and maxillofacial surgery, orthodontics, and emergency care.

B. Why is this success significant?

Routine and preventive dental care is essential not only for good oral health, but for a person's overall health. Before implementation of this initiative, adults in I/DD waivers had access to denture only coverage. This has expanded oral healthcare coverage for over 10,000 Louisiana Medicaid beneficiaries.

C. Who benefits and how?

Adults 21 years of age and older who are enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver now have access to the following services, provided through the contracted Dental Benefit Plan Managers:

- Diagnostic services
- Preventive services
- Restorative services
- Endodontics
- Periodontics
- Prosthodontics
- Oral and maxillofacial surgery
- Orthodontics
- Emergency care

D. How was the accomplishment achieved?

Act 450 (House Bill 172) of the 2021 Regular Session provided funding to ensure comprehensive dental care to adults enrolled in a Medicaid I/DD waiver.

LDH obtained a waiver from CMS to allow comprehensive dental coverage for adults enrolled in a Medicaid I/DD waiver, engaged actuaries for rate setting, engaged vendors for systems design and development changes, published rulemaking/notice of intent, implemented a communications plan, and published provider manuals and fee schedules.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
(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?
No

Accomplishment #4: Medicaid Provider Enrollment Portal

A. What was achieved?
Louisiana Medicaid launched its Louisiana Medicaid Provider Enrollment Portal July 26, 2021 to screen and enroll all Medicaid providers as required by the 21st Century Cures Act. This includes current managed care organization (MCO) only providers, Dental Benefits Program Manager (DBPM) providers, Coordinated System of Care (CSoC) providers and existing fee-for-service providers.

B. Why is this success significant?
As a part of the Affordable Care Act and later refined in the 21st Century Cures Act, federal laws enforced by CMS require that states screen and enroll providers. The Louisiana Medicaid Provider Enrollment Portal will bring Louisiana Medicaid into compliance with CMS revalidation and managed care screening requirements and federal law.

C. Who benefits and how?
This will bring the state into compliance with current federal requirements. Per CMS requirements, all providers must be screened by the state at the following intervals:

• When they initially apply for and submit an application to become a Medicaid provider

• Upon reenrollment (reactivation of a previously closed provider number) in the state's Medicaid program; and

• At least once every five years to revalidate their enrollment, which is similar to the re-credentialing process that all MCOs and DBPMs complete every three years.

Provider enrollment is a key program integrity tool to protect Medicaid from fraudulent and abusive providers

D. How was the accomplishment achieved?
The Louisiana Medicaid Provider Enrollment Portal was designed to meet a Centers for Medicare and Medicaid Services (CMS) requirement and must be used by any providers that provide care to Medicaid members and file claims with Louisiana Medicaid.

Louisiana Medicaid's fiscal intermediary sent an invitation to the mailing address on file for current providers. The portal was prepopulated with information that the state, MCOs, DBPMs and Magellan already have on file so that the provider could more easily submit an application through the portal. This streamlined process eliminates the need to complete and mail a paper application. Also, providers have the ability to track their application through the portal.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
(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?
No

Accomplishment #5: Coverage of Community Health Workers

A. What was achieved?
Louisiana Medicaid added coverage of services rendered by qualified Community Health Workers (CHW), effective for dates on or after January 1, 2022 to help bridge the gap between patients and providers. Community health workers are lay people with specialized training who can help people understand their medical care, develop and stick to a treatment plan, navigate the healthcare system, and help address needs like transportation, housing, and food.

B. Why is this success significant?
Community health worker services have been shown to improve treatment of chronic diseases, improve quality of care, and reduce costs from complications, as well as the following:

- Improved access to health care services.
- Increased health and screening.
- Better understanding between community members and the health and social service system.
- Enhanced communication between community members and health providers.
- Increased use of health care services.
- Improved adherence to health recommendations.
- Reduced need for emergency and specialty service

C. Who benefits and how?
Louisiana Medicaid beneficiaries benefit by enabling access to the following services:

- Health promotion and coaching. This can include assessment and screening for health related social needs, setting goals and creating an action plan, on-site observation of beneficiaries' living situations, and providing information and/or coaching in an

individual or group setting;
- Care planning with the beneficiary and their healthcare team. This should occur as part of a person-centered approach to improve health by meeting a beneficiary's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention; and
- Health system navigation and resource coordination services. This can include helping to engage, re-engage, or ensure patient follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions

D. How was the accomplishment achieved?

Implementation was achieved through a submission of a State Plan Amendment for Community Health Worker services, and development of a service description, qualifications, and reimbursement for CHWs.

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

(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?

No

Accomplishment #6: Workforce Development Training Program

A. What was achieved?

In FY22, Medicaid successfully launched and completed a workforce development training program with a goal of hiring and training 100 individuals, with 25% of new hires to be current Medicaid recipients. LDH partnered with Louisiana State Civil Service, the Louisiana Workforce Commission, and other state partners in the development of a workforce development training pilot program. The pilot program consisted of the development of a screening tool to measure the proficiency of new hires in core competencies specific to Medicaid Analysts and supplemental training to enhance competency.

B. Why is this success significant?

Over the course of FY22, Medicaid surpassed the initial goal to which 111 individuals were employed; 5 did not complete the training as they resigned. 106 individuals remain employed by LDH as of June 30, 2022 and are fully trained. 43% (46 of the 106) individuals who remain employed are Medicaid recipients, exceeding the initial goal of 25%. All deliverables and goals were met for this Business Plan initiative.

C. Who benefits and how?

Citizens benefit by having the opportunity to join our team and learn on-the-job skills to make them proficient in the positions. Additionally, Medicaid beneficiaries, including

those employed by this initiative, benefit by having sufficiently staffed workforce to make timely and accurate Medicaid eligibility determinations.

D. How was the accomplishment achieved?

In order to fulfill this initiative, a number of recruitment strategies were utilized, including participating in over 15 outreach events, such as job fairs and community events/festivals. Events coined "Reach & Recruits" were set up in areas such as universities, rural shopping centers, and parking lots to reach community members who otherwise may not have had access to this job opportunity. Staff shared Medicaid Facebook messages to reach their friends and families, increasing word of mouth outreach. Medicaid analyst supervisors led much of the outreach in order to achieve this goal. Flyers outlining the benefits of working for Medicaid were distributed across Louisiana, reaching the most remote rural areas. The regional Medicaid staff invested in building their teams.

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

Yes, Activity 1 – Medicaid and CHIP Eligibility Determination. FY2017-2022LDHStrategicPlan.pdf

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: Increased transparency, accountability, and compliance in Medicaid eligibility determinations

A. What was achieved?

The Medicaid team worked to develop a standard reporting mechanism that allows dissemination of Medicaid application and renewal processing metrics, case review findings with corrective action plans, and error trends to all Medicaid eligibility team members with a goal to reduce eligibility error rates to 6% or less by June 30, 2022 and to maintain monthly case review error rates below 10% after the COVID-19 PHE ends.

B. Why is this success significant?

A Medicaid Monthly Case Review Report began to be disseminated in March 2021, which contained monthly error rates by program, eligibility criteria area and region. Statewide and region-specific remedial trainings were held to address identified common error trends. As of June 30, 2022, error rates decreased from a maintained rate of 10% to 7%. Though the end of the COVID-19 PHE did not occur in FY22, LDH is continuously working to achieve the overall monthly goal of 6% or less, thus making the likelihood to maintain an error rate below 10% post-PHE much more probable.

C. Who benefits and how?

All parties to Medicaid eligibility benefit from this accomplishment. Decreasing the monthly rate potentially leads to increased accuracy in expenditure of federal and state dollars, less audit findings and disallowances to the agency, increased accuracy and job satisfaction for Medicaid analysts, and timely and accurate determinations for Medicaid beneficiaries.

D. How was the accomplishment achieved?
Remedial trainings were provided to all eligibility team members based on the error type identified on the error report generated and disseminated on a monthly basis. In addition to the remedial trainings, Supervisors worked with individual team members on errors identified in the monthly report to reduce errors in the future.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, Activity 1 – Medicaid and CHIP Eligibility Determination.
FY2017-2022LDHStrategicPlan.pdf

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

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

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

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

Accomplishment #1: Act 421/TEFRA
The Act 421 program was implemented on schedule. Routine meetings with the Act 421 workgroup allowed the group to identify and get ahead of issues before they became problems. The investment to create this program allows children access to Medicaid covered services who would otherwise be ineligible.

Accomplishment #2: Public University Partnership Program (PUPP)
Medicaid implemented the Public University Partnership Program (PUPP) as a cost sharing partnership to fund research applications of Louisiana Public Universities which focus on improvement opportunities within the Medicaid priorities. In this initial year, university research at Louisiana State University Health Sciences Center and Pennington Biomedical Research Center received funding to address opioid use, health policy review, maternal and newborn outcomes and improvements in diabetes care.

Accomplishment #3: Comprehensive Dental Coverage
No answer available.

Accomplishment #4: Medicaid Provider Enrollment Portal
No answer available.

Accomplishment #5: Coverage of Community Health Workers
No answer available.

Accomplishment #6: Workforce Development Training Program
The Medicaid Eligibility Division attempts to recruit and retain employees while empowering its employees and creating an innovative work environment. Continuous process improvements, remedial trainings and professional development along with strategies such as flexible work schedules, out-stationing and telecommuting are beneficial by allowing flexibility in managing work and family responsibilities and improving morale. These strategies create a more favorable work environment which results in higher levels of service to the residents we serve.

Accomplishment #7: Increased transparency, accountability, and compliance in Medicaid eligibility determinations
In November 2018, LDH replaced its decades old Medicaid eligibility and enrollment system with modern technology. The new system (LaMEDS) improves customer service to applicants and enrollees. A "self-service" web portal provides applicants and enrollees with the convenience of updating their own information – addresses, employment, household characteristics – 24 hours a day, seven days a week. Eligibility decisions are faster – within minutes for online applications and renewals when additional information or documentation is not required. In addition to real-time eligibility decisions, automated checks of 20 state and federal databases provide greater assurance that benefits go only to those who meet eligibility requirements, increasing program integrity. Likewise, the use of an automated business rules engine provides for consistent application of a complex and dynamic set of rules governing Medicaid eligibility and regulatory compliance. With this new, highly automated system and technology-reliant customer service functions, Medicaid strives to strike the right balance between streamlining enrollment and continuing coverage of people who meet eligibility requirements and preventing enrollment or ending coverage of people who do not.

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

  1. To what do you attribute this success? For example:
     - Is progress largely due to the effects of external factors? Would the same

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

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

Accomplishment #1: Act 421/TEFRA

As of August 5, 2022, 413 children were enrolled in the Act 421 program and eligible for Medicaid. Ramp up of the program is still occurring and we have not yet experienced a "leveling off" of applications. Throughout the remainder of the calendar year, enrollment is expected to continue to grow as more families learn of this program.

Success of this program may in part be attributed to the cross-agency workgroup that was established, routine meetings to ensure timely completion of deliverables, and allocation of a dedicated project manager for a large portion of the planning and development period. Success following implementation may be defined by the number of children enrolled in the program and this number is expected to increase at least throughout the remainder of the calendar year.

Accomplishment #2: Public University Partnership Program (PUPP)

The Agency positioned itself to be a resource to our current university awardees by providing guidance through the process of contracting and onboarding. This meets the goal of enhancing customer service. Our goal is to guide the university through the administrative process to allow them to return to research objectives as timely as possible.

The Agency wants to ensure that information about this new program is disseminated to all eligible university researchers and related programs. The information may need additional effort during our initial year to reach interested parties, especially to those who previously may have been diverted from Hurricane IDA recovery. The Agency leveraged information about the university awardees in press releases to increase awareness of the program. The Agency is promoting information through traditional media as well as aggressive outreach to other Louisiana colleges and universities not yet participating. The Agency has expanded outreach to identify multiple contacts at Louisiana public colleges and universities and has made direct telephone and email communication to their Sponsored Programs Department

Accomplishment #6: Workforce Development Training Program

We are currently facing a tremendous reduction of force and have been diligently working towards ensuring that our agency remains a competitive employer without compromising our goals. The development of the pilot program to measure the

proficiency of new hires in core competencies specific to Medicaid Analysts has been beneficial. Progress is being monitored to enhance competencies.

Medicaid expects to see progress due to flexible work schedules. In addition, we expect to see significant progress in the areas of recruitment and retention as LDH is currently in discussion with HR/Civil Service regarding Special Entrance Rates and Premium Pay for eligibility determinations staff.

Accomplishment #7: Increased transparency, accountability, and compliance in Medicaid eligibility determinations

Since implementation and throughout the PHE, over 5500 enhancements has been made to the system. Many of these enhancements are in preparation for the end of the PHE Progress is expected to continue through continuous improvement that is technology driven.

- **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?

Accomplishment #2: Public University Partnership Program (PUPP)

Since the awards are on yearly timeframe, the delays experienced in Year 1 due to Hurricane IDA recovery will not impact subsequent years, unless Louisiana experiences a similar scenario during the NOFO application timeframe. Year 1 University Awardees were completely funded in March for LSUHSC and July for PBRC.

Accomplishment #7: Increased transparency, accountability, and compliance in Medicaid eligibility determinations

Employee retention and recruitment. It is unknown whether this set of circumstances will continue in light of the end of the PHE.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?** To check one of the boxes, place your cursor on the appropriate box and double click. When another box appears, under "default value" choose "checked."

Accomplishment #1: Act 421/TEFRA

☐ Yes. If so, what adjustments have been made and how will they address the situation?
☒ No. If not, why not?
No strategic plan revisions necessary for this accomplishment.

Accomplishment #2: Public University Partnership Program (PUPP)

☐ Yes. If so, what adjustments have been made and how will they address the situation?
☒ No. If not, why not?
No strategic plan revisions necessary for this accomplishment.

Accomplishment #3: Comprehensive Dental Coverage

☐ Yes. If so, what adjustments have been made and how will they address the situation?
☒ No. If not, why not?
No strategic plan revisions necessary for this accomplishment.

Accomplishment #4: Medicaid Provider Enrollment Portal

☐ Yes. If so, what adjustments have been made and how will they address the situation?
☒ No. If not, why not?
No strategic plan revisions necessary for this accomplishment.

Accomplishment #5: Coverage of Community Health Workers

☐ Yes. If so, what adjustments have been made and how will they address the situation?
☒ No. If not, why not?
No strategic plan revisions necessary for this accomplishment.

Accomplishment #6: Workforce Development Training Program

☐ Yes. If so, what adjustments have been made and how will they address the situation?
☒ No. If not, why not?
No strategic plan revisions necessary for this accomplishment.

Accomplishment #7: Increased transparency, accountability, and compliance in Medicaid eligibility determinations

☐ Yes. If so, what adjustments have been made and how will they address the situation?
☒ No. If not, why not?
No strategic plan revisions necessary for this accomplishment.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**
On a Department-wide level, Performance-Based-Budgeting activities (including 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.

Additionally, Medicaid staff helped develop the LDH Business Plan in furtherance of our Strategic Plan goals as our roadmap for Fiscal Year 2023. In Medicaid, each project target division generates weekly reports and goals with progress update. These updates are prepared for leadership to assess progress on strategic priorities.

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?**
   With the end of the COVID-19 Public Health Emergency (PHE) potentially looming, Medicaid is under-resourced to handle the impending workload for the eligibility maintenance of effort unwind. Eligibility verifications have backlogged without Medicaid being able to take action for two and a half years. Staff members facing personal PHE struggles and fear of return to work/hybrid work schedules due to safety concerns amplifies this issue.

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

3. **What organizational unit in the department is experiencing the problem or issue?**
   The agency is limited to a certain number of staff that remains stagnant, unable to expand resources to support program growth due to state budget constraints, and often unable to recruit viable candidates because salaries are not competitive with the commercial and private sectors. All of this leads to a lean workforce and shallow resource pool. Further, we are now reducing contract budgets to address state budget shortfalls, many of which are staff augmentation contracts that Medicaid relies on to help fill the resource gaps due to internal/civil service limitations. To assume that all staff will manage individual programs within the Medicaid framework is not practical. Rather, they manage complex facets of the overall program. Medicaid continues to work with Civil Service to address these challenges.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   This problem affects external customers, specifically Medicaid enrollees. Additionally, if enrollee information is not correct, this affects provider payments if retroactive corrections occur.

5. **How long has the problem or issue existed?**
   This has been a problem since the passage of the Families First Coronavirus Response Act.

6. **What are the causes of the problem or issue? How do you know?**
   The ability to hire additional staff are limited by budgetary constraints. Additionally, Civil Service requirements do not allow for appropriate flexibility.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   The consequences of failure to comply with the timeline set by CMS could potentially be disallowed funds, audit, as well as, loss of public resources that should have been cost avoided. In addition, we anticipate staff fatigue and attrition resulting from the workload volume.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? To check one of the boxes, place your cursor on the appropriate box and double click. When another box appears, under "default value" choose "checked."

   ☒ 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?

To check one of the boxes, place your cursor on the appropriate box and double click. When another box appears, under "default value" choose "checked."

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 c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews

LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive 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 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, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

Report #1

1. **Title of Report or Program Evaluation**:
   Continuity of Care for Newborns
2. **Date completed**:
   January 2022
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 repost 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 re-hospitalization rate for infants born during calendar year 2020 who were born premature at less than 37 weeks' gestational age and are in their first six months of life is 3.21 percent. The calendar year 2020 re-hospitalization rate was 3.21 percent. This indicates that the re-hospitalization rate in this group of newborns has improved slightly over the past two reporting years.
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/index.cfm/newsroom/detail/2928
10. **Contact person for more information:**
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #2

1. **Title of Report or Program Evaluation**:
   Louisiana Medicaid Diabetes and Obesity Report
2. **Date completed**:
   January 2022
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/index.cfm/page/2115
10. **Contact person for more information:**
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #3

1. **Title of Report or Program Evaluation**:
   Medicaid Managed Care Quarterly Transparency Reports SFY 2022
2. **Date completed**:
   Quarterly 2022
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 2021 (July 1, 2021 to June 30, 2022) 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/news/5061
10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #4

1. **Title of Report or Program Evaluation**:
   Healthy Louisiana Claims Report
2. **Date completed**:
   Quarterly 2022
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)**:
   Healthy Louisiana Claims Report | Department of Health | State of Louisiana
10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #5

1. **Title of Report or Program Evaluation**:
   LaCHIP Annual Report (Mid-Year)
2. **Date completed**:
   February 2022
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**:
   178,085 children and pregnant women have acquired access to critical healthcare coverage in SFY 2022. 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/index.cfm/newsroom/detail/2238
10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #6

1. **Title of Report or Program Evaluation**:
   Medicaid Forecast Report SFY 21/22
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)**:
   Medicaid Forecast Reports SFY 2020/2021 | Department of Health | State of Louisiana (la.gov)

10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #7

1. **Title of Report or Program Evaluation**:
   Quarterly Crowd-Out Report (HCR 57)
2. **Date completed**:
   May 2022
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   Provides data from potential Medicaid enrollees about their private health insurance status and participation in, or offers of, employer-sponsored insurance at both the time of their application and the time of their eligibility redetermination.
4. **Methodology used for analysis or evaluation**:
   During the application and renewal process, potential and active Medicaid enrollee are asked about their private health insurance status and participation in, or offers of, employer sponsored insurance. Additionally, at renewal, applicant checks occur against Third Party Liability (TPL) data files that determine if the enrollees have private insurance. Due to the PHE, standard renewal packets were paused from March 2020 through January 2021.
5. **Cost (allocation of in-house resources or purchase price)**:
   Report complete by in-house staff.
6. **Major Findings and Conclusions**:
   As of 6/23/22, LDH has sent 82,203 standard renewal packets and 504,114 members were eligible for renewal during the third quarter reporting period.
7. **Major Recommendations**:
   (Not Applicable)
8. **Action taken in response to the report or evaluation**:
   (Not Applicable)
9. **Availability (hard copy, electronic file, website)**:
   Response to HCR 57 of the 2020 Regular Session | Department of Health | State of Louisiana
10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #8

1. **Title of Report or Program Evaluation**:
   Medicaid Managed Care Transparency Report - Annual
2. **Date completed**:
   July 2022
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   This report is the seventh in a series produced by the Louisiana Department of Health (LDH) to satisfy statutory reporting requirements intended to ensure certain outcomes achieved by Medicaid Managed Care Programs as per La Revised Statute 40:1253.2.
4. **Methodology used for analysis or evaluation**:
   To the greatest extent possible, the data are extracted from state systems that routinely collect and maintain operational data on the Medicaid Managed Care Program, the Medicaid Management Information System (MMIS), Management Administrative Reporting Subsystem (MARS Data Warehouse or MDW), or ISIS the state administrative system. When unavailable from state sources, data were collected from the managed care entities or sourced from either routine reporting deliverables or ad hoc reports requested specifically for this purpose.
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/page/4487
10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #9

1. **Title of Report or Program Evaluation**:
   HCR 2 Quarterly Report – Medicaid Expansion Enrollment and Claims Data
2. **Date completed**:
   May 2022
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   In response to House Concurrent Resolution 2 (HCR 2) of the 2021 Regular Session, the Louisiana Department of Health (LDH) submits the report. The resolution requires LDH to publish on a quarterly basis a report containing data

directly related to payment for health care services through the implementation of a health coverage expansion of the Louisiana medical assistance program.

4. **Methodology used for analysis or evaluation**:
   (a) Total Medicaid expansion enrollment on a monthly basis from July 2021 through March 2022.
   (b) The average monthly expansion premium paid to managed care organizations providing benefits and services to eligible Medicaid enrollees and the portion of the premium related to hospital payments for the January 1, 2022 rates.
   (c) The aggregate Medicaid expansion claims payment by provider type for July 2021 through March 2022.
   (d) The total amount of inpatient and outpatient Medicaid expansion claims paid to hospitals delineated by individual hospital for July 2021 through March 2022 separated into two attachments by inpatient and outpatient.
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/news/6385
10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #10

1. **Title of Report or Program Evaluation**:
   Act 540 Uncompensated Care Cost Report - Collected per Survey for Dates of Service 7/1/2020 through 6/30/2021
2. **Date completed**:
   November 2021
3. **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.
4. **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.

5. **Cost (allocation of in-house resources or purchase price)**:
   Myers & Stauffer, LC: as part of contract.
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/news/1454
10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #11

1. **Title of Report or Program Evaluation**:
   HR 196 RS 2021 NEMT Financing Report
2. **Date completed**:
   October 2021
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   House Resolution (HR) 196 and Senate Resolution (SR) 211 of the 2021 Regular Legislative Session directed LDH to examine existing reimbursement rates for transportation providers, as well as means of financing.
4. **Methodology used for analysis or evaluation**:
   Rates were obtained from Louisiana's fee schedule and the fee schedules of the eight comparator states (Appendix A). The effective rate floor (the sum of the base rate floor and per-mile rate floor) was calculated for trip legs of five different mileages for each of the nine states.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by internal staff
6. **Major Findings and Conclusions**:
   In comparison to other states included in this study, Louisiana's effective rate

floor ranked seventh out of nine for five-mile trip legs and fifth out of nine for trip legs longer than 15 miles. The ambulatory per-mile rate floor and wheelchair per-mile rate floor would need to be raised to $2.22 (an increase of $1.12 over the current floor) and $4.08 (an increase of $2.78 over the current floor), respectively, for Louisiana's effective rate floors to be in the top quartile for 5 mile transports. Note that raising the per-mile rate floor would put Louisiana firmly in the top quartile for longer trip leg as well.

7. **Major Recommendations**:
   To provide additional financial support to transportation providers, LDH added a $9 million bonus payment in the home and community based spending plan. This will provide a supplemental payment to each NEMT provider of $500 per vehicle per month, with a maximum payment of $1,500 per month for each transportation provider.
8. **Action taken in response to the report or evaluation**:
   In accordance with the LDH Business Plan, LDH will establish a rate review process for all rates set by the department. The rates for all providers will be reviewed no less than every three years and a report will be provided to the Legislature for funding consideration. LDH has done a rate review for NEMT and will be recommending an adjustment for the rate year beginning January 2022 along with other adjustments. LDH believes that those annual recommendations are best reviewed in a package so that all competing recommendations may be reviewed together in consideration of limited funding. LDH is also committed to reviewing current program spending trends and adjusting existing funding to more efficiently use state dollars. Using this process can eliminate or reduce the need to ask for additional state dollars when efficiencies are identified. Additionally, having a defined process that looks at more than referenced states with differing state laws and program requirements does provide a complete level of information for analysis. Finally, unlike other providers, NEMT providers are not required to submit cost reports for LDH to determine if rates approximate the cost of doing business.
9. **Availability (hard copy, electronic file, website)**:
   https://ldh.la.gov/news/6389
10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #12

1. **Title of Report or Program Evaluation**:
   HCR 34 Medicaid Dental Coverage for Adult ICF Residents
2. **Date completed**:
   January 2022

3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   During the 2021 Regular Session, the Louisiana Legislature passed House Concurrent Resolution (HCR) 34, requiring Louisiana Department of Health (LDH) to research available means of financing to add dental benefits for adults residing in intermediate care facilities (ICFs). LDH has determined that inclusion of the administration of dental services in ICFs is a federal requirement. The Department will achieve this mandate by amending the current ICF provider agreements to include the requirement to contract with the Louisiana Medicaid dental benefit plan managers (DBPM).
4. **Methodology used for analysis or evaluation**:
   As part of the research for this report, a survey was created by LDH and distributed to ICFs to determine the current state of dental services provided by the ICFs. Of the 21 facilities that responded all but two stated that their residents ages 21 and older currently receive some dental services from the facility. Of those 21 facilities, five stated that some level of their dental services are provided on site at the facility. The remaining facilities provide all dental services off site. All facilities noted that their beneficiaries receive at least one routine dental exam per year. Concerning the current payment for services, nine facilities stated that all dental services are covered through the existing per diem paid by Medicaid. Five facilities stated that some services are paid through the per diem but other services are billed separately. Seven facilities stated that their dental services are either billed separately to Medicaid or charged to the resident's family.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by internal staff
6. **Major Findings and Conclusions**:
   In order to implement coverage for these beneficiaries, LDH will need to work with the ICFs to amend their provider agreements. Contracts between the ICFs and the DBPMs will be necessary to ensure compliance with all requirements of the program. LDH will need to work with its contracted actuary to establish actuarially sound PMPM rates for the ICF population. Amendments to the DBPM contracts and CMS approval will also be required.
7. **Major Recommendations**:
   Not Applicable
8. **Action taken in response to the report or evaluation**:
   In responding to the survey, several facilities noted that, while they provide dental services to their residents, the per diem that they receive from the state currently does not cover all of the expenses that are incurred in the regular treatment of their residents. As of January 2021, Medicaid enrolled adult ICF residents into a DBPM for denture services only. ICF residents had previously received adult denture benefits through a fee-for-service delivery system. Enrollment into a DBPM offered a plan choice, as well as access to some value-added services such as extractions.
9. **Availability (hard copy, electronic file, website)**:

https://ldh.la.gov/news/6497

10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #13

1. **Title of Report or Program Evaluation**:
   SR 82 RS 2021 Louisiana Medicaid Non-opioid Pain Treatment and Opioid Alternatives
2. **Date completed**:
   December 2021
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   In response to this issue, Senate Resolution (SR) 82 of the 2021 Regular Legislative Session, resolved that the Louisiana Department of Health (LDH) shall report on options regarding reimbursements for non-opioid pain treatment and opioid alternatives in the Louisiana Medicaid program. This report is divided into three sections:
   - Non-opioid pharmacologic treatments
   - Medical and restorative services and devices
   - Interventional procedures
4. **Methodology used for analysis or evaluation**:
   LDH identified evidence-based treatments through review of the Pain Management Best Practices Inter-Agency Task Force Report produced by the United States Department of Health and Human Services (HHS).
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by internal staff
6. **Major Findings and Conclusions**:
   Under federal law (Section 1927 of the Social Security Act), state Medicaid programs must cover all U.S. Food and Drug Administration (FDA) approved medications where the manufacturer has signed a rebate agreement with the Centers for Medicare & Medicaid Services (CMS). In addition, while not coverable by Medicaid, RS 40:1046 and RS 40:1047 established the Medical Marijuana Program in Louisiana.
7. **Major Recommendations**:
   Not Applicable
8. **Action taken in response to the report or evaluation**:
   Not Applicable
9. **Availability (hard copy, electronic file, website)**:
   chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://ldh.la.gov/assets/docs/

LegisReports/SR82_LegislativeReport.pdf

10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #14

1. **Title of Report or Program Evaluation**:
   Medicaid PDL (MPP) Response to Act 207 of the 2003 Regular Session
2. **Date completed**:
   February 2022
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) 2022.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by internal staff
6. **Major Findings and Conclusions**:
   Expenses for these services to members, which includes capitation payments, totaled $27,327,621 during the first six months of SFY 2022. Since the inception of MPP, 27,210 individuals have been enrolled in the program. Enrollment through December 31, 2021 was 5,681 individuals. Enrollment decreased significantly from SFY 2021 as many previously enrolled MPP members transitioned to the Adult Expansion Group.
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/news/1397
10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #15

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**:
   October 2021
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 2015-2016 (FY2016) and the first quarter of fiscal year 2016-2017 (FY2017).
5. **Cost (allocation of in-house resources or purchase price)**:
   Magellan Rx Management Company
6. **Major Findings and Conclusions**:
   The LDH PDL program continues to be very successful. Savings for FY2020 were over $73 million; savings have increased from FY2019 due to the Single PDL implementation on May 1, 2019. Louisiana's estimated savings for FY 2021 are over $66.86 million. The implementation of the innovative Hepatitis C Subscription Model is an important achievement for Louisiana Medicaid in FY2020.
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/news/1452

10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Report #16

1. **Title of Report or Program Evaluation**:
   HR 185 RS 2021 Medicaid Estate Recovery Report
2. **Date completed**:
   March 2022
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   In response to House Resolution 185 (HR 185) of the 2021 Regular Session requires LDH to produce a one-time report containing certain data relating to Medicaid estate recovery cases, in order to facilitate potential changes in public policy for the enhancement of program effectiveness.
4. **Methodology used for analysis or evaluation**:
   The resolution directs LDH to provide the following, individual-level case data on each Medicaid enrollee who died in calendar years 2016, 2017, 2018, 2019 and 2020, and whose succession estate was subject to the estate recovery program, as provided for in LA R.S. 46:153.4:1
   1) Total cost to Louisiana's Medicaid program of the Long-Term Care (LTC) services that the decedent received.
   2) Value of the decedent's succession estate.
   3) Maximum dollar amount LDH is authorized to recover from the decedent's succession estate.
   4) Whether LDH opened a Medicaid estate recovery case to recover from the decedent's estate.
   5) If LDH pursued recovery from the decedent's estate, the Department also reports the following:
      a. The amount recovered.
      b. The exemptions granted in connection with the estate recovery case, if any, and the total dollar value of those exemptions.

   In addition to the above, individual-level case data, HR 185 requires that LDH provide the following aggregate data in quintiles by the total cost to the Louisiana Medicaid program of LTC services the aforementioned population of Medicaid decedents received:
   I. The total cost to the Louisiana Medicaid program of the LTC that the group of decedents in the quintile received.
   II. The maximum dollar amount LDH is authorized to recover from the collective succession estates of the group of decedents in the quintile.
5. **Cost (allocation of in-house resources or purchase price)**:

Compiled by internal staff

6. **Major Findings and Conclusions**:
   In total, from 2016 to 2020, 28,423 members were subject to estate recovery totaling $4,869,120,932.67 in LTC costs. Of this total, the estate recovery team received a referral for 390 members. However, because cases can be opened by other means, a total of 5,214 members were examined for estate recovery. Of the 5,214 members, only 2,215 were evaluated fully for estate recovery, meaning the case was not closed, removed and/or otherwise deemed not actionable. The data in the following tables will provide the individual-level case data requested for items 2-5 for the 2,215 members.
7. **Major Recommendations**:
   Not Applicable
8. **Action taken in response to the report or evaluation**:
   Not Applicable
9. **Availability (hard copy, electronic file, website)**:
   chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://ldh.la.gov/assets/docs/LegisReports/HR185RS2021.pdf
10. **Contact person for more information**:
    Name: Tara Leblanc
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Tara.LeBlanc@LA.GOV

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

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

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

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

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

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

Accomplishment #1: LDH Unveils New Business Plan titled, "Together: Building a Stronger LDH and a Healthier Louisiana"

A. What was achieved?

Louisiana Department of Health (LDH) released its first business plan in almost a decade for state fiscal year (FY) 2022. The business plan, titled "Together: Building a Stronger LDH and a Healthier Louisiana" identifies and details 17 initiatives and 42 goals under four major commitments. This plan also defines how the Department will measurably improve its programs, services, and outcomes in the upcoming years.

The initiatives, goals and deliverables in the plan focus on key areas that LDH will embrace and prioritize in the coming year to help strengthen its foundations, allowing the Department to make the greatest impact for the people we serve.

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

The initiatives in the plan are aimed at improving the health and well-being of Louisianans with an emphasis on prevention; reshaping the #TeamLDH work culture; and enhance customer service, partnerships and community relations, while being transparent, accountable and compliant with state and federal regulations. In addition, the initiatives, goals and deliverables will help strengthen our foundations and allow us to make the greatest impact for the people we serve.

The 17 plan initiatives are:

1. Assess Dental Coverage and Services for Adult Medicaid Enrollees to Improve Health Outcomes
2. Improve Access to Substance Use Disorder Treatment and the Quality of Care
3. Improve Care for Individuals with Serious Mental Illness
4. Improve Early Detection of Colorectal Cancer and Treatment of High Blood Pressure and Diabetes
5. Improve Health Outcomes from Pregnancy through Childhood
6. Increase and Strengthen Service Delivery for Vulnerable Residents
7. Advance Equity, Diversity and Inclusion within LDH
8. Improve #TeamLDH Culture, Recruitment, and Retention
9. Forge New Strategic Partnerships with Public Universities
10. Improve the Sustainability of Public Water Systems
11. Leverage Community Partnerships to Improve Participation in LDH Programs and Improve Program Design
12. Pilot a Workforce Development Program
13. Support Efforts to Increase Diversity in the State's Healthcare Workforce
14. Develop and Implement an Annual Comprehensive Medicaid Provider Rate Review Process
15. Develop Sustainable, Equitable, and Comprehensive Supplemental Payment Systems
16. Improve LDH Compliance with State, Federal, and Agency Requirements
17. Increase Accountability and Transparency through Medicaid Managed Care Organization (MCO) Contract

C. **Who benefits and how?**

The goals and priorities in our business plan will enhance the services we provide to the people of Louisiana, and strengthen the fabric of #TeamLDH and our partnerships with community leaders and public universities, all while striving to be the best possible steward of public resources.

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

More than a year of meticulous research and planning went into the development of this plan. This was achieved by LDH Secretary, Courtney N. Phillips and the LDH Executive Management Team. The new plan represents a tremendous undertaking that resulted in a bold and visionary business plan.

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

Yes, LDH is committed to its mission of protecting and promoting the health of all residents of Louisiana.

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

No, however the initiatives, goals and deliverables in the plan focus on key areas that Team LDH will embrace and prioritize in the coming year to help strengthen our foundations, which will allow us to make the greatest impact for the people we serve.

Accomplishment #2: Louisiana Department of Health Receives CMS Approval to Launch TEFRA

A. **What was achieved?**

Effective January 1, 2022, the Centers for Medicare and Medicaid Services (CMS) granted approval for Louisiana Medicaid to launch Act 421 Children's Medicaid Option, or TEFRA (Tax Equity and Fiscal Responsibility Act). TEFRA allows states to make medical assistance available to children under 19 years of age with disabilities without counting their parent's income.

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

This program allows certain children under 19 years of age with disabilities to receive Medicaid coverage, regardless of parental income. The TEFRA option also disregards family income for children with disabilities who meet specific criteria, so they may qualify for Medicaid to cover the services they need to grow and thrive while living at home.

TEFRA will be a huge help in assisting families with the extraordinary cost of raising a child with a disability.

C. Who benefits and how?

This accomplishment will benefit working families and children with disabilities. To qualify, children must have a disability that is recognized under the definition utilized in the Supplemental Security Income program of the Social Security Administration and must meet basic Medicaid and institutional level-of-care requirements.

Additionally, their care must cost less at home than in an institution. TEFRA will allow these children to avoid long stays in hospitals and get the care they need while living at home in the comfort of their family and friends.

D. How was the accomplishment achieved?

This accomplishment was achieved by working with stakeholders, community partners, legislators and CMS.

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

Yes, one of LDH's goal is to help individuals receive care in a safe setting of their choice. TEFRA will be a huge help in assisting families with the extraordinary cost of raising a child with a disability. TEFRA will have a significant impact on our working families and children with disabilities, as it will help make their lives easier while providing much-needed services.

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 #3: Louisiana Department of Health Recognizes 27 Hospitals that Achieved Birth Ready Designations

A. **What was achieved?**

The Louisiana Department of Health (LDH) and the Louisiana Perinatal Quality Collaborative (LaPQC) recognized 27 hospitals that achieved new Birth Ready Designations for committing to practices that improve quality and outcomes for persons giving birth.

The Birth Ready Designation is a system that reinforces and ensures birthing facilities are implementing best practices to improve readiness for addressing the leading causes of maternal deaths. The Birth Ready Designation is part of an initiative in the LDH Business Plan, which includes a focus on improving maternal health and outcomes from pregnancy through childhood.

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

Twenty-seven of the state's 49 hospitals have now been recognized as Birth Ready, with eight of the hospitals achieving the Birth Ready+ Designation.

Birth outcomes in Louisiana have historically been among the worst in the nation. Between 2011 and 2016, about half of all deaths associated with a recent birth were preventable.

C. **Who benefits and how?**

Birth Ready Designation celebrates improved perinatal health outcomes, the result of implementing clinical practices that promote safe, equitable and dignified birth for all birthing persons in Louisiana.

Improving birthing outcomes ensures that everyone has an equitable opportunity to have a safe and dignified birth. Disparities in birth outcomes experienced by mothers in Louisiana are well documented, but through the LaPQC we are working to change that narrative.

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

To achieve the Birth Ready Designation, facilities had to meet criteria in five dimensions, including implementation of policies and procedures, promoting patient partnership, and addressing health disparities and equity.

Hospitals that achieved the Birth Ready+ Designation have met a higher threshold of compliance and achievement of requirements. Regardless of level, all facilities that achieved this designation have done the hard work of improving the consistency and culture of care at their facilities.

Facilities receiving this honor went through a rigorous application and review process by the LaPQC in order to receive the designation.

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

Yes. The LaPQC was created to promote the implementation of evidence-based practices to reduce significant factors that contribute to poor birth outcomes. The Collaborative focuses on promoting health equity and reducing racial and ethnic disparities.

The work of the LaPQC, an initiative of the LDH's Bureau of Family Health, is dedicated to improving perinatal and neonatal outcomes across Louisiana.

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

No.

Accomplishment #4: LDH receives $1.2M CDC grant focused on extreme heat protection

A. **What was achieved?**

The Louisiana Department of Health will receive $1.2 million over the next five years to protect Louisiana workers and communities from extreme heat through a grant from the Centers for Disease Prevention and Control's (CDC) National Institute of Occupational Safety and Health (NIOSH).

The funding will be used to collaborate with local climate agencies, research centers and community organizations to access, analyze and interpret climate and health data; provide training and education on heat and health risks; and strengthen Louisiana communities' climate adaptation and resilience.

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

Climate change is increasing the frequency and intensity of extreme heat events. Louisiana has some of the most at-risk workers in the country due to high heat and humidity, a large percentage of workers employed in outdoor and physically demanding jobs, frequent natural disasters, and high levels of poverty and other social inequities.

C. **Who benefits and how?**

Louisiana workers and communities will benefit from this achievement. During periods of high heat, Louisianans who work outdoors or in indoor settings without adequate air conditioning are at risk of dangerous heat exposure which can cause heat exhaustion, heat stroke, injuries, multi-organ failure and, in extreme cases, death. Heat exposure is the leading cause of death among all weather-related phenomena. Extreme heat also leads to loss of productivity and labor capacity. These health and economic impacts have an enormous toll on workers, their families and communities.

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

The Office of Public Health's Occupational Health Program leads the project in close collaboration with key climate and health agencies including Louisiana State Climatologist Dr. Barry Keim, LSU Department of Geology and Anthropology, LSU Health Sciences Center, National Weather Service, Southern Climate Impact Planning Program, Johns Hopkins Bloomberg School of Public Health and the RAND Corporation.

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

Yes, as one of LDH's mission (within the Office of Public Health) is to protect and promote the health and wellness of all individuals and communities in Louisiana.

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: LDH launches COVID-19 Support Hotline

A. What was achieved?

The Louisiana Department of Health has launched its new COVID-19 Support Hotline, which merges the former contact tracing hotline and the COVID-19 vaccine hotline to

provide the general public one convenient resource to get their COVID-19 and vaccine questions answered.

B. Why is this success significant?

Residents can call the new COVID-19 Support Hotline (1-855-453-0774) to:

- Schedule vaccine and booster appointments
- Schedule a homebound vaccination appointment
- Speak to a medical professional
- Get their questions answered on what to do next after becoming COVID positive or exposed
- Get connected to resources while in isolation or quarantine (assuming eligibility and availability)

All calls are confidential and phone menu options are listed in both English and Spanish. The hotline is available Monday through Saturday from 8 a.m. to 8 p.m. and on Sunday from noon to 8 p.m.

C. Who benefits and how?

Louisiana residents & the general public will benefit from this accomplishment. If you test positive or suspect you have been exposed to COVID-19 and have questions, you can also call the COVID-19 Support Hotline. Or you can opt to receive a text message with general information on isolation and quarantine guidance.

D. How was the accomplishment achieved?

Following CDC guidance, the LDH no longer conducts case investigations and contact tracing of individual cases of COVID-19. However, LDH continues to investigate COVID-19 outbreaks and cases in high risk settings and the COVID-19 Support Hotline is available for Louisianans who have questions about COVID-19, need resources to help them isolate safely, or want to schedule a COVID-19 vaccine.

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

Yes, as one of LDH's mission (within the Office of Public Health) is to protect and promote the health and wellness of all individuals and communities in Louisiana.

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/Business Plan on time and on target for accomplishment?

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

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

  LDH/Office of the Secretary Strategic Plan: Yes, the strategic plan for the Department is on time for accomplishment. Our 5-Year Strategic Plan was revised in July 2022. The revised plan covers fiscal years 2023-2028. The next update will occur in three years. This plan provides: (1) a general picture of intended performance across the agency, (2) a general discussion of strategies and resources the agency will use to achieve its goals, and (3) general confidence and reliability that agency performance information will be credible.

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

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

- **Where are you 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:

  Teamwork is at the core of who we are as Louisianans, and it's at the heart of what we do for the more than 4.6 million people the Louisiana Department of Health (LDH) is privileged to serve. LDH's first business plan in nearly a decade is titled Together: Building a Stronger LDH and a Healthier Louisiana. This ambitious plan is a blueprint for specific, measurable initiatives that builds upon our foundations while setting new goals, being open to change, and seeking to be progressive and better, every day.

  Through the end of Fiscal Year 2022, our progress will be carried out and measured through 4 major commitments aimed at:

  - Improving the health and well-being of Louisianans with an emphasis on prevention
  - Reshaping the #TeamLDH work culture

- Enhancing customer service, partnerships, and community relations
- Being transparent, accountable, and compliant with state and federal regulations

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

Together, we will fulfill these commitments through 17 initiatives consisting of 42 goals designed to drive us forward as a more efficient, effective, and responsive state agency. Our goals will enhance the services we provide to the people of Louisiana, and strengthen the fabric of #TeamLDH and our partnerships with community leaders and public universities, all while striving to be the best steward of public resources possible.

At the end of FY22, LDH will provide a report detailing our achievements, lessons learned, and opportunities for further improvement. While unforeseen challenges will undoubtedly arise throughout the year, especially as we work urgently to end a pandemic, having our priorities and goals clearly defined in this business plan will help us maintain our focus and commitment to achieving them.

- **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?

In FY22, LDH revised its 5-year strategic plan. This revised plan is good through FY 2028 and will be updated in three years. Strategic plan revisions occur within each office/section on a continuous basis to address critical needs and issues within each office. Our offices continue to identify and quantify electronic processes to improve efficiencies, address needed rule revisions for consistency with processes and new statutes, and address resources needed for improved 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, but not limited to, strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. If modifications are needed, recommendations are made directly to the Assistant Secretaries or the Executive Directors. 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 their review should be used to improve strategic and operational planning, or program management operations.

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

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective

service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

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

No department management or operational problems exist.

A. Problem/Issue Description

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

B. Corrective Actions

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

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

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

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
      - How much progress has been made and how much additional progress is needed?
   b. If not:

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

5. Do corrective actions carry a cost?

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

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

A. Check all that apply.

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

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

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

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Executive Director: **Lisa Schilling**

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

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

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

Accomplishment #1: SCLHSA Quickly Resumes Operations Following Hurricane Ida

A. **What was achieved?**

The South Central Louisiana Human Services Authority (SCLHSA) service area was devastated by Hurricane Ida on August 29, 2021. Hurricane Ida wove a destructive path through our seven parish catchment area of Assumption, Lafourche, St, Charles, St. James, St. John the Baptist, St. Mary and Terrebonne. Businesses were obliterated, homes were shredded to ribbons and our community was completely knocked off our foundation. The next day the recovery efforts began. SCLHSA was up and running in all its clinic settings and developmental disability office the very next week with staggered openings and skeleton staffing. The CALL Line which was previously available after hours,

weekends and holidays became the single point of entry for many of our patients that had evacuated and could not return to the area or had nothing to return to as far as a home was concerned. Through the CALL Line, SCLHSA fielded numerous call from patients needing medication refills, new patients needing medication to cope from the devastation and loss and used peer support specialists to be an ear for those needing to share their story and benefit from an empathetic ear. SCLHSA was able to speak with LDH Leadership, local parish government partners and stakeholders to assist in finding the tools to help regain connectivity in the form of generators from the Army Corps of Engineers, fuel and some supplies from parish governments. The SCLHSA Facebook page became the agency voice to the masses by sharing much needed resource information on a daily basis of where to find food, gas and other necessities of daily living to educational information on survival and resilience during the aftermath. SCLHSA's three state owned sites suffered massive damage and Administration took steps to have them remediated immediately and asked our lease owners to do the same. The Mobile Unit was sent on the road travelling down the bayous of Lafourche and Terrebonne, Assumption and St. John Parish. Staff went on the local television station weekly to share tips on coping and updates on treatment availability. SCLHSA survived and helped patients and the community at large to do the same by not missing a beat in our service provision. By becoming creative and thinking out of the box, SCLHSA managed to provide services to the community still in shock, suffering from anxiety and depression and looking for any information and support to help cope.

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

This accomplishment was significant because SCLHSA was able to maintain the majority of our patient base and help them to stay in touch with their providers for medication refills/changes, speak to their counselor as part of their treatment process and connect with their support system from the numerous groups they were a part of at our agency. After any type of disaster or event in life, it is imperative that all individuals and specifically behavioral health and developmental disability populations are able to keep their daily activities the same as possible. Any change in a daily routine for a behavioral health or developmental disability patient can cause them to rebound to substance use, detach from family/friends and become isolated, angry and in some cases violent. Maintaining as much normalcy as possible in treatment routines assisted with the patient maintaining some of the gains prior to the disaster and finding ways to help return to their former activities of daily living.

C. **Who benefits and how?**

Quite simply – everyone! Patients benefitted from having availability through the same mechanisms available to them before the storm – The CALL Line, clinic services, developmental disability services, mobile unit deployment and walk-ins as well. Truly, the SCLHSA service structure remained intact and available to individuals by multiple modems. Telehealth is something that has been a part of SCLHSA deliverable services since 2012 and greatly expanded during the COVID pandemic. The expanded use of telehealth after Hurricane Ida gave staff the capability to maintain contact and attend to the needs of clientele while maneuvering recovery efforts at all SCLHSA sites.

D. **How was the accomplishment achieved?**
This accomplishment was achieved through the hard work and dedication of the entire SCLHSA staff and professional contractors. After the storm, SCLHSA Administration began to receive multiple texts and emails from staff at all seven of our sites wanting to know when they were to return to work. Staff voiced concern over patients that needed to receive their injections, those that were vulnerable before the storm and needed to be checked on, new patients that needed assessments because they were recently discharged from an inpatient setting. SCLHSA Administration asked staff to wait a week until we could have sites ready for services whether by generator or though mobile access. Staff chose to work over the following months even though they could have remained at home as the state closures lasted several months in Region III. Executive Management, Senior Management, all levels of staff went above and beyond to ensure that our patients were taken care of even in the midst of their own destruction and recovery process.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
The terms accessibility, efficiency, effectiveness all have a new meaning since Hurricane Ida visited Region III in 2021. Staff provided drive by injections for those on medication therapy, visited patients in shelters and community settings to assess and treat, found placement for those needing transition services and educated numerous individuals on coping skills in the face of their own tragedy. All of these services support the South Central Louisiana Human Services Authority (SCLHSA) Strategic Plan short term goals to include; 1.) Create staffing patterns that are reflective of population shifts and service needs, 2.) Integrate service provision among behavioral health clinics and 3.) Integrate Community Support teams to outlying communities. Most importantly it emphasizes one of the SCLHSA intentions to provide comprehensive services and supports which improve the quality of life and community participation for persons in crisis and/or with serious and persistent mental illness, emotional and behavioral disorders, addictive disorders, and/or developmental disabilities, while providing appropriate and best practices to individuals with less severe needs.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Many of the strategies that SCLHSA employed mirrored some of the Best Practice Interventions sited by the Black Dog Institute for Mental Health Intervention Following Disasters to include:
   a. Offer practical support and good quality information: Acute stress reactions within the first few weeks should not necessarily be regarded as pathological or in need of professional intervention. Most affected individuals are likely to simply need support and resources in the early phase's post-event, rather than clinical treatment. Prioritizing practical support and provision of resources (food, shelter, money, and communication) is recommended to re-establish psychological comfort and safety. Other forms of practical support include emotional reassurance, assistance with daily living tasks, and information on how to access much needed resources. It is vital that good quality evidence about normal responses to trauma and pathways to recovery is made readily available and that a sense of hope and both self and collective efficacy

is promoted.

b. Strengthen social support networks: There is overwhelming evidence that social support is a major protective factor after disasters and can act as a buffer against psychological distress. Sources of support can include kin, friends, neighbors, co-workers and the wider community. Community resources are there to assist those in need, disseminate essential information and advocate for external aid following disasters. Affected communities need to be provided with resources and support to unite in ways that best fit their existing context, culture and history.
c. Provide problem-solving and resilience focused interventions: Psychological interventions based on problem-solving skills and resilience can provide affected individuals with coping skills to manage post-disaster stressors. This approach is consistent with a strong body of evidence indicating that brief problem-solving programs delivered to people affected by adversity can markedly reduce anxiety and depression and is endorsed by the World Health Organization. Research suggests that psychological interventions can be effective in the months to years following the disaster, especially when used in combination with some form of screening for those at-risk.
d. Offer technology-enabled mental health services: Technology-enabled mental health services such as mobile apps, telehealth, and online treatment is an efficient and practical means of delivering treatment to affected individuals and communities. These services have the added advantage of being able to overcome much of the stigma that can impede traditional help-seeking. These measures have shown some promise in reaching more people as well as reducing distress in individuals affected by disasters and mass violence.

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

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

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

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

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

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

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

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

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

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

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

- **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?

South Central Louisiana Human Services Authority is not experiencing any significant lack of progress.

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

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

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

  ☐ 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 South Central Louisiana Human Services Authority, a Local Governing Entity, adheres to the Carver Policy Governance Model. The Board of Directors establishes the Authority's Mission, Vision, and Priorities, and selects an Executive Director to provide ongoing administration and operational management of the Authority. The Executive

Director presents the Board of Directors with monthly updates and an annual Ends Policy Monitoring Report detailing progress toward the organization's Strategic Plan Goals and Objectives. As an organization that has adopted and actively practices both Accountable Care and Performance and Performance Improvement models/philosophies, South Central Louisiana Human Services Authority continuously communicates, monitors, reports, and implements corrective action/process improvement activities with regard to Strategic Plan Goals, Objectives, and Performance Indicators via a broad range of venues (from individual supervision to performance reporting available to staff).

Each Service Director assists the Authority developing an annual organizational specific business plan in support of the South Central Louisiana Human Services Authority Strategic Plan. Each Director is also required to provide monthly Progress reports to the Executive Director and other members of the Executive Management Team. Additionally, the Executive Management Team develops, adopts, and implements cross-divisional annual Performance Improvement Initiatives (PI) to further insure South Central Louisiana Human Services Authority will meet and/or exceed Strategic Plan Goals and Objectives and to support the successful sustainability of the Authority. As with the business plan, the full Executive Management Team delivers quarterly progress reports, in this case, to the Board and Senior Management.

South Central Louisiana Human Services Authority informs employees about Strategic Plan Goals, Objectives, and Performance Indicators via monthly Manager Meetings and, Directors involve staff in data collection, analysis, and reporting of Performance Indicator outcomes. Clinic Managers lead discussion about the Performance Improvement Plan during staff meetings (held weekly), reporting progress, obtaining staff input, and emphasizing accountability for reaching goals and objectives. The Executive Director schedules quarterly All-Staff Videoconference meetings each year with the entire agency. Performance improvement is a routine part of the agenda. Further, the Executive Director bases a significant portion of the Division Directors' annual performance reviews on their contributions to the South Central Louisiana Human Services Authority Strategic Plan and Performance Improvement Initiatives as well as on their degree of success in accomplishing organizational goals and objectives. Monthly

Executive Management Team (EMT) meetings and occasional planning retreats are used as both group supervision and as forums for discussion of progress on meeting/exceeding Goals and for development of corrective action and/or performance improvement plans. The Executive Director holds the Executive Management Team accountable on both an individual and group basis for the successful implementation of the South Central Louisiana Human Services Authority Strategic Plan, Division-specific Plans, and Performance Improvement Initiatives. Each South Central Louisiana Human Services Authority staff member has job-specific performance factors and expectations included in his/her annual planning document to support Authority Goals. Managers and Supervisors are expected to meet with individual staff members reporting to them as outlined in South Central Louisiana Human Services Authority's Staff Development and Supervision Guidelines (weekly for new employees, monthly for established employees, and as needed for employees in need of performance improvement) to review and discuss progress

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

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

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

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

A. Problem/Issue Description

1. **What is the nature of the problem or issue?**
   During FY 2020-2021, South Central Louisiana Human Services Authority was impacted due to Hurricane Ida which landed on August 29, 2021. Ida left destruction in six of the seven parishes that are a part of the Region III catchment area. Those parishes that were impacted included Assumption, Lafourche, St. Charles, St. James, St. John the Baptist and Terrebonne. Because of the storm and the inability to return to normal operations immediately in all six of these parishes, SCLHSA was unable to spend down federal grant funding received from the Louisiana Department of Health (LDH) – Office of Behavioral Health (OBH) through interagency transfer. This action does hamper the ability to provide some services to patients, but does not impede work capability. SCLHSA was forced to restrict purchasing and distribution as well as limiting some services to patients in the community setting. SCLHSA was able to request that the grants funds that were not expended in FY'22 be carry forward to FY'23 for use.

2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)**
   No, the South Central Louisiana Human Services Authority continues to adapt its goals and strategies to remain within funding levels and sustain viability in the provision of services to the behavioral health and developmental disabilities

communities.

3. **What organizational unit in the department is experiencing the problem or issue?**
   The Interagency Transfer Funds (federal grant funding) affects mostly the activities in the Behavioral Health Departments (mental health and addictive disorders) and the Administration component (which includes utilization management, contract monitoring, human resources, information technology and fiscal functions, etc.) due to having to shift funds and resources within the budget and for service provision.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   The ability to have the grant funds carried over into Fiscal Year 22/23 will greatly impact the following customers/stakeholder in a positive light:
   - Individuals Served in the Behavioral Health Department at SCLHSA
   - Residents of South Central Louisiana Human Services Authority catchment area to include Assumption, Lafourche, St. Charles, St. James, St. John the Baptist and Terrebonne parishes.
   - Behavioral Health employees (all areas and at all levels)
   - Contractors and their employees
   - Community Partners such as the seven Parish Presidents and Council/Jurors, Sheriff's Office, Coroner's Office, Public School Systems, District Attorney's Office, Juvenile Judges, and local not-for-profit community hospitals and social service organizations, etc.

5. **How long has the problem or issue existed?**
   The is the first year that SCLHSA has had the capability to carry forward such a large amount of unspent grant funding to be a part of its annual appropriation. This move means that SCLHSA does not have to wait for a budget amendment to be approved separately and the agency can start expending the funds immediately in FY 22/23. SCLHSA and the parishes it serves to include Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne are still in the rebuilding process after Hurricane Ida and will be for quite some time. Some areas down the bayous of Lafourche and Terrebonne have not begun to be remediated yet and some families/businesses have elected not to return to the area. These funds are meant to be spent on services that will help them in recovery and to maintain resiliency in their everyday lives.

6. **What are the causes of the problem or issue? How do you know?**
   South Central Louisiana Human Services Authority receives the bulk of its funding from the State of Louisiana. About one quarter of the entire SCLHSA Budget is funded from grants obtained by the LDH-OBH through federal grants. Since Hurricane Ida, there have been multiple issues with connectivity (energy, telephone, computer, etc.) and a vast number of community resource agencies have not come back on line to date. Staffing issues exist because a lot of individuals did not return

to the region or are choosing not to work at this time which makes hiring qualified counselors or case workers to run or provide services in grant funded models extremely difficult at best. Additionally, the real estate market for business buildings has been slow to come back on line. The grants funds received represent lease space, personnel, operating, supply and travel costs which are at a minimum at this time. It is then incumbent upon the agency to find ways to maximize grant funded services without affecting patient care – a very difficult and sometimes impossible feat to accomplish.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   South Central Louisiana Human Services Authority will address all impacts and potential impacts of grant funding with urgency to expedite service implementation and carry forward funding spend down. SCLHSA utilizes effective and flexible strategies/tactics to continuously improve performance, service quality and to identify alternative solutions to funding utilization while still providing core services to its patient population.

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?

- Continue execution of the agency Performance Improvement Plan to assure best use of limited resources, streamlined operations and service delivery, high levels of productivity, open capacity, and high quality outcomes for individuals receiving services and supports.
- Work with LDH, the Division of Administration (DOA), the Bayou Legislative Delegation and the Louisiana State Legislature to ensure that the unexpended grant funds carried over to FY 22/23 will be utilized for evidence-based practices offered by SCLHSA in the clinic setting and in the community.
- Implement programs to fully utilize grant funds for expansion of new programs and/or to sustain existing programs.
- Continue implementation of the South Central Louisiana Human Services Authority Compliance and Risk Management Plan.
- Explore opportunities to partner with community partners/stakeholders to create evidenced based programs for behavioral health and developmental disabilities.
- Continue to explore and seek relationships with private payors to open new

streams of revenue.
- Link with as many insurance vendors as possible to secure reimbursement for services provided to insured patients outside of the state vendor system.

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

   No – this is the first time that SCLHSA has addressed the issue of such a large amount of interagency transfer of funds in our reporting as a carry forward and hopes that it is not an issue in the future. Hurricane Ida was a natural disaster and SCLHSA has outlined numerous steps to insure the viability of our agency as part of our mitigation plan for sustainability.

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?

      The majority of the corrective actions identified above are ongoing and will continue to be monitored for completion with no end date established at the present time. SCLHSA was able to obtain approval trough LDH Fiscal, DOA and the Legislature to include the unexpended grant funds from FY21/22 as part of its FY22/23 Appropriation. Carrying forward of these funds gives us the capability to begin spend down at the beginning of the fiscal year process without having to wait for a Budget Adjustment (BA-7) to happen at midyear. SCLHSA is expected to spend down all the carry forward funds during FY'23.

   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?

Corrective Actions for the South Central Louisiana Human Services Authority are viewed as business and service delivery processes woven into the fabric of SCLHSA's daily operations. Primary responsibility for setting expectations and monitoring progress rests with the Board of Directors and the Executive Director; primary responsibility for execution of corrective actions rests with members of the Executive Management Team, Senior Management and all SCLHSA Staff. Resources needed to successfully carry out these processes are through the Human Resources component; related duties and responsibilities are included in each Executive Management Team member's position description and in employees performance planning and rating documents. The Executive Management Team staff are to assure processes are ongoing and expectations are met or exceeded.

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.

South Central Louisiana Human Services Authority's Administrative Services Division provides ongoing monitoring of clinical and administrative functions. Audit tools, with identified criteria and targets are utilized; results are reported;

and, appropriate process improvement and/or corrective actions are executed. Further, South Central Louisiana Human Services Authority developed process improvement and fiscal functions to audit Authority performance using benchmarks set forth in the Council on Accreditation of Rehabilitation Facilities (CARF) standards and to implement process improvement and/or corrective action as needed. A member of the Executive Management Team oversees each of these areas to assure there is no duplication of effort.

☒ **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.

South Central Louisiana Human Services Authority is audited on an annual basis through the Office of the Legislative Auditor as well as by the Louisiana Department of Health - Office of Behavioral Health Licensing Standards and Office of Developmental Disabilities and the Louisiana Department of State Civil Service.

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

☒ **Policy, research, planning, and/or quality assurance functions by contract**
The South Central Louisiana Human Services Authority Adult, Child, Prevention Services and Developmental Disabilities Contract Monitors meet monthly with all contracted services for review of contract objectives and to gather service data information. The contract agency or individual has the opportunity to share any issues with service provision or funding at that time. SCLHSA Executive Director, Chief Fiscal Officer, Fiscal Staff, Division Directors and Contract Monitors meet on a quarterly basis to review contracts, billing, invoices and services provided to insure that contract goals and objectives are being met.

☒ **Program evaluation by in-house staff**
Performance is monitored on an ongoing basis utilizing the South Central Louisiana Human Services Authority's Strategic Plan, Operational Plan,

Performance Improvement Plan, Risk Management Plan, and position-specific performance expectations. All have clearly stated expectations and performance targets. The Executive Director, Executive Management Team, Managers and Supervisory Staff share responsibility for oversight of these functions. Outcomes are reviewed and reported to the Board, staff and stakeholders on a quarterly basis.

☒ **Program evaluation by contract**

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

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

The 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. SLHSA also utilizes national benchmarks for the majority of its programs and in implementing productivity standards for staff.

☒ **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. SCLHSA initiates a Statement of Work (SOW) for every contract entered into by the agency. The SOW clearly defines the work product, accountability for services, goals and objectives to be met by both the contract agency and SCLHSA. Additional paperwork required includes the Code of Conduct Form, Disclosure of Outside, Employment/Contract Form and the Permission for Public Information on Social Media Form

☒ **Peer review**
South Central Louisiana Human Services Authority's Performance Improvement Program uses peer review as part of the ongoing performance and quality improvement initiative. The Authority's Medical Director leads comprehensive multi-disciplinary peer review in cases. The Authority has initiated an ongoing peer review process to be conducted annually as part of the compliance standards implemented for the CARF accreditation process. SCLHSA also participates in the Peer Review process with other Local Governing Entities (LGE's) annually with oversight from LDH-OBH and LDH-OCDD.

☒ **Accreditation review**
South Central Louisiana Human Services Authority has implemented an Authority-wide plan for re-accreditation readiness with the Commission on Accreditation of Rehabilitation Facilities (CARF). Communication between the Authority and Commission on Accreditation of Rehabilitation Facilities (CARF) is ongoing and formal application was filed. As stated previously, the South Central Louisiana Human Services Authority has active process improvement functions that focus on meeting and/or exceeding requirements set forth in the Commission on Accreditation of Rehabilitation Facilities (CARF) Standards, the Statewide Management Organization and the Department of Health and Hospitals.

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

meetings.

☐ Other (please specify):

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

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

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

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, including:
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

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

Lisa Schilling, Executive Director
South Central Louisiana Human Services Authority (SCLHSA)
985-876-8885
lisa.schilling@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department:	**Louisiana Department of Health (LDH)** 09-310 Northeast Delta Human Services Authority
Department Head:	**Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
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.

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

Accomplishment #1: Integrated Care Network and Services

A. **What was achieved?**

NEDHSA successfully implemented numerous special initiatives that stem from our integrative behavioral health approach. 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. 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, and education, and outreach continue to be the driving forces underlying the agency's success and improved outcomes of the individual served. Some of these initiatives included:

Louisiana Opioid Crisis

To continue NEDHSA's efforts to provide ongoing education about Louisiana's opioid crisis, NEDHSA's Prevention and Wellness services for FY22 focused on educating community leaders, school-aged children, and the general community. NEDHSA's Opioid Use Disorder Prevention Manager spoke at a faith-based conference to address the issue and share how faith-based leaders and organizations can help bring hope and healing. Also, NEDHSA hosted its own events for National Prescription Drug Take-Back in Ouachita and Morehouse parishes. The agency collected 65 pounds of unused and expired prescription pills.

NEDHSA's Prescription Drug Take Back Day events that was hosted across 5 locations throughout NELA. NEDHSA's Opioid Misuse and Abuse Team collected more than 100 pounds of prescription drugs, which will help prevent misuse and abuse of drugs in our region.

Faith-Based Outreach

Through the Faith Partnership Initiative, NEDHSA engaged faith-based community leaders to better understand their challenges, along with the challenges of their congregations. NEDHSA knows that faith can offset hopelessness, and equipping the faith community with the skills necessary to address substance use disorders and addiction helps create effective congregational team ministries who are prepared to provide support and assistance to congregation members and their families.

NEDHSA partnered with New Living Word Ministries (NLW) to provide outreach services to residents of Lincoln Parish. In addition to food distribution, the NLW outreach workers also provided Hepatitis B and C, HIV/AIDS, substance abuse, and mental health treatment education and linkage to testing and treatment services. These services are part of the NEDHSA SAPT Block Grant Requirement for high-risk populations.

Second Opportunity Workforce Solutions Program

The NEDHSA Second Opportunity Workforce Solutions (SOWS) program provides supportive employment services to citizens who are clients of NEDHSA and its integrated care network, including citizens who are non-violent criminal offenders being released from incarceration. This program addresses access to employment, which is a social determinant that significantly affects a person's health and ability to thrive in society. The SOWS Program utilizes evidence-based practices to develop Individual Outcome Plans, which reinforce a client's treatment progress. Job readiness skills are provided to assist participants in achieving and maintaining employment in their community of choice. Since it began as a pilot program during the 4th quarter of FY17, 328 clients have been referred to SOWS, with 178 clients being admitted to the workforce program. In FY2021, 99 clients were referred to SOWS. Of these, 68 got admitted. The number of clients who remained employed for at least 30 days, 60 days, and 90 days in FY2021 are 34, 29, and 22, respectively. In FY2022, 244 clients were referred to SOWS. Of these, 128 got admitted. The number of clients who remained employed for at least 30 days, 60 days, and 90 days in FY2022 are 54, 47, and 43, respectively.

Partners in Employment Program

NEDHSA's vision to build a unified region where individuals are thriving and reaching

their full human potential has led it to create Partners in Employment (PIE) as a developmental disability workforce initiative. PIE is an employment-based program to address the lack of employment opportunities for persons with developmental disabilities during and after graduating from high school. PIE seeks to combat this structural inequity so that everyone willing to work can. PIE supports individuals with developmental disabilities with job training, counseling, and placement. Further, it utilizes a person-centered approach to help meet individual participant needs, wants, desires, and goals to ensure positive programmatic outcomes and increased participation.

Operation Golden Years

In FY22, NEDHSA continued its partnership with the University of Louisiana at Monroe's College of Business and Social Sciences for its Operation Golden Years initiative. The Operation Golden Years initiative focuses on helping seniors with addiction, drug, and mental challenges and was created to provide increased awareness and support to individuals in our region who are aged 60 and above. The program provides home and community-based services to seniors in need and education and information to seniors about prescription medications and NEDHSA's existing behavioral health and substance abuse and addiction services. The MOU with ULM will allow for increased services, access, and opportunity for our region's older populations. Twice a year, NEDHSA partners with other organizations to provide prescription take-back boxes as part of National Prescription Take Back Day, allowing seniors to dispose of unused prescription medications safely.

Underage Drinking

In FY 22, NEDHSA brought awareness to underage drinking, drug use, mental health, and more among the teenage population in northeast Louisiana in a two-hour Virtual Youth Summit event. The theme for the Youth Summit was "We L.I.T.: Leaders in Training," which focused on the impact youth can make in the community and helped them understand the power within themselves. The goal of this event was to raise awareness of underage drinking and help youth recognize the power they have for positive change. The event featured three panelists and a keynote speaker.

Tobacco Reduction

In FY22, the Tobacco Reduction team participated in World No Tobacco Day and No Mental Sunday. Tobacco-related illness is still the primary cause of death for African Americans. It is commonly known that menthol makes smoking easier to start and harder to quit. This is no exception for African Americans who consistently report more quit attempts than the general smoking population, yet experience lower success rates. Because more than 85% of African American smokers prefer menthols (as compared to 30% of Caucasian smokers), particular attention should be given to the elimination of mentholated tobacco products.

Mental Health &Food Insecurity Assessment

In FY 22, NEDHSA conducted the study to provide insight into the region’s needs regarding food insecurity, food inadequacy, mental health, and addictive disorder services. The information used from the report will allow NEDHSA to serve its patients better and improve its award-winning integrated care model and network, which addresses negative social determinants of health. The report contains data from the survey collected from November 4, 2022, to March 2, 2022. All assessments were completed either on paper, by

telephone, or online through Google Forms. Individuals over the age of 18 completed the assessment voluntarily responding to areas such as demographics; personal relationships and living situation; employment; resource concerns, including household finances, food security, healthcare, and mental and behavioral health status. The study found that 49% of the total respondents have some level of anxiety, 52% have some level of depression, and 90% are food insecure at some level.

Food Bank of NELA Partnership

(NEDHSA) and the Food Bank of Northeast Louisiana (Food Bank of NELA) have entered into a memorandum of understanding to help meet the mental health, physical health, and food insecurity needs of vulnerable communities in Northeast Louisiana. This strategic partnership further advances Northeast Delta's integrated healthcare delivery model and efforts to reduce negative social determinants of health like inadequate housing, unemployment, food insecurity, loneliness, and limited education.

This partnership led to NEDHSA's creation of an analytic tool and methodology to help ascertain the severity of food insecurity in Northeast Louisiana. The survey tool was developed in partnership with the Food Bank of NELA and distributed throughout both networks and the 12-parish region. In particular, the survey instrument asked an array of questions about mental health, addiction, primary health, food insecurity, negative social determinants, and trauma.

The report contains data from the survey collected from November 4, 2022, to March 2, 2022. All assessments were completed either on paper, by telephone, or online through Google Forms. Individuals over the age of 18 completed the assessment voluntarily responding to areas such as demographics; personal relationships and living situation; employment; resource concerns, including household finances, food security, healthcare, and mental and behavioral health status. The study found that 49% of the total respondents have some level of anxiety, 52% have some level of depression, and 90% are food insecure at some level.

Prime Time Head Start MOU

NEDHSA and Prime Time Head Start have agreed to coordinate behavioral healthcare services, parenting and family engagement classes and presentations, and mutual sharing of program events for clients and staff. This agreement allows NEDHSA access to more than 500 3-and-4-year-olds and their families through full-day, school year service across four centers located in high-needs communities. Prime Time focuses on positive child and family outcomes to close the achievement gap and build a better future for Ouachita Parish children and families. Since 2016, Prime Time has administered the Head Start Program in Ouachita Parish. Its approach emphasizes data-driven decision-making at all levels and has a proven early childhood education approach featuring comprehensive teacher training, coaching, assessment, family engagement, and community partnerships. Additionally, Prime Time integrates inquiry-based teaching and learning strategies.

One of NEDHSA's missions is to make behavioral and primary healthcare accessible to the 12-parish region by offsetting the unique challenges of the people it serves. Utilizing evidence-based practices, NEDHSA developed its Integrated Care model, an innovative approach to bridging the gap in its clients' needs by offering a holistic approach to treatment. NEDHSA Integrated Care addresses behavioral health, primary health, and

social determinants of health. NEDHSA's early childhood and adolescent prevention program serves more than 1200 children with Al's Pals-Kids Making Healthy Choices, equating to 55 classrooms servicing Ouachita's Monroe City Schools, Madison, Jackson, Bienville, East Carroll, and Richland parishes. The program includes 20 Pinebelt, and Delta Community Action Head Starts in the 12-parish region. NEDHSA serves 300 adolescents in Madison Parish through its Signs of Suicide Prevention Program. NEDHSA's Student Ambassador program has nearly 70 students throughout Neville High, Franklin High, and Madison Parish High School as part of its high school prevention services. NEDHSA directs and manages community-based programs to improve the quality of life of people with major mental illnesses, addictive disorders, and developmental disabilities by offering integrated primary and behavioral health services and a Phoenix Clinic for individuals who have a developmental disability and mental health disorder.

Louisiana Delta Community College MOU

NEDHSA and Louisiana Delta Community College (LDCC) signed a memorandum of understanding that will allow both entities to work closely in sharing resources for veterans. NEDHSA and LDCC's TRIO Veterans Upward Bound (VUB) will provide a targeted focus on meeting the needs of coordinated care for veterans seeking mental health, addictive disorder, prevention and wellness, developmental disability, and food insecurity services in the 12 parishes of Northeast Louisiana.

These veteran referrals will include but are not limited to the following: short-term remedial or refresher courses such as English, math, science, foreign languages, computer skills, and study skills, referrals for local support services, academic counseling, financial and economic literacy workshops, college tours, cultural experiences, tutorial services, mentorship, assistance with preparing for college entrance exams, career assessment and planning, intensive basic skills development, and more.

Similarly, the partnership allows LDCC TRIO VUB to make appropriate referrals to NEDHSA and include but are not limited to the following: primary and behavioral health services, addiction treatment, prevention, and wellness services such as peer support, grief counseling, partnered workforce programs, partnered housing assistance, tobacco treatment, gambling addiction treatment, health education, and other services deemed out of the score of care for LDCC TRIO VUB.

Mary Bird Perkins Cancer Center MOU

NEDHSA and Mary Bird Perkins Cancer Center (MBPCC) have entered into an agreement to ensure citizens with mental health, substance use disorders, and developmental disabilities in Northeast Louisiana can have convenient access to cancer prevention and early detection screening services. NEDHSA and MBPCC agree to share service resources, make appropriate referrals for screening, education, and treatment services, and conduct other planned activities that are mutually beneficial to both agencies. In order to help mitigate negative social determinants of health that are often correlated with mental illness, addiction, disability, and primary health care challenges, NEDHSA's Integrated Care model incorporates housing, food, education, transportation, workforce development, and prevention and wellness strategies.

Art as Medicine Initiative

Northeast Delta Human Services Authority (NEDHSA) has adopted arts as one of its

integrated health care, evidence-based prevention, communications, and treatment strategies to help serve persons with mental health, addictive disorders, and developmental disabilities. To support this work, the agency has partnered with the Black Creatives Circle of North Louisiana (BCCNL), an artist think tank designed to nurture, encourage, and discuss art-related issues with North Louisiana artisans from the African Diaspora. BCCNL encompasses animators, cartoonists, designers, filmmakers, graphic designers, illustrators, painters, photographers, printmakers, poets, orators, screenwriters, sculptors, stylists, and writers. Through BCCNL, NEDHSA established murals in downtown development districts throughout the region to heal and restore the places where people live, work, play, and worship.

In December 2021, NEDHSA sponsored a mural created by the University of Louisiana Monroe Honors Art Class and the Art & Entrepreneurship Class that was designed and created as a public art project to inspire ULM students to seek help, destigmatize seeking help, and provide solutions to help overcome mental health issues. Since then, the agency has displayed the mural at the Northeast Louisiana Delta African American Heritage Museum in Monroe, Union Museum of History & Art in Farmerville, Madison Parish High School in Tallulah, and the Chennault Aviation Museum in Monroe. In April 2022, NEDHSA and BCCNL revealed NEDHSA’s first wall art in downtown Monroe's Art Alley to help bring awareness and reduce mental health and addiction-related stigma.

Mobile Health Care Clinic

NEDHSA has deployed a state-of-the-art mobile health clinic to increase access to critical mental health, addiction services, and primary healthcare screenings in Louisiana’s Delta. This mobile health asset is part of NEDHSA’s Integrated Healthcare deployment model. While NEDHSA has worked to provide quality and competent health care, transportation has been a constant negative social determinant barrier to the agency’s Integrated Healthcare services.

NEDHSA will deploy the mobile health clinic in the rural areas throughout the region and to areas where there are barriers to public transportation. The mobile health clinic will be safely secured and stationed in a highly trafficked centralized space known to the local community for 5-day periods with the necessary staff to perform its Integrated Healthcare services and treatment. The deployment of the mobile health clinic is also another opportunity for NEDHSA to provide further service following recent Rise Above Stigma town hall sessions in the region. NEDHSA's Rise Above Stigma initiative aims to help increase access to behavioral health support services, provide mental health awareness, and offer other culturally and linguistically appropriate training for the twelve-parish communities in northeast Louisiana.

Children & Family Clinic

NEDHSA announced the opening of its Children & Family Clinic, a facility dedicated to serving the needs of children and families with mental health and addiction disorders. The Children & Family Clinic, located at 2525 Ferrand Street in Monroe, is part of NEDHSA's Integrated Care model, which addresses negative social determinants of health while enhancing the quality of care and quality of life for the citizens of the region.

Services available include: early childhood services for three-to-five-year-olds; outpatient services to children whose parents are concerned about emotional, behavioral, or

relationship problems; psychiatric evaluations/assessments; mental health and substance use evaluations/assessments; medication management (specific age requirements based by provider); diagnostic and psychological testing; psychosocial interventions; first episode psychosis services (15-17 year-olds); and, school-based prevention services. Services specific to parents are also a strong focus of treatment. These services include parent education and training.

As part of its Integrated Care model, NEDHSA has added housing, food, education, transportation, workforce development, and prevention and wellness strategies to its service options. It also includes working collaboratively with regional education, business, faith-based, veterans, seniors, and regional city municipalities and parish governments.

Pharmaceutical Solutions for Region 8

Northeast Delta Human Services Authority (NEDHSA) has developed the infrastructure to expand pharmacy solutions to citizens in Louisiana's Delta as part of its Integrated Healthcare model. The Integrated Healthcare system NEDHSA built will ensure that vulnerable populations in northeast Louisiana have access to the care they need, no matter where they enter the healthcare system. The integrated model goes further than traditional clinical models and addresses negative social determinants of health. Specifically, the agency has added housing, food, education, transportation, workforce development, and prevention and wellness strategies to its service options. It also includes working collaboratively with regional education, business, faith-based, veterans, seniors, and regional city municipalities and parish governments. This expansion of services also strengthens NEDHSA's opioid abuse and misuse work. Since the start of the pandemic, approximately two in five U.S. adults have reported symptoms of anxiety and depression, up from one in five before COVID-19, and overdose deaths from opioids have hit new highs.

Rise Above Stigma Campaign

NEDHSA contracted SheRay's & Associates to facilitate and evaluate the agency's Stigma Reduction Plan implementation for the time period of July 2021 to December 2021. NEDHSA then selected The Measurement Group LLC to independently evaluate the Rise Above Stigma campaign at the 6-month mark. NEDHSA continued the Rise Above Stigma project and focused on the objectives, outcomes, and long-term goals of its Logic Model, such as: reducing behavioral health stigma; increasing access to behavioral health support services; engaging marginalized populations in accessing recovery into the paraprofessional workforce; and, ensuring safety and wellbeing of individuals in each parish.

In FY 2022, NEDHSA provided 25,708 services to outpatient clients. The total service includes 9,685 billable services and 16,023 non-billable services. From FY21 to FY22, billable, non-billable, and total services increased by 19%, 258%, and 103%, respectively. The number of unique clients served also increased by 8%. Through marketing and communication efforts, NEDHSA's anti-stigma messaging garnered 6.8 million impressions and more than 194,000 total engagements through its billboard, newspaper, social media, and traditional media platforms.

Alky-Users: An Ongoing Tragedy

NEDHSA and Candy Studio LLC are partnering to produce two showings of “Users/Alky,”

a play to educate the public about the dangers and realities of alcohol and substance abuse. The theatrical production was presented on May 27-28, at the University of Louisiana Monroe Brown's Theatre.

The production was part of NEDHSA's Rise Above Stigma initiative, which aims to help increase access to behavioral health support services, provide mental health awareness, and other culturally and linguistically appropriate training for the twelve parish communities in northeast Louisiana.

Operation Leave No Veteran Behind

Northeast Delta Human Services Authority (NEDHSA) announced its Operation Leave No Veteran Behind initiative, an effort to ensure that military veterans in Northeast Louisiana have quality and competent primary and behavioral health care. The agency has always worked to serve the veteran population and meet its needs that stem from combat, training, and traumatic and stress-generating settings. This initiative highlights the strategic approach to improving veteran health outcomes.

We want to do our part to ensure that our brave 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 feel abandoned, alone, suicidal, hungry, or homeless. They should have a safety net that meets their needs. NEDHSA plans to further partner with businesses, colleges and universities, non-profit agencies, and other governmental systems to help bring much-needed awareness and services to veterans living in Louisiana's Delta.

Through its prevention and wellness department, NEDHSA plans to provide education and wellness resources to help veterans. Additionally, through its integrated healthcare service delivery model, NEDHSA will provide mental health, case management, employment opportunities, and work to mitigate those negative social determinants of health that hold many veterans and the general population behind. The needs and people of our region are diverse. Operation Leave No Veteran Behind ensures that those who served our country can get the lifesaving services they need to reach their full human potential. Those who have honorably served our nation deserve nothing less. We intend to leave no veteran or person who needs our services behind.

Health Insurance, Demographics and Clinic Activities Report

In FY21-22, NEDHSA's Executive Director and Director of Behavioral and Primary Health Analytics created a publication that shows the distribution of healthcare insurance type, coverage plans, and total billed, adjusted, written off, and collected amounts by gender, race, and diagnosis for each NEDHSA outpatient behavioral health clinic for the fiscal years 2020, 2021, and 2022* (until March 2022).

A total of 11,413, 8,216, and 6,980 billable services were provided in FYs 2020, 2021, and 2022, respectively. NEDHSA served 1,773, 1,226, and 1,225 unique clients in the respective fiscal years. This report does not include the agency's prevention and wellness, developmental disabilities, and contracted inpatient addictions services. In all three fiscal years, the number of female clients was more than 50%. Compared to male clients, the number of female clients was higher in Medicaid and Medicare. However, the female client enrollment was lower in 3rd party insurance, indigent3, and private insurance. Overall,

more than 50% of the NEDHSA clients were under Medicaid. More than 93% of the clients were Whites and Blacks. The proportions of Black to White clients were 1.07, 1.2, and 1.16 in the FYs, 2020, 2021, and 2022, respectively. Under the 3rd party and private insurance, the number of White clients was more than the Black clients. Moreover, the number of Medicaid-insured clients was highest in each race category.

Under the Indigent plan, NEDHSA provided free services to 120, 36, and 29 clients in FYs 2020, 2021, and 2022, respectively. Most of them were diagnosed under the category of substance use and addictive disorder. Healthy Blue, Louisiana Healthcare Connect, and United Healthcare Community Plan were the major insurance types covering a higher number of NEDHSA clients, including all gender and race types. NEDHSA's majority of billing is Medicaid and Medicare. Write-offs/Insurance adjustments significantly decreased from 24% in 2020 to 19% in 2021. The write-off amount was higher for females, Blacks, and individuals diagnosed with depressive disorders.

Determinants of Telehealth Service Use among Mental Health Patients: A Case of Rural Louisiana

Our study investigated the sociodemographic and clinical correlates of the intensity of telehealth use among mental health patients residing in rural Louisiana, United States. The study sample included 7069 telehealth visits by 1115 unique patients encountered from 1 April 2020 to 31 March 2021 at six mental health outpatient clinics managed by the Northeast Delta Human Services Authority (NEDHSA). We performed a negative binomial regression analysis with the intensity of service use as the outcome variable. Being younger, female, and more educated were associated with a higher number of telehealth visits. The prevalence of other chronic conditions increased telehealth visits by 10%. The telehealth service intensity varied across the nature of mental health diagnoses, with patients diagnosed with the schizophrenia spectrum and other psychotic disorders utilizing 15% fewer telehealth visits than patients diagnosed with depressive disorders. The promotion of telehealth services among mental health patients in the rural setting might require the elimination of the digital divide with a particular focus on the elderly, less educated, and those with serious mental health illnesses such as schizophrenia and psychotic disorders.

B. Why is this success significant?
Behavioral Health Initiatives that are implemented ensure that our citizens have access to the care they need, no matter where they enter the health care system, to address the various social determinants faced.

C. Who benefits and how?
The nationally recognized integrative approach includes collaborative work with regional partners in prevention, education, business, and regional municipalities/parishes to serve our citizens. NEDHSA works diligently to reduce barriers to quality healthcare that arise from negative societal health determinants such as poverty, joblessness, and access to adequate housing.

D. How was the accomplishment achieved?
NEDHSA consistently works to understand the unique behavioral health needs of the citizens of northeast Louisiana and actively puts programs and services that meet

citizens' needs and fill healthcare gaps.

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, NEDHSA utilizes approaches that align with best practices and the agency's vision, mission, and tenets.

Accomplishment #2: Integrated Behavioral and Primary Healthcare

A. What was achieved?
In the fall of 2018, Northeast Delta Human Services Authority (NEDHSA) was selected as one of four state-wide grantees by the Louisiana Department of Health, Office of Behavioral Health to be awarded the SAMHSA Grant "Promoting Integration of Primary and Behavioral Healthcare (PIPBHC)." Since that time, NEDHSA has continued to expand integrated behavioral and primary healthcare efforts.

The PIPBHC program is located at Bastrop BHC and Monroe BHC, with expansion to all other NEDHSA clinic locations going forward. In FY2022, 208 clients were enrolled in the PIPBHC Grant program. The current staffing model for this program consists of:

- Integrated Care Grant Manager
- LPN Care Coordinator
- Data Analyst
- Peer Support
- APRN

In addition to the integration of Behavioral Health and Primary Care, NEDHSA staff have worked to become a paperless agency. Over the fiscal year, several goals were identified: (1) fully functioning Electronic Health Record System, (2) improve service to clients by making it easier for clients to pay on their accounts for services, (3) increase the speed in which staff can work online, and (4) increase the capability of staff to work and provide services with greater accessibility.

NEDHSA’s technology department have worked to ensure staff have needed equipment to work outside the office and to upgrade agency infrastructure, to increase the speed in which staff can access the internet, as well as, shared drives/documents.

Integrated Care staff have worked alongside representatives from ClaimTrak to maximum use of all functions relative to the EHR. This includes updating client records, embedding agency forms into the system, and constructing reports within the EHR to better retrieve agency data.

B. Why is this success significant?
Behavioral Health and Primary Care Integration are one of the three interdependent frameworks representing NEDHSA's logical framework of program and service delivery. Agency programs and services are built on the foundation of healthcare integration and specifically developed to address the ongoing needs of the clients served. Since its establishment in 2013, NEDHSA has worked to provide integrated health services by not only offering clients access to outpatient and inpatient services for behavioral health and substance abuse and addiction disorders, but also providing clients with access to prevention and wellness programs and other services aimed at treating the whole person. Integrated care further addresses the clients' social and socioeconomic needs, including housing, transportation, and employment, as well as primary healthcare needs. Serving as a grant awardee for this important federal initiative, NEDHSA was allowed to expand existing primary health services by providing funding for additional services and programs related to primary healthcare, significantly expanding our primary healthcare team, and reaching more clients in need of primary healthcare. Expanding PIPBHC-specific programmatic services to an additional NEDHSA clinic is another step in the agency's goal of fully integrated healthcare services at all outpatient clinics in the future.

By increasing access to healthcare, NEDHSA is able to provide much-needed primary healthcare services to our behavioral health clients. Many of our mental health and substance abuse clients have never visited a dentist or a primary care physician. The lack of primary health access may not only encumber needed behavioral health treatment, but may also lead to the development of preventable illnesses easily detected with basic health screenings. Further, lack of access to regular, ongoing primary care can have a negative impact on patient medication and treatment plan compliance, satisfaction and contentment with health services providers, quality of life, and other variables essential to the maintenance of health and wellness. Thus, having the ability to expand our integrated behavioral and primary health integration program through the acquisition of grant funds continues to have a significant impact on the clients we serve.

C. Who benefits and how?
This five-year grant is aimed at promoting full integration and collaboration of behavioral and primary healthcare, improving overall wellness and physical health of adults with serious mental illness by offering integrated healthcare services, screening, diagnosis, prevention, and treatments of mental health and substance disorders and co-occurring physical health conditions. Awarded funds have allowed for the expansion of our existing integrated care model. NEDHSA clients in need of one or more services are eligible to enroll in the grant, where they are followed at 6-month intervals and assessed for primary healthcare needs as well as ongoing service and program needs. Grant participants are screened for diabetes, high cholesterol, obesity, and other primary health concerns and undergo lab work and a basic physical examination. Minor health concerns are treated by the NEDHSA primary health team and more complex health issues are referred out.

D. How was the accomplishment achieved?
NEDHSA's Executive Director conceptualized a fully integrated healthcare approach to service delivery at the onset of the agency's establishment. Utilizing evidence-based practices, an innovative approach to healthcare was developed, bridging the gap in our clients' needs by offering a holistic approach to treatment, which addressed behavioral health, social determinants, and primary health. When the opportunity to enhance the existing integrated care model arose through the proposed SAMHSA PIPBHC grant, NEDHSA's Executive Director appointed a team to pursue funding. Much effort was put into the grant application and other required application documents. The hard work and dedication of staff made these accomplishments possible.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, one of the primary strategic initiatives outlined in NEDHSA's Strategic Plan for FY 2020-2025 is Integrated Behavioral and Primary Healthcare, specifically acknowledging SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) Program and its goals of improving the physical health status of people with mental illness and addictions.

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 integrated behavioral and primary healthcare model should be shared with other executive branch departments and agencies.

Accomplishment #3: Development Disabilities Services

A. What was achieved?
Initiated in December 2017, the Partners in Employment (PIE) program has continued to establish relationships with employers and providers throughout the region, building capacity and providing needed advocacy for people with disabilities to achieve competitive, community-based employment. The program transitioned into direct job training, job development, and ongoing job support at the end of FY 20, moving into full implementation of these outcomes during FY 21. A virtual workshop was held in the spring and featured self-advocates and leaders from around the state. The webinar was well attended and included a reverse job fair component featuring PIE program enrollees. Twenty Five people were enrolled in PIE during the fiscal year, joining the 15 who had enrolled during the previous fiscal year. Nineteen people in PIE have completed job skills training, and one person is currently enrolled in a national entrepreneurship training program. Twenty Three people have been assisted with employment applications, and 15 have attended interviews resulting in four achieving the 90 days of employment milestone and two reaching the 30-day employment milestone by the end of the Fiscal year. A total of six people gained competitive employment during a year that included barriers associated with a global pandemic in addition to historical obstacles. PIE, an employment model funded entirely by NEDHSA, has proven that successful employment can happen for the citizens within our region with appropriate funding, detailed planning, and direct implementation of

specific program outcomes and expectations.

The NEDHSA Developmental Disabilities Medicaid Waiver program unit provided programmatic oversight and implementation of 4 unique Medicaid Waiver programs, including the New Opportunities Waiver, Children's Choice Waiver, Supports Waiver, and the Residential Options Waiver. Some of the activities performed include certification of plans of care and revisions throughout the year for these recipients ensuring that criteria set by Louisiana's contract with CMS and the federal government's requirements for use of Medicaid funds is met. This oversight includes accountability of over 1,300 Medicaid Waiver participants within the region that are either currently certified or in the process of certification with active applications for Waiver supports and services. In addition, this program unit provided ongoing technical assistance and training to approximately 60 private provider agencies and three Support Coordination agencies within the region that is contracted to provide supports and services to Waiver participants within the region.

The Northeast Delta Human Services Authority Developmental Disability Services Department (NEDHSA DD) continues to participate in the systems transformation initiative for developmental disability service delivery. During FY21, the NEDHSA DD department served 1,850 individuals through primary programs utilizing ACT 378 funds and in the Medicaid Waiver Programs. The ACT 378 funds are legislatively allocated to provide goods and services to citizens with developmental disabilities within the NEDHSA Region 8 area through the Family Support and the Flexible Family Fund Programs. Through these programs, NEDHSA spent over $800,000 to provide for the needs of 464 people through 431 individualized agreements allowing for stipends, goods, and services directly into the developmental disabilities community. Funds were utilized to purchase Personal Care Services, incontinent\personal supplies, home and vehicle modifications, medical equipment, and other services\items that support individuals and their families to remain living in their homes in the community.

During FY 22, the NEDHSA Developmental Disabilities department service spent over $800,000 to provide for the needs of 333 people allowing for stipends, goods, and services directly into the developmental disabilities community.

B. Why is this success significant?
The PIE initiative, in particular, is significant to NEDHSA's efforts to take a lead role in making systematic changes that will improve the success rate for people with developmental disabilities that want to go to work. NEDHSA has heard from people in the developmental disabilities community that traditional employment resources and processes are not successful in helping them reach their goals of becoming employed. NEDHSA has proven through PIE that employment opportunities are available in the community, and people can go to work with individualized supports without excessively long wait times for assistance to reach their goals. All of the work performed by the NEDHSA DD department is critical to the ongoing service delivery system for people within the NEDHSA area. Delivery of needed services to people who have no other resource to obtain these services is vital for people to remain in their homes and

communities. Management of these services and funds must ensure quality and compliance to maintain funding, cost efficiency, and sustainability.

C. Who benefits and how?
People with developmental disabilities within our state, specifically within the NEDHSA area, benefit from the activities of NEDHSA. NEDHSA serves as the single point of entry into the state's developmental disability system, provides funding for services needed for people to live in their homes and communities, along with monitors and manages programs mandated by the Centers for Medicare/Medicaid (CMS-Federal Government). Leading the way in spotlighting the significant need for more people to become employed gives individuals the opportunity for self-sufficiency, social contact, and the ability to contribute their gifts and talents to society along with economical contribution to the economy.

D. How was the accomplishment achieved?
The Hard work and dedication of staff made these accomplishments possible. An intentional effort by management was made to keep staff focused on NEDHSA's mission, vision, and tenets, along with ongoing training and information. Collaboration and complete buy-in from the Executive Director to implementing staff is also a contributing factor to these accomplishments. NEDHSA cultivates a culture of focus on the improvement of the lives of people with developmental disabilities.

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.

Accomplishment #4: Prevention and Wellness Services

A. What was achieved?
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 Information dissemination, formation and implementation of community coalitions, community education, alternative activities for youth, school-based interventions, and tobacco retailer (SYNAR) compliance checks. Below is a brief summary of prevention activities for FY21-22:

Opioid Summit

NEDHSA hosted its 2022 Opioid Summit on Thursday, June 16 in West Monroe. The theme for the 2022 Opioid Summit was "O.U.R. (Openly Using Recovery) Strategies to Rise Above Stigma."

NEDHSA Executive Director Dr. Monteic A. Sizer said this event is vital to the region and state, and that "attendees will learn how to better identify the casual and correlated factors associated with opioid addiction, and learn how to implement prevention and evidence-based treatment strategies to help mitigate opioid addiction."

LaSOR NARCAN Training and Kit Distribution

NEDHSA hosted 60 NARCAN Training and Kit Distribution events during FY21. The events were held across all twelve parishes in the service area, and 326 kits were distributed during these events. Additionally, 209 kits were distributed to the institutions of higher education (Louisiana Delta Community College – 45 kits, Grambling State University – 40 kits, Louisiana Tech University – 74 kits, University of Louisiana at Monroe – 50 kits). This brings NEDHSA'S total Narcan kit distribution to 535. NEDHSA's NARCAN training is free and provides information to attendees to help (1) learn how to determine if a person may be overdosing from opioid use and how to respond to an opioid overdose; (2) learn how to properly administer Narcan (naloxone), a medication used to block the effects of opioids, to an individual experiencing an opioid overdose: and (3) learn about ways to reduce opioid overdose deaths and ways individuals can help stay safe.

During FY22, NEDHSA continued efforts to train and bring kits to the region. In December, we conducted NARCAN training with the Morehouse Parish Sheriff's Office. This training can be done for private and public entities, as well faith-based organizations.

SYNAR Checks

The SYNAR Program, overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA), requires states to establish and enforce laws to prohibit the distribution and sale of tobacco products to minors. Regular SYNAR checks are performed to ensure compliance with these laws.

School-Based Opioid Education and Student Ambassadors

In FY20, NEDHSA began providing opioid education to students who are in 3rd to 11th grade. These efforts have expanded to providing continued education opportunities across the region. The Prevention & Wellness team are have conducted various workshops about alcohol and drug awareness to area students.

Mind Motivation

NEDHSA partnered with Mind Motivation, a 501(c)(3) non-profit organization, to conduct an essay contest aimed at underage drinking prevention and financial literacy among youth. This initiative is another facet of NEDHSA's Office of Prevention & Wellness Louisiana Partnerships For Success work as it offers evidence-based practices to help children overcome adverse experiences. On Thursday, December 9, the contest

winners were announced, comprising of second and third grade students from Clara Hall, Swayze, Burg Jones Lane, Robinson, and Madison James Foster Elementary Schools, a total of 30 students. As part of the essay contest, participants were asked to describe what motivates their minds to stay healthy and away from alcohol and drugs in one paragraph in their own words. Also, the participants wrote in a separate paragraph why saving money is essential to them. The school administrators selected the winners.

NEDHSA, Mind Motivation, and Pelican State Credit Union conducted mentoring sessions on underage drinking prevention, financial literacy, and mind motivation. Additionally, Pelican State Credit Union will allow the contest winners to open bank accounts, and Pelican State Credit Union will deposit a small amount of money for each A on the students' report card until high school graduation. At that time, the student then becomes eligible to apply for the Pelican State Bank scholarship.

Prevention and Wellness Community Events

NEDHSA's Prevention and Wellness Department hosted a series of events aimed at building stronger communities one person at a time. As the COVID-19 pandemic increased the level of anxiety and trauma in our region, especially for those already dealing with mental illness and other challenges, NEDHSA hosted these events to help the people of northeast Louisiana remain hopeful and informed. The events were well-attended and included the following:

- Yoga and Meditation Workshop: Transforming the mind, body, and spirit
    - The agency hosted its Yoga & Meditation workshop to focus on the benefits of light stretching of the body, deep breathing, and meditation techniques.

- Stop the Violence Bike Ride
    - NEDHSA also partnered with Rated E, LLC as the title sponsor to present the inaugural "Stop the Violence" bike ride in FY2021. The event welcomed community citizens of Monroe and featured live music, vendors, yoga, and special guest speakers who shared messages of hope, peace, and more.

- Red Ribbon Week
    - NEDHSA hosted a series of activities during national Red Ribbon Week for students, teachers, and faculty in Ouachita Parish to promote a drug and alcohol-free lifestyle.

- I Am Enough for God: Addressing the Opioid Crisis

- Transforming Grief Talk:
    - Recovery NEDHSA partners with St. Joseph MBC of West Monroe to discuss "Transforming Grief Talk: The Role of Grief and Loss in Addiction Recovery".

B. Why is this success significant?
Initiatives that are implemented within the NEDHSA Integrative Behavioral Health and Primary Care Model ensure that our citizens have access to the care they need, no matter where they enter the health care system. Prevention efforts are crucial to providing integrated care.

C. Who benefits and how?
This nationally recognized, integrative approach includes collaborative work with regional partners in prevention, education, business, and in regional municipalities/parishes to serve our citizens. NEDHSA works diligently to reduce barriers to quality healthcare that arise from negative societal health determinants such as poverty, joblessness, and access to adequate housing...

D. How was the accomplishment achieved?
NEDHSA consistently works to understand the unique health care needs of the citizens of northeast Louisiana and actively puts programs and services in place that meet citizens' needs and fill healthcare gaps.

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, NEDHSA utilizes approaches that are in line with best practices along with the agency's vision, mission, and tenets.

Accomplishment #5: Regional COVID-19 Response

A. What was achieved?
With the health, well-being, and safety of agency clients, as well as the region as a whole, in mind, Northeast Delta Human Services Authority (NEDHSA) implemented several COVID-19 related initiatives in FY20. We continued those services in FY2021. The emerging issue of the COVID-19 pandemic called for action to not only employ preventative measures and safety precautions to protect the health of our clients, but to also assist them, the community's most vulnerable populations, in dealing with this health crisis. NEDHSA took many steps to not only prevent the spread of illness within the agency's clinics and facilities but to educate staff, clients, contractors, and the community about COVID-19's impact in our region.

COVID-19 Information Portal
A COVID-19 Information Portal was provided to the NEDHSA agency website to provide continual updates on the operating status of our outpatient clinics, 24-hour

access contact information, and COVID-19 related information. The addition of the COVID-19 portal allowed for easy access by agency clients, as well as the general public, to information such as the COVID-19 Prevention Fact Sheet, What You Need to Know About COVID-19 Fact Sheet, Supporting Young Children Isolated due to COVID-19, Coping with Stress During Infectious Disease Outbreaks, Mental Health Considerations during COVID-19 Outbreak, COVID-19 Frequently Asked Questions, Update on COVID-19, as well NEDHSA's Continuity of Operations Plan and LDH state information on free COVID-19 mobile testing and LDH Keep Calm Through COVID-19 24/7 Counseling Hotline information. The web page also contains information such as proper hand-washing techniques and social distancing practices.

We Will Rise: Creating Hope - Daily Inspirational Calls

As the number of COVID-19 cases in northeast Louisiana rose, NEDHSA called upon regional faith leaders to help share messages of faith and hope through daily inspirational calls. The agency's Faith Partnership Initiative exists as a means of engaging with faith-based communities to help enrich traditional behavioral health services in a unique way that the government alone cannot. Several religious leaders throughout the region facilitated the daily calls and offered messages of hope, understanding, encouragement, and overcoming adversity to help our clients and others in our region cope with the uncertainties that came with the COVID-19 pandemic. All citizens were invited to join the daily inspirational calls Monday through Friday at noon by accessing a toll-free number.

COVID-19 Client and Community Access

In FY21, NEDHSA continued the telehealth visits agency-wide to avoid any disruption in client services during the COVID-19 pandemic. NEDHSA clients were able to continue their scheduled access to agency clinicians, and NEDHSA clinical staff implemented increased wellness checks on agency clients throughout the course of outpatient clinical physical closure, as well, in addition to the scheduled telehealth visits. The NEDHSA Prevention and Wellness Department partnered with Louisiana State Representative Katrina Jackson in a COVID-19 response to Feeding the Community with first responders and provided information on how to access NEDHSA behavioral health services with NEDHSA. These efforts continued during FY22.

B. Why is this success significant?

All of the additional initiatives and actions put into place in response to the COVID-19 pandemic were important to the promotion and maintenance of our clients' mental and behavioral health and personal well-being. Recognizing the potential effects and devastation of COVID-19, NEDHSA proactively sought to identify our clients' concerns and the specific issues faced that may contribute to their increased behavioral, physical, and social health needs through implementing the COVID-19 Social Health Impact Assessment. NEDHSA also recognized the necessity of being calm amidst the storm for our clients who already struggle with many aspects of daily living and were now faced with an uncertain future due to the pandemic and subsequent loss of employment, food insecurities, and other challenges. Therefore, offering daily messages of hope and providing a public platform through the COVID-19 Information

Portal on our agency website was important in maintaining a positive connection with our clients and contributing to the promotion of their mental health.

C. Who benefits and how?
NEDHSA agency clients, as well as the citizens of Region 8, benefitted from the initiation of these COVID-19 related activities. NEDHSA continually works to explore and understand the unique challenges and healthcare needs of the citizens of northeast Louisiana in order to establish and provide assistance, programs, and services that specifically address those challenges and needs.

D. How was the accomplishment achieved?
Intentional efforts by management were made to provide NEDHSA clients with as much information, assistance, and encouragement as possible throughout the COVID-19 pandemic. By staying focused on NEDHSA's mission, vision, and tenets and the agency's underlying data-driven decision-making approach, collaborative efforts between the agency's Executive Director and staff made these accomplishments possible.

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 client-centered approach to program and assessment development should be shared with other executive branch departments and agencies.

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

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

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

  NEDHSA strategic plan goals were implemented as outlined in the FY2020-2025 Strategic Plan. Continued progress is being tracked, documented, and reported. Performance improvement processes were implemented in FY19 and continued in FY20 and FY2021 to monitor the number of referrals to NEDHSA partner agencies. The number of persons receiving individual and family support services, Flexible Family

Fund services, and developmental disabilities services is noted in the FY2021. Achievement in meeting performance standards is further evidenced by the agency's expansion of services and quality 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:
Our agency is tracking above average on many indicators, but not significantly higher than anticipated. We consider this a measure of stability in our ability to project with increased accuracy and managing the expectations of meeting our goals.

  1. To what do you attribute this success? 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.

     We attribute our success to our continuous quality assurance measures, including quarterly performance improvement meetings and consistent messaging across our agency. We have stabilized our psychiatric support and are maximizing the use of additional grant funds to support our operations.

     By implementing the agency's Five-Year Strategic Plan and aligning with the overarching vision, mission, and tenets, Northeast Delta Human Services Authority (NEDHSA) experienced continual growth and realized numerous outstanding accomplishments during FY21. These accomplishments resulted from the careful and deliberate planning of new programs and services, establishment of new community partnerships, expansion of current services, and a continued focus on the specific needs of the individuals served.

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

     No, and we are not expecting an accelerated gain. Our focus is moderate, measurable, and sustainable gain.

- **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.

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.

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

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

  NEDHSA's FY2021-2025 Strategic Plan was developed with an outcomes-based approach where evaluation, planning, and development of services and programs will be data-driven. New strategies are added to existing ones in order to achieve agency goals. This will allow us to build upon our current successes and further grow in areas where we are continually evolving.

- **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 AIP reviews. Our agency has quarterly performance improvement committee meetings to discuss the performance indicators and strategies to enhance our delivery of services. As leadership makes data-driven decisions about management and funding, we consider the performance indicators to help us determine how to streamline our funds and

processes for improved outcomes.

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

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

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

There are no management or operational problems or issues to report.

A. Problem/Issue Description

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

B. Corrective Actions

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

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

☒ **Internal audit**
The 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 c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

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

☒ **Policy, research, planning, and/or quality assurance functions in-house**
NEDHSA has a Corporate Compliance Department which collaborates with the various NEDHSA departments to update and develop policies. In addition, corporate compliance oversees the functions of quality assurance functions, such as peer reviews and quality assurance meetings.

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

☒ **Program evaluation by in-house staff**
NEDHSA's Corporate Compliance Department conducts evaluations of clinical services through record reviews, reviews of consumer complaints, critical incident analysis, and review and analysis of measures in the TeleSage Outcomes Measurement System (TOMS).

☐ 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**
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).

☒ **Customer/stakeholder feedback**
NEDHSA collects consumer satisfaction surveys on a quarterly basis along with TOMS quality of care surveys on a semiannual basis.

☐ Other (please specify):

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department: **Louisiana Department of Health (LDH)**
09-320 Office of Aging and Adult Services

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Assistant Secretary: **Melinda Richard, MT (ASCP), CLSSMBB**

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

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

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

Accomplishment #1: Permanent Supportive Housing 50% increase in housing:

A. **What was achieved?**
The Permanent Supportive Housing (PSH) program housed 612 households during fiscal year 2022. This number reflects a 50% increase in leasing from pre-pandemic leasing numbers. Each household includes at least one person who lives with a disability.

B. **Why is this success significant?**
This is important in assuring the state's compliance with the Americans with Disabilities Act and the U.S. Supreme Court Olmstead decision. It is also essential to the state's agreement with the U.S. Department of Justice (DOJ) in moving individuals living with serious mental illness from institutions into the community by providing safe and

affordable housing and home based community services to support successful tenancies.

C. **Who benefits and how?**
Low income individuals with disabilities and their household members benefit from having access to high quality, community-integrated, affordable housing with tenancy supports to help them be successful tenants and maintain housing stability. PSH has a 94% program retention rate and 59% of households see an increase in income after they are housed by the program. PSH reduces inpatient hospital, emergency department, and institutional care, which benefits the health outcomes of the population it serves, as well as taxpayers.

D. **How was the accomplishment achieved?**
This accomplishment was achieved through strong partnerships with both state and local level agencies, including other LDH programs, creative strategies, an increase in funding streams and great customer service. PSH staff continued to work in the field throughout the pandemic. At the height of the pandemic, several homeless continuums partnered with the state to move homeless individuals into hotels to reduce the risk and spread of Covid19 within this incredibly vulnerable population. A large number of these households transitioned from hotels into Rapid Rehousing programs, which are time limited.

The PSH office worked closely with continuums and provider agencies to determine PSH eligibility for those households who were identified as potentially being eligible for the program. Those who were eligible were able to remain in their current unit and payments for those units were transitioned to a PSH Subsidy Administrator. This strategy enabled these disabled households to avoid another episode of homelessness. The increase in the number of households served through this particular subsidy was the result of grant savings. The grant savings was a direct result of the number of PSH clients with an increase in their income, enabling them to pay a portion of the rent, reducing the rent burden for the program.

Through our partnership with Louisiana Housing Corporation (LHC), HUD waivers were extended to remove some housing barriers. Staff continued to be creative in finding safe ways to complete tasks that are required under Federal guidelines in terms of viewing units, completing paperwork and conducting inspections. They also included nontraditional strategies such as reaching out to landlords who typically rent on a short-term basis who were losing money during the pandemic and discussing the benefits of working with a long-term subsidized program. Additionally, the program was able to take advantage of properties with multiple vacancies that were willing to accept rental subsidies and vouchers.

The program worked closely with Transition Coordinators in OAAS and OBH to transition individuals from nursing homes. During this time, the OCDD Money Follows the Person (MFP) program started making referrals to the PSH office and the PSH office worked with those Transition Coordinators to facilitate transitions under PSH subsidies. Additionally, funding for My Choice Rental Assistance was increased by $800,000

enabling the program to significantly increase the number of transitions for members of the target population.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, this accomplishment contributes to the success of program goal #2 within our strategic plan by improving access, quality and outcomes for populations receiving or at risk of needing long-term supports and 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, best practices include collaborating with community partners and strategically aligning with other industry partners that could benefit in a synergistic manner to achieve a higher level of success. The OAAS PSH manager also effectively managed the PSH team during unprecedented pandemic times, to include meeting as a team safely in appropriate settings, ongoing team building and communication methods to maintain a connections amongst the team and to maintain motivation.

Accomplishment #2: The Implementation of the new interRAI Home Care Assessment

A. **What was achieved?**
The Office of Aging and Adult Services (OAAS) partnered with interRAI to develop and implement use of a Louisiana specific assessment tool. The interRAI Home Care (iHC) assessment is used to inform case managers of a person's needs, which is essential to a comprehensive person centered care planning process for older adults and persons with adult onset disabilities needing OAAS managed home and community based services (HCBS). These assessments are conducted in person by well-trained certified assessors. The previous tool used by OAAS was version 2.0, copyrighted in 2002. The new iHC assessment is version 9.4.3, copyrighted very recently and captures the latest evidenced based outcomes essential to the quality delivery of home and community based services.

The assessment, in addition to being updated, was successfully built into OAAS's custom software solution, the OAAS Participant Tracking System (OPTS). OPTS captures demographic data, functional assessment information, and plans of care for individuals applying for and receiving OAAS services. The iHC assessment module was successfully launched into OPTS on December 10, 2021.

B. **Why is this success significant?**
The iHC assessment tool, version 9.4.3, benefits from interRAI's evidence based data and statistics regarding best practices in long term care. Additionally, OAAS's statewide training team managed the implementation of a new training program to align with this updated assessment tool. Nearly 200 assessors, representing 100% of OAAS's assessors, have been certified to use the new iHC assessment. The integration of the assessment in OPTS will assist assessors with making appropriate care planning recommendations and

improve the coordination of care for participants receiving OAAS services.

C. **Who benefits and how?**
The updated iHC assessment tool includes increased sensitivity to the long term care needs of older adults and persons with adult onset disability. This guides case managers to more accurately identify the needs of individuals receiving services, therefore aiding in quality case management support. Additionally, implementation of the updated assessment into OAAS's custom software solution benefits participants by enabling assessor to properly allocate services using the updated assessment, which is a product of rigorous research that supports reliable and valid results. The updated assessment tool also benefits the certified assessors statewide who are mandated to use this tool to assess participant needs and eligibility. The OAAS custom software solution has enabled OAAS to automate previously manual assessment processes, thereby decreasing erroneous system errors.

D. **How was the accomplishment achieved?**
OAAS worked very closely with interRAI and the organization's consultants, as well as, OAAS's contracted software developers to develop and implement the updated assessment tool. Through effective staff and time management, OAAS completed vigorous testing and trained nearly 200 existing statewide assessors to recertify them on the new assessment tool prior to launching. Assessors are a mixture of OAAS staff and external contracted staff who provide case management and service implementation to all waiver, PACE and LTPCS participants.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, this accomplishment contributes to the success of program goal #2 within our strategic plan by improving access, quality and outcomes for populations receiving or at risk of needing long-term supports and services. It also contributes to goal #3 of administering and operating OAAS programs in a cost-effective manner while achieving high quality outcomes; as this updated technology creates efficiency through reduction in wasted time when assessments are not done correctly.

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 was achieved through effective project management, which enabled OAAS to launch the custom assessment software. Additionally, OAAS's data analytics team, through statistical expertise and vigorous testing ensured all assessment algorithms were programmed into the assessment software correctly. Finally, skilled OAAS training staff redesigned the assessment training and certification program to manage the successful training and certification of 200 assessors in a 3-month timeframe.

Accomplishment #3: Waitlist Reduction Plan Implementation

A. **What was achieved?**

The LDH Office of Aging and Adult Services (OAAS) has made significant progress in reducing the number of applicants waiting for a service on the Community Choices Waiver (CCW) Request for Services registry. LDH has already been successful in eliminating the wait for services for people with developmental disabilities and wanted to extend this success to older adults and those with adult-onset disabilities and their families. As of July 31, 2022, there were 5,652 individuals on the Registry, down from nearly 30,000 individuals on the Registry in 2017. Of the 5,652 individuals on the CCW Request for Services Registry, only 1,368 people are waiting without receiving any other services. Through CMS approval, OAAS now prioritizes waiver opportunities to these individuals.

During the 2021 Legislative session, OAAS requested and received an additional 500 CCW slots. During fiscal year 2022, facing multiple challenges and workforce shortages both internally and externally with enrolled, contracted and licensed providers, OAAS Program Operations staff played a crucial role in successfully approving services and filling all 500 of the legislatively approved CCW slots. OAAS Program Operations staff applied efficient and effective management strategies to track individuals through the approval process, developed risk mitigation strategies to overcome challenges with care approval and provided technical assistance to Support Coordination Agencies to ensure all 500 Community Choices Waiver slots were filled and the individuals were approved for services.

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

Long waiting lists, by themselves, or in conjunction with other factors, place states at risk for lawsuits based upon the Americans with Disabilities Act (ADA) and the ADA-based U.S. Supreme court Olmstead decision. Individuals waiting for services are often at high risk of nursing facility placement and may end up receiving more expensive forms of care if their support needs are not addressed within reasonable timeframes.

C. Who benefits and how?

The community benefits as individuals request, and then receive, support from Community Choices Waiver. This program provides Medicaid in-home and community-based services that are an alternative to nursing home care for older adults and people with adult-onset disabilities, increasing the number of individuals receiving quality support in the setting of their choosing. Community Choices Waiver is also a cost effective alternative to Nursing Facility care, benefitting the State and Department of Health.

D. How was the accomplishment achieved?

In June 2019, CMS authorized the state to give priority for waiver offers to individuals not already receiving another form of Medicaid home and community-based service. This allowed LDH and OAAS to prioritize those who truly are waiting for in home care and have no other form of home-based assistance from Medicaid.

Achieving the 500 waiver slot certification goal for fiscal year 2022 required additional efforts from OAAS Regional Office (RO) staff working in conjunction with the Medicaid long-term care section and OAAS contracted Support Coordination Agencies (SCAs). OAAS RO staff tracked each CCW linkage until certification; reaching out and assisting the individual requesting services, the assigned Medicaid analyst, and the Support Coordinator until the person was certified and approved for services. OAAS state office management designated an OAAS Area Manager as a Medicaid liaison to streamline Medicaid contacts and provide assistance working through cases that presented a non-typical challenge. OAAS data analytics section developed a data dashboard to provide real time numbers and visual graphics for progress updates.

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

Yes, this accomplishment contributes to the success of program goal #2 within our strategic plan by improving access, quality and outcomes for populations receiving or at risk of needing long-term supports and 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, having individuals achieve successful reintegration into the community leads to better health outcomes and cost savings for the state and is an accomplishment that should be shared with others agencies and replicated where applicable.

Accomplishment #4: In-Reach Implemented via Agreement with Department Of Justice (DOJ)

A. **What was achieved?**

In 2014, the United States DOJ initiated an investigation of the State of Louisiana's use of nursing home placement for people with serious mental illness to assess compliance with Title II of the Americans with Disabilities Act (ADA). Following this investigation, in 2016 the DOJ alleged that Louisiana unnecessarily relies on nursing facilities to serve people with serious mental illness (SMI) instead of serving them in the most integrated setting appropriate to their needs as required by the ADA.

LDH has named the new program "My Choice Louisiana" to reflect two of the key principles discussed in the Agreement, self-determination and choice. To achieve these principles the goals as outlined in the Agreement include:

- Divert individuals with serious mental illness away from inappropriate nursing facility placements by requiring comprehensive evaluations and services designed to enable them to live in community-based settings; and
- Identify people with SMI who have been admitted to nursing facilities but are able to and would like to transition to the community, and provide them with transition and discharge planning and community-based services sufficient to meet their needs.

In June 2018, after a long negotiation, which included working closely with the Governor's office, Louisiana Department of Health (LDH) signed an agreement with the DOJ to help ensure compliance with the ADA. Under this Agreement, the State is required to create and implement a plan to transition and divert individuals with mental illness from nursing facilities, including expanding the array of community-based services such as: crisis services, case management, integrated day services and supportive housing.

During calendar year 2021, LDH implemented an in-reach strategy to engage with all individuals, identified as members of the Target Population (TP) on the Master List (ML), residing in nursing facilities regarding choices and community living options. These discussions were conducted by peer in-reach specialists (PIRS), medical certification specialists (MCS) and transition coordinators (TC). The strategy included having an informal discussion with each member to gauge interest in transitioning. Those individuals indicating interest in transitioning were added to the active caseload to initiate transition activities. LDH established an initial goal to contact over 1,500 people between April 2021 and April 2022. LDH exceeded the goal established by contacting 1,939 people resulting in 478 people indicating interest that were able to be connected with a My Choice transition coordinator to initiate transition activities. This goal was surpassed by effective tracking and management of staff members completing the In Reach work.

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

During the initial implementation phase of the Agreement, there were various mechanisms utilized to identify individuals that may be good candidates for transition and/or may have expressed interest in moving to the community. The mechanisms employed had varying degrees of success. TCs spent a large percentage of their time engaging with these individuals with little movement in terms of achieving the intended outcomes as outlined in the Agreement specific to transition. LDH needed and developed a new process to identify individuals who were interested in transition through in-reach and engagement efforts. These efforts have resulted in LDH connecting with people expressing interest in transition more quickly and an overall increase in the number of transitions.

C. **Who benefits and how?**

Individuals identified as members of the target population for the Agreement benefit as we are able to maximize resources linking transition coordinators to individuals that are interested and motivated to move.

The Agreement defines individuals in the Target Population (TP) as follows:

- Medicaid-eligible individuals over the age of 18 with a SMI who are either residing in a nursing facility (NF), or
- Individuals who are referred to PASRR Level II screening for NF admission during the course of this agreement
- Individuals with a primary diagnosis of dementia are excluded from the TP.

D. **How was the accomplishment achieved?**
This accomplishment was achieved by coordinating across program offices and departments to identify and maximize available resources, develop, implement, and execute the plan to achieve the intended outcome. This included making direct contact with the members of the target population, and there is no substitute for building trust and really connecting with these individuals as they are making these life decisions.

E. **Does this accomplishment contribute to the success of your strategic plan?**
Yes, this accomplishment contributes to the success of program goal**s** #1 and #2 within our strategic plan by achieving and maintaining a legally compliant and appropriately balanced LTSS system, which assures choice and improving access, quality and outcomes for populations receiving or at risk of needing long-term supports and services. Both of these goals also supports Louisiana in meeting the goals in the Agreement with the US Department of Justice.

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 efficient management of staff, application of new strategies directly developed through lessons learned and effective tracking of data, as well as, rapid implementation of newly developed strategies.

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

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

Yes, OAAS continues to make progress in many areas related to its strategic goals and objectives.

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

The accomplishments above contribute significantly to the OAAS strategic progress. They correspond to OAAS strategies as outlined in the OAAS Strategic Plan and have helped the agency make progress on Program Goals including:

1. Achieve and maintain a legally compliant and appropriately balanced LTSS system, which assures choice within a sustainable, cost-effective continuum of community-based services and facility-based services.

2. Improve access, quality and outcomes for populations receiving and at risk of needing long-term supports and services.

3. Administer and operate OAAS programs in a cost-effective manner while achieving high quality outcomes.

- **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 housing in the Permanent Supportive Housing (PSH) Program, Implementation of the new interRAI Home Care Assessment, the Waitlist Reduction, and the Department of Justice In-Reach Activity, among other accomplishments within OAAS all contribute to our OAAS mission of providing access to quality long-term care 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.

  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?

  Progress would not have occurred 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?)

  Accomplishments were achieved through allocations of new resources, strategic use of existing resources and implementation of updated technology.

     - 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?

  Although many of our efforts were joint with other agencies such as Louisiana Housing Corporation, and other sections within LDH, such as the Office for Citizens with Developmental Disabilities, Office of Behavioral Health, Medicaid and others, most of these efforts were led by OAAS.

     - Other? Please specify.

  N/A

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

   These accomplishments will produce ongoing gain.

- **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.

  Due to structural issues in statute and regulation, Medicaid spending for nursing facility care continues to rise faster than increases in access to and payment for community-based care. Furthermore, delivery of Long Term Services and Supports (LTSS) alone is not sufficient to address the significant chronic care needs of the population served by OAAS; a problem which contributes to the state's low ranking on various national health and LTSS scorecards.

  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 in rebalancing more towards community-based care and away from use of nursing homes is due primarily to statutory requirements and constraints that impact Medicaid long term supports and services funding and is likely to continue, especially as the population ages.

- **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?

  OAAS made minor revisions to its strategic plan in FY22 for FY23-28, but kept the same basic goals and objectives we have been working towards for many years. As

stated above, any shortfalls we have experienced are/were beyond our control.

- **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 vision that OAAS maintains of increasing access to home and community-based services as a sustainable, cost-effective alternative to nursing home care, in addition to improving access, efficiency, and quality in all OAAS programs, is key to integration of the OAAS strategic plan in other departmental processes such as budget and business plan development. Whether it takes the form of AMPAR reporting, LAPAS performance indicators, "transformative" business objectives, or budget explanations/justifications. OAAS strategic goals and objectives are clear, have been consistent over time and administrative changes, and understood by all OAAS staff. OAAS has been fortunate in having access to data that allows management and staff to monitor program outcomes, often against national goals and benchmarks. This allows OAAS to adjust strategies as needed to attain office objectives. Because OAAS administers Medicaid funded programs, OAAS works very closely with that agency and 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? N/A

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

There are no significant management or operational problems to report.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   There are no significant department, management or operational problems to be noted.
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) N/A.
   3. What organizational unit in the department is experiencing the problem or issue? N/A.
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) N/A.
   5. How long has the problem or issue existed? N/A.
   6. What are the causes of the problem or issue? How do you know? N/A.
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? N/A.

B. Corrective Actions

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

   ☒ 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? N/A

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

4. Are corrective actions underway? N/A
   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? N/A

   ☐ 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 c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

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

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive 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**
OAAS conducts consumer experience surveys with recipients of Medicaid home and community-based services and uses survey findings to improve those programs and services. OAAS also meets regularly with external stakeholders including quarterly provider trainings/meetings at the regional level; quarterly meetings with Support Coordination agencies; and Advisory Group meetings for the Department of Justice Agreement.

☐ Other (please specify):

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department: **Louisiana Department of Health (LDH)**
09-324 Louisiana Emergency Response Network

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

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.

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

Accomplishment #1: Level III Trauma Program in LDH Region 8

A. **What was achieved?**
Two hospitals met requirements, signed Level III Trauma Program attestation and are functioning as a Level III Trauma Program. These hospitals are St. Francis Medical Center and Ochsner LSU Monroe.

B. **Why is this success significant?**
The LERN Boards vision has always been to achieve an ACS verified trauma center in every region of the state. LERN has achieved this vision in all regions except LDH Region 8 and 3. This is important because Region 8 trauma patients were being

transported long distances for care. In CY 2021, 431 trauma patients were transferred out of the region for care – most traveling two hours away to Shreveport. In fact, during the 2015 Regular Legislative Session, SCR 42 was passed, authorizing LERN to facilitate a working group of healthcare providers to develop recommendations for a Level III Trauma Center in Northeast Louisiana. LERN continued to promote this initiative and developed the "Trauma Program" process to help hospitals build their programs and achieve full verification as a "Trauma Center".

C. **Who benefits and how?**
Citizens and anyone injured in Region 8. Specialized services closer to home saves lives. Multiple studies prove injured patients have better outcomes when receiving care in a trauma center.

D. **How was the accomplishment achieved?**
Data collected by the LERN Communication Center helped to identify the lack trauma resources in Region 8 and in other areas of the state. The LERN Board studied other state trauma systems, evaluated the data, and set a vision to achieve at least one trauma center in every region of the state. The LERN regional commission continued to promote the development of a trauma center and the LERN Trauma Medical Director focused his efforts on working with the administration at the hospitals to understand the value and ultimately commit resources and support to achieving trauma center status. Each hospital will have their ACS consultative survey by the end of this year and will have their full verification survey next year. The LERN Trauma Medical Director (TMD) will continue his consultative services to help ensure success. In addition to the TMD support, the LERN regional coordinator has and will continue to teach Trauma Nurse Core Curriculum (TNCC) and Emergency Nurse Pediatric Course (ENPC) to trauma program staff. These are requirements for verification. LERN also secured grant funding for ENPC and Trauma Care after Resuscitation (TCAR) – over $30,000 to help fund these educational efforts.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes – it contributes to strategy I.1.1 Utilize the expertise of the LERN Trauma Medical Director to facilitate the establishment of a verified trauma center in each of the LDH regions by 2028.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes – Set a vision and direct resources to the achievement of that vision. Also, the trauma program and medical director consultation is probably unique to LERN. Developing mechanisms to provide consultation and a road map to achieve a desired goal should be a best practice for all.

Accomplishment #2: Primary Stroke Center Region 8

A. **What was achieved?**
First Joint Commission Certified Primary Stroke Center (PSC) in Region 8.

B. **Why is this success significant?**
The typical stroke patient loses 1.9 million neurons each minute in which a stroke is untreated. Primary Stroke Centers assists organizations in establishing a consistent approach to care, reducing variation and the risk of error. Demonstrates commitment to a higher standard of clinical service. Provides a framework to improve patient outcomes. Helps to organize teams across the continuum of care.

C. **Who benefits and how?**
LERN Call Center data from CY 2021 indicates 116 stroke patients were transferred out of the region for care. The establishment of a PSC in the region should help provide time sensitive care, closer to home – saving precious brain cells and increasing the likelihood of an independent outcome from the stroke. All citizens in Region 8 will benefit from timely access to care.

D. **How was the accomplishment achieved?**
In 2019, when the LERN Board established our 3 year strategic plan, the LERN Stroke Medical Director sent the goal of achieving a new Primary Stroke Center in Regions 3 and 8. These were the only two regions without a PSC. The LERN Board adopted this recommendation and it became a strategic priority. The LERN Stroke Medical Director met with leadership at Region 8 hospitals to discuss strategies to achieve PSC. One hospital was interested and the LERN Stroke Medical Director provided consultation on site and via the quarterly feedback reports. These reports are in response to quarterly stroke data submitted to LERN by Acute Stroke Ready Hospitals (level below PSC). Through these two mechanisms their performance improved to a point where they were successfully certified by the Joint Commission as a Primary Stroke Center.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes – this contributes to Goal III – Ensure that all citizens gain access to the statewide networks for trauma and time sensitive related issues. Objective III.2: Develop a statewide system of stroke care to improve outcomes for Louisiana citizens regardless of where they live 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?**
No.

Accomplishment #3: 1st Level II Pediatric Trauma Center in Louisiana

A. **What was achieved?**

First American College of Surgeons-Committee on Trauma (ACS-COT) Pediatric verified trauma center in Louisiana. The Level 2 pediatric trauma center is located at Ochsner LSU Health Shreveport.

B. **Why is this success significant?**
There are zero pediatric trauma centers in Louisiana. There are only two other Pediatric Trauma Programs in Louisiana – both located in South Louisiana at Children's Hospital New Orleans and the other in Baton Rouge at Our Lady of the Lake Children's Hospital.

C. **Who benefits and how?**
Children injured in Louisiana North of Alexandria. More children die of injury each year than from all other causes combined. Only 57 percent of the nation's 74 million children live within 30 miles of a pediatric trauma center that can treat pediatric injuries, regardless of severity. Although most traumatic injuries are treated in hospital emergency departments, hospitals may not have the resources needed to treat injured children. For example, they may lack specially sized medical equipment, or surgeons willing/capable of operating on pediatric patients. Pediatric trauma centers, however, are required to have these resources.

D. **How was the accomplishment achieved?**
The LERN Board directed the LERN Executive Director and the Trauma Medical Director to engage hospitals with pediatric capability and ask them to consider pursuing pediatric trauma center verification. We focused on existing adult trauma centers and other hospitals specializing in pediatric medicine. We made the case for the need and community benefit.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes – it contributes to Goal I and strategy 1.1 Utilize the expertise of the LERN Trauma Medical Director to facilitate the establishment of a verified trauma center in each of the LDH regions by 2028.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
The trauma program and medical director consultation is probably unique to LERN. Developing mechanisms to provide consultation and a road map to achieve a desired goal should be a best practice for all.

Accomplishment #4: Addition of Burn Screen in ESF-8 Portal

A. **What was achieved?**
Added a burn screen to the ESF-8 portal.

B. **Why is this success significant?**
Provides real time visibility of the availability of burn beds in Louisiana. We only have four hospitals in the state with dedicated burn units and often times these beds are occupied. This screen allows hospitals to quickly identify available beds in order to transport burn patients timely to definitive care. For instance – as I type this, there are only 6 adult burn beds available in Louisiana and 7 pediatric burn beds.

C. **Who benefits and how?**
Burn patients and hospitals referring to burn units. See above.

D. **How was the accomplishment achieved?**
LERN worked with the Louisiana Hospital Association (LHA) and the regional Health Care Coalitions (HCC) to achieve this. A requirement of the Hospital Preparedness Program was to develop the Burn Annex to the states disaster plan. To this end, LERN, LHA, and the HCC's identified this need. LERN also convened quarterly meetings with the Burn Medical Directors from the 4 burn centers. These physicians helped guide the development of the annex and the burn screen.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes – burn is defined as a form of trauma and is included in LERNs mission to (Goal I) decrease the risk adjusted trauma-related deaths and incidents of morbidity and mortality due to trauma in Louisiana. Specifically Objective I, strategy 1.2 – operate first class communication center to efficiently route injured patients to definitive care hospitals. This burn screen in used by the LCC to route patients quickly and efficiently to the closest appropriate burn center.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes – collaboration with subject matter experts (burn medical directors) and established coalitions helps to build support and effective plans.

Accomplishment #5: LERN Response to Hurricane IDA

A. **What was achieved?**
During Hurricane Ida, LERN activated the Emergency Medical Service Tactical Operation Center (EMS TOC). The EMS TOC is responsible for coordination of ambulance assets during a declared event. In order to provide resources to cover the increase call volume, evacuations and transports, the state health officer activated the federal ambulance contract and the state ambulance surge contract. This provided and additional 387 assets, which included 300 ambulances and 87 paratransit vehicles for the response. LERN, via the EMS TOC, managed these 387 assets.

B. **Why is this success significant?**
EMS systems and regional hospitals were greatly impacted by hurricane IDA – specifically Terrebonne /Thibodaux area. This CAT 4 hurricane hit on the heels of a COVID wave that was already impacting EMS staffing and hospital bed capacity. There were not enough EMS assets in the area or state to respond to the critical needs of the impacted area. LERN, through the state health officer, activated the state EMS surge contract and the federal contract. This provided the assets needed to safely and quickly evacuate 4 hospitals in the area, multiple nursing homes and respond to other community needs. This is significant because the coordination and activation of these assets saved lives by transporting hospital patients to non-impacted hospitals out of the area and transporting citizens to shelters and return to home when safe to do so.

C. **Who benefits and how?**
Patients, hospitals, community members and EMS providers.

Patients = LERN facilitated the evacuation of 72 patients out of Terrebonne General Hospital (both placement, transport, and tracking). They benefit by having their health care provided by a hospital that is operational and able to meet their needs. Also, the nursing home population evacuated to Waterberry in Amite benefited. Many lives would have been either lost or greatly impacted if it were not for the EMS assets directed to evacuate the residents from Waterberry to safer locations throughout the state.

EMS providers = EMS did not have enough units to meet the demands of the community. These additional units/staff benefited EMS by helping them meet the needs of their community and provide needed rest for their staff. In addition, some agencies were impacted by COVID and needed additional staff to simply maintain their normal response times and service to their catchment areas.

Community = Region 3 and surrounding areas were severely impacted by Hurricane Ida. The community benefited from the para-transit vehicles which were utilized to transport individuals and families to hotels outside of the affected area.

D. **How was the accomplishment achieved?**
The ESF-8 network prepares yearly to respond to disasters. This was accomplished by maintaining the Hospital Preparedness Program network, conducting annual drills and maintaining relationships with response partners. The State EMS Surge Contract and federal contract was also key to the response effort.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, Goal 4: Establish and codify protocols that specify the role of LERN in ESF-8 activities. Strategy 4.3: Continue LERN's role in ESF-8 activities as manager of EMS Tactical Operations Center.

F. **Does this accomplishment or its methodology represent a Best Management**

Practice that should be shared with other executive branch departments or agencies?
Yes, but I believe all agencies at LDH actively participate in disaster planning and response.

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

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

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

  Yes, we are progressing towards meeting the goals and objectives set forth by our strategic priorities. Progress was slowed a bit due to COVID-19. Returns on investment are being met, but without comprehensive trauma, stroke and STEMI registries it is difficult to demonstrate outcomes.

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

- Seven Louisiana Trauma Centers are participating in the Trauma Quality Improvement Program (TQIP). The collaborative allows for us to look at benchmark risk-adjusted outcomes as a state system against all nationally participating TQIP centers, discover areas for system-level trauma center quality improvement and identify and share best practices among collaborative participants.
- We do not have a comprehensive trauma registry. We have 12 hospitals submitting data to the state trauma registry. This is up from seven in CY 16. We made tremendous progress fixing the major issues encountered in 2019 with our trauma registry
- We now have ten designated trauma centers in the state.
  - Ochsner LSU Health Shreveport – Level I Trauma Center
  - University Medical Center New Orleans – Level I Trauma Center
  - Rapides Regional Medical Center – Level 2 Trauma Center
  - Our Lady of the Lake Regional Medical Center – Level 2 Trauma Center
  - North Oaks Medical Center – Level 2 Trauma Center
  - Lafayette General Medical Center – Level 2 Trauma Center
  - Lakeview Regional Medical Center – Level 2 Trauma Center
  - Ochsner LSU Health Shreveport – Level II Pediatric Trauma Center
  - St. Tammany Parish Hospital – Level 3 Trauma Center
  - Lake Charles Memorial Hospital – Level 3 Trauma Center
- We have two trauma programs in Monroe – Region 8 are and two Pediatric Trauma Programs (one in Baton Rouge at Our Lady of the Lake Children's Hospital and one at Children's Hospital New Orleans)

- Burn system established and burn annex to state disaster plan completed.
- All of these efforts are improving morbidity and mortality, but we need a comprehensive registry and an upgraded state trauma registry in order to provide valid data.

Goal 2: Maximize the return on investment (ROI) of state dollars and supplement of general fund dollars with alternative funding sources.

- 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), for the past 3 years, have a 3% secondary transfer rate. In CY 2020 the secondary transfer rate for the LCC was 4%. We believe this increase was due to the bed capacity issues statewide due to COVID and multiple hurricanes. In CY 2021 we were back to a 3% secondary transfer rate for patients directed by the LCC. 2018, patients not directed by the LCC had a 24% secondary transfer rate, in CY 2019 this increased to 31% , in CY 2020 a further increase to 37% and in 2021 a dramatic increase to 52% for patients not routed by the LCC. 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.
    - We continue to look for grant funds.
    - Grant from Highway Safety Research Group for Basic Trauma Registrar Class and ICD-10 Course = $21,800 (52 students attended)
    - Funding bill for LERN presented in 2019 Regular Session. The bill did not pass.

Goal 3: Ensure that all citizens gain access to the statewide networks for trauma and time sensitive related illnesses.

- LERN has participation agreements with 98.3% of the Tier 3 hospitals in the state.
- The expansion of the number of trauma centers from two in 2011 to 10 in 2021 provides 82.2% 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. Four hospitals have taken advantage of this process and subsequently passed verification by the American College of Surgeons (ACS):
    - Lake Charles Memorial Hospital
    - St. Tammany Parish Hospital
    - Lafayette General Medical Center
    - Ochsner LSU Health Shreveport Pediatric Trauma Center

The following three hospitals have been approved as a trauma program:

- Our Lady of the Lake Regional Medical Center –ACS consultative survey held October 2021. They will be surveyed in August 2022 for Level II Verification.
- Children's Hospital New Orleans – Consultation visit February 2022. Expect verification visit in January 2023.
- Ochsner LSU Monroe attestation for Level III Program was approved by the LERN Executive Committee in October 2021. Consultative visit by ACS July 2022. Expect verification survey in July 2023.
- St. Francis Medical Center attestation for Level III Program was approved by the LERN Executive Committee in October 2021. Consultative visit by ACS August 2022. Expect verification survey in August 2023.
- When considering the ten Verified Trauma Centers and the four trauma programs, 89.4% 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.
- 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 established criteria for four levels of stroke hospitals. These levels are used by the public and EMS to access the appropriate hospital for stroke care. Due to new levels of stroke care nationally, the LERN Board changed the nomenclature from Level 1-4 to accommodate Thrombectomy Capable Stroke Centers. The new LERN Levels are: Comprehensive Stroke Center (CSC= formerly Level I), Thrombectomy Capable Stroke Center (TSC= new), Primary Stroke Center (PSC = formerly Level II), Primary Stroke Center with Endovascular (PSC-E = new), Acute Stroke Ready Hospital (ASRH = formerly Level III), and Stroke Bypass Hospital (formerly Level IV). A stroke bypass hospital does NOT have the capability of taking care of 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.
- Performance metrics for stroke meet or exceed national benchmarks:
  - Door to Needle for Acute Stroke Ready Hospitals = 54 minutes with 66% of treated patients receiving alteplase within 60 minutes and 29% within 45 minutes. 5% were treated within 30 minutes of arrival. National benchmark is 60 minutes.
  - Door to Needle for CSC, TSC and PSC = 44 minutes
- LERN established criteria for STEMI Receiving centers which require 24/7/365 access to a cardiac catheterization lab. In CY 2020, the LERN Board re-evaluated the STEMI Receiving Center Requirements and vetted the agreed upon changes with the 9 Regional Commissions and the State STEMI Workgroup. These changes were adopted by the LERN Board in January 2021. There are 37 STEMI Receiving Centers in the state. These 37 hospitals provide 96.6% 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 37 Receiving Centers and two Referral Centers.
- Median Door to Needle time for Louisiana STEMI Receiving Centers = 60 minutes
- LERN also formalized the burn system in Louisiana, helping to provide timely burn care statewide. LERN continues to meet with the LERN Burn workgroup to implement and evaluate the state burn system. The 4 burn medical directors developed a course for

LERN's learning management system = "Burn Basics for EMS". LERN secured 3 continuing education hours for paramedics who successfully complete the course. We continue to make this course available for new medics and 168 EMS practitioners have completed the course.

- Despite COVID, LERN continued education efforts across the state as appropriate and safe. For CY 2021, those courses included:
  - Trauma Nurse Core Curriculum (TNCC) = 23 classes, 177 students
  - Emergency Nurse Pediatric Course (ENPC) = 15 classes, 122 students
  - 12 Lead EKG Course = 9 classes, 155 students
  - Rural Trauma Team Development Course = 0
  - Stop the Bleed Course = 31 classes, 751 students
  - Advanced Trauma Life Support = 1 class, 12 students
- EMS Registry continues to be developed. We now have 45 EMS agencies participating in the registry. In December 2012, we only had 13 providers submitting data to the state registry. We are sharing data from the EMS Registry with LDH for an opioid surveillance project. We submitted data to NEMESIS again this year per our goal and are completely compliant with NEMSIS 3.4 requirements. Developed standard EMS reports for specific metrics which are distributed to EMS agencies quarterly. Working to transition to NEMSIS 3.5.

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
- Conducted tabletop exercise with the EMS Surge Ambulance contractor to test our processes and procedures.
- Completed BURN Annex in the state disaster response plan. This will fill requirements of the Hospital Preparedness grant.
- Activated TOC for Hurricane Ida

- **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?

  This past year we made significant progress expanding the trauma system. The addition of two trauma programs in Northeast Louisiana significantly increases access to trauma care in the region. This progress is attributable to the LERN Board's vision, institution of the trauma program process and support of the LERN medical director and staff.

  We also expanded access to stroke care in Northeast Louisiana, with the establishment

of a Primary Stroke Center at Ochsner LSU Monroe.

- 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?)

  This success is directly related to the LERN Board implementing the trauma program attestation process and to the Trauma Medical Director (TMD) providing consultative services. The Trauma Program process is a "stepping stone" to fulfilling full verification. Once this process was initiated, centers were more engaged and welcomed the support from the TMD. The expansion of the stroke program is directly related to years of LERN developing and implementing the state stroke system. Specifically, identifying stroke resources via the stroke attestation process, collecting stroke data, and providing individual quarterly feedback to hospitals to help them achieve the highest level of stroke care.

- 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?

  No, this progress is directly related to LERNs efforts.

- Other? Please specify.

We also made significant process in expanding stroke access in Region 8 (Northeast Louisiana). Establishment of a PSC in region 8 has been a strategic goal for the past 5 years. Progress is related to LERN establishing a system and working with hospital providers to recognize the need and benefit of achieving certification.

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

   The addition of trauma centers will slow. We have almost achieved the LERN Boards vision, which is, to achieve an ACS verified trauma center in every region of the state. By 2024, LDH Region 3 will be the only region without a trauma center.

- **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 where we are experiencing a significant lack of progress is in lessening the dependence on the state general fund for LERN.

  I am also concerned about the EMS paramedic shortage. The LERN Communication Center is currently staffed, but it has become increasingly difficult to find staff. This is the result of two factors:

  - EMS shortage
  - Due to this shortage, EMS providers are paying higher salaries than the current staffing contract allows or the LERN budget can cover.

  In addition to staffing shortages in EMS, the LERN Call Center volume has increase 18% over two years. We are on the verge of needing to add a third communicator during peak volume times.

- Is the lack of progress due to budget or other constraint?

  The EMS staffing issue is both a budget issue and an EMS shortage issue. LDH did support increasing the budget for the staffing contract for FY23. This will help, but will not completely solve the issue.

  The EMS shortage is due to the factors affecting the industry: COVID and EMS now being able to work in non-conventional roles (community para-medicine, IV infusion and now Emergency Departments). This expansion is good for the profession, but the supply of paramedics needs to keep pace.

- 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.

  See above.

- 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?

   Lack of funding will continue to be a limiting factor in LERN being able to fully build out systems of care for Trauma, Stroke and STEMI. The reliance on the state general fund will continue until we can pass legislation to create a dedicated funding source outside of the State General Fund to fund the system. 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. State trauma systems funded via fees or fines use this revenue to fund the state trauma registry. Dr. Phillips directed LDH staff to utilize COVID grant funds to help staff two additional positions for LERN: a statewide education coordinator and a disaster preparedness manager. Both are job appointments and LERN management plans to request permanent T.O. and funding.

- **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 2021, we developed new strategic priorities for 2022-2024.

  ☐ No. If not, why not?

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

The Executive Director provides a report to the LERN Board of Directors (BOD) at least quarterly. This report includes progress to goals for each strategic priority. The strategic plan is completely re-evaluated annually by the LERN BOD. The LERN Regional Commissions are informed through the Tri-Regional Coordinators, the LERN Administration and Medical Directors. 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?**
   An issue is the EMS shortage in the state.
   LERN location is also a problem. We are not in a hardened location and during hurricane Ida we lost all internet and phone contact. The LERN Call center had to move to our redundant location. Our generator ran out of fuel all while LERN was operating the EMS Tactical Operation Center.
2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)**
   No – The LERN Executive Director worked with the Deputy Commission of the Division of Administration and we are in the process of moving locations. We are moving to the Public Safety Campus where redundancy will be significantly improved and we will be close to resources needed to adequately respond to declared disasters.
3. **What organizational unit in the department is experiencing the problem or issue?**
   LERN
4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   We are solving the issue of the need a hardened facility. Our plan was to move before this hurricane season, but this will not happened due to issues outside of LERNs control. Our new target date to move is November/December 2022. If we lose connectivity again this year, it puts the EMS TOC and LERN Communication at risk – effecting our response to stakeholders.
5. **How long has the problem or issue existed?**
   - EMS shortage (2 years)
   - LERN location - Issue escalated and immediately responded to in November 2021.
6. **What are the causes of the problem or issue? How do you know?**
   - National EMS Shortage
   - LERN Location → As LERN has expanded our duties related to disaster response and the states dependence on us has increased, our current location is no longer adequate. We are located in a strip mall off of Airline highway. The move is related to our growth and there is a plan in place.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   - Inability to adequately operate the EMS tactical operation center during a disaster.

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?

We requested additional funding in FY 23 budget to help with overtime costs ($45K) and it was approved. While this helped, it is not enough to add a third communicator. We plan to request the funding in FY 24 budget.

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?

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.

      $205,509 to hire another call communicator. The staffing contract is currently funded via LINCCA.

   b. How much has been expended so far?
      $954,450 is the yearly staffing contract

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?

   No, it cannot be managed within our existing budget.

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.
     - $205,509 annually. The LCC Staffing Contract is actually funded out of LDH's budget via a LINCCA agreement with Louisiana Clinical Services.
   - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?
     - They will be; this will be communicated in August when budget development begins.

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 c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

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

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive 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:

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, including:
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

1. **Title of Report or Program Evaluation**:
   LERN Annual Report FY 20-21

2. **Date completed**:
   March 2022

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 the EMS registry, stroke registry, and education-tracking log.

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

6. **Major Findings and Conclusions**:
   Progress is being made in all systems of care.

7. **Major Recommendations**:
   Need to move the LERN office.

8. **Action taken in response to the report or evaluation**:
   Contacted Deputy Commission of DOA and worked with Facility Planning and OTS to identify an adequate location.

9. **Availability (hard copy, electronic file, website):**
   Available on the LERN Website (www.LERN.La.Gov) or the following link: https://drive.google.com/file/d/1S4qk6r0fZzO4ueL01TKZBC2AccwMJPxU/view. Hard copy available upon request and also at Poynter Library.

10. **Contact person for more information**:
    Name: Paige Hargrove
    Title: Executive Director
    Agency & Program: LDH/ Louisiana Emergency Response Network
    Telephone: (225)756-3440
    E-mail: Paige.Hargrove@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department: **Louisiana Department of Health (LDH)**
09-325 Acadiana Area Human Services District

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Executive Director: **Brad Farmer**

I. What outstanding accomplishments did your department achieve during the previous fiscal year? For each accomplishment, please discuss and explain each item below.

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

Accomplishment #1: Three Year CARF Accreditation

A. **What was achieved?**
National accreditation – a three year award from the Commission on Accreditation of Rehabilitation Facilities (CARF) International, the highest level of accreditation possible, for the fourth time in a row. The current accreditation will extend through June 30, 2025.

B. **Why is this success significant?**
First, national accreditation is required by the SMO as Louisiana moves toward a managed system of care; secondly it demonstrates competence and commitment toward internationally recognized standards of practice; and it provides a foundation for AAHSD to operate more effectively and efficiently.

C. **Who benefits and how?**
Clients benefit as the organization increases the use of 'best practices' and also monitors significant clinical indicators to ensure the effectiveness of services. Additionally, AAHSD has implemented a quality improvement (QI) process and also monitors service access. The community at large and funders of services benefit as AAHSD demonstrates its competence in both administrative and clinical operations, along with the additional accountability of the accreditation review cycle.

D. **How was the accomplishment achieved?**
The development and implementation of an organizational Policy/Procedure manual and other supporting documentation, staff training, the designation and leadership of an 'Accreditation Team', and an on-site review by a CARF survey team.

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

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

Accomplishment #2: Partnership Heart of Hospice and Families Helping Families to provide Easter baskets for children with developmental disabilities and/or dealing with mental health issues in the community

A. **What was achieved?**
Partnered with Heart of Hospice and 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, 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 Heart of Hospice and 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 #3: 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. Once approval from CMS was given, waiver opportunities began under this new criteria in the final quarter of fiscal year, 2017-2018.

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: Initiation of Telehealth Services

A. **What was achieved?**
Telehealth prescriber services were initiated in January 2020, followed by full provision of clinical services by all staff beginning March 2020 (due to COVID-19 restrictions).

B. **Why is this success significant?**
The initial prescriber services were implemented to fill service time vacated by contract prescriber moving out of the area. Going to full-delivery of telehealth services was the only way for clients to receive non-emergency services once offices were closed due to COVID-19.

C. **Who benefits and how?**
All clients benefit from the continuation of routine, non-emergent, services.

D. **How was the accomplishment achieved?**
The initial prescriber telehealth was provided through contract with Genoa. The remainder of the telehealth deployment involved monitoring changes in telehealth restrictions among the clinical disciplines and providing staff with direction, training, and support in use of tele video platforms for provision of services.

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: Behavioral Health Coverage for COVID-19 shelter at Chicot State Park

A. **What was achieved?**

AAHSD was able to fulfill participation in the ESF-8 portion of coverage for the shelter. Both on-site and on-call coverage was provided in order to assess impacts of sheltering/COVID-19 on residents housed.

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

This success insure that the behavioral health needs of residents were addressed appropriately, which allowed for the sheltering operation to remain safe for all involved.

C. **Who benefits and how?**

Shelter residents, as well as shelter staff personnel and residents of Louisiana, in general, who potentially have need for placement in a shelter.

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

Through coordination with Region IV OPH, LDH, and DCFS; via shift staffing, phone contact with shelter residents, and coordination with outside agencies, when necessary, to facilitate behavioral health assessments of incoming shelter residents, as well as referral for assessment for hospitalization.

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 community to provide shoe boxes with daily living products for adults with developmental disabilities in the community

A. **What was achieved?**
Partnered with the community to give shoe boxes to adults with DD.

B. **Why is this success significant?**
It allowed the community and adults with developmental disabilities to interact with community partners and receive a shoe box. Also provided adults with DD the same opportunities available to all.

C. **Who benefits and how?**
Adults 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 the community by those willing to donate items. Shoe boxes were collected through their networks and all assisted with delivery of the baskets to the adults.

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: Distribution of Narcan to Law Enforcement, Fire Departments, and other Public-Service Agencies in the community

A. **What was achieved?**
Partnered with Office of Public Health to prioritize community needs and to distribute over 1,000 Narcan kits.

B. **Why is this success significant?**
This allows police officers, fire departments an opportunity to carry Narcan when responding to emergencies, along with the ability to administer Narcan prior to ambulance/EMT arrival.

C. **Who benefits and how?**
The entire 7-parish AAHSD catchment area benefits as all agencies are supplied/re-supplied by allowing these agencies to respond in rural and smaller municipal areas.

D. **How was the accomplishment achieved?**
AAHSD reallocated SAPT Block Grant funding that was not utilized during the fiscal year.

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.

Acadiana Area Human Services District (AAHSD) submitted our initial five-year Strategic Plan in June 2019. 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?

Acadiana Area Human Services District (AAHSD) is progressing towards accomplishing goals and objectives, such as: developing clear policy objectives; providing behavioral health treatment services as part of the State's continuum of care; improving accessibility; increasing stakeholders' involvement; and, providing quality services and supports. These strategies are effective in ensuring persons served receive the highest quality care.

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

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

    Other? Please specify.

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?

Acadiana Area Human Services District is not experiencing any management or operational issues.

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):
Human Services 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:
2. Date completed:

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

1. **Title of Report or Program Evaluation**
   AAHSD Management Report

2. **Date completed:**
   June 2022

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.
   - 2020/2021 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 four 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.
- Selected staff has completed training in Applied Suicide Intervention Skills Training (ASIST) and have provided training to sixty-three (46) community practitioners.
- AAHSD was trained and participated in OPH/Emergency Preparedness exercises/activities.

7. Major Recommendations:
None

8. Action taken in response to the report or evaluation:
None

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

10. Contact person for more information:
Name: Brad Farmer
Title: CEOAgency & Program: AAHSD
Telephone: 337-262-4190
E-mail: Brad.Farmer@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department:	**Louisiana Department of Health (LDH)** 09-326 Office of Public Health
Department Head:	Dr. **Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Assistant Secretary:	**Doris G. Brown, Med, MS, APRN, CNS**

I. What outstanding accomplishments did your department achieve during the previous fiscal year? For each accomplishment, please discuss and explain each item below.

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

BUREAU OF NUTRITION SERVICES - BONS

Accomplishment #1: Navigating Women, Infants, and Children (WIC) Services during the Formula Shortage

A. **What was achieved?**

LDH/OPH/BONS implemented policies and updated procedures in an effort to mitigate the effects of the COVID-19 public health emergency and the February 18, 2022, recall of Abbott Similac products. Louisiana WIC received approval for applicable federal waivers and expanded formula options to participants in the

Louisiana WIC Program by adding over 80 substitutions to the Louisiana WIC formulary and Approved Product List.

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

The federal waivers and the addition of formula substitutions allowed Louisiana WIC to continue to meet the needs of Louisiana's WIC Participants in finding safe substitutions for recalled infant formula. Additionally, the Louisiana WIC Breastfeeding Peer Counselor Program has been talking to more pregnant and postpartum WIC participants to help them initiate and continue breastfeeding during the formula recall/shortage.

C. **Who benefits and how?**

Louisiana WIC Participants and other Louisiana residents impacted by the recall/shortage directly benefited from the addition of formula substitutions to the Louisiana WIC program. Participants were able to select from formula substitutes that included more name and store brands, more formula types (powder, liquid concentrate, read-to-feed), and more formula product/unit sizes.

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

BONS staff collaborated with the USDA on the submission, approval, and implementation of waivers related to the formula shortage/recall. BONS staff also worked diligently to explore, review, and add additional formula substitutions to the Louisiana WIC Approved Product List (APL). BONS collaborated with LDH, OPH, and BMAC on media outreach to provide information to all Louisiana residents impacted by the formula recall/shortage. Additionally, BONS staff engaged with internal and external stakeholders via the Formula Recall Task Force and the Vendor Advisory Committee to receive and provide updates on the formula recall/shortage in real-time.

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

Due to the shortage, Louisiana WIC has seen an increase (approximately 39%) in the number of infant WIC Participants who are fully breastfeeding since February, which is a primary objective in 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?**

No

Accomplishment #2: Self-Checkout Options

A. **What was achieved?**

As of April 2022, self-checkout is now available for WIC participant's at all WIC-approved Walmart stores across the state.

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

The addition of self-checkout options at WIC approved grocery stores enhances the overall experience by improving shopping dignity for WIC families. Though the option is only available in participating Walmart locations currently, there are plans to expand these services to other WIC approved grocery stores.

C. **Who benefits and how?**

Louisiana WIC Participants and Authorized Vendors benefit from having additional shopping options that allow them to utilize their WIC benefits in a manner similar to other customers.

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

Louisiana WIC collaborated with Walmart to test and pilot self-checkout in Region 2, submitted policy and procedure updates to the USDA to allow the use of self-checkout at Louisiana WIC Vendor outlets, and coordinated state-wide rollout of self-checkout at all Walmart stores once policy updates and in-store testing/piloting were complete.

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

Yes, part of our plan includes the investigation of new technologies to improve the shopping experience for WIC participants, and this accomplishment does so.

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 use of technology, with the goal of improving efficiency and access, is a best management practice and should be a priority for every agency in the state.

Accomplishment #3: Anti-Hunger Summit

A. **What was achieved?**

Senate Resolution 77 (SR 77) called on the Louisiana Department of Health (LDH) to

convene a Summit to address the increase of hunger across the state of Louisiana by sharing information, expertise and resources to better coordinate public, private, and charitable sector efforts to abate hunger across the state. The Bureau of Nutrition Services (BONS) in the Office of Public Health (OPH) was tasked with responding to SR 77, knowing that the resolution aligned closely with the Bureaus' mission statement and strategic goals. BONS staff met with Feeding Louisiana staff regularly to plan for the Summit and on December 2, 2021, the Louisiana Anti-Hunger Summit was held.

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

The summit provided an opportunity for the four state agencies that oversee the eight federal feeding programs in Louisiana: the Department of Health, the Department of Children and Family Services, the Department of Education, and the Department of Agriculture and Forestry, to work together to develop plans to improve services that are vital to the health and wellbeing of Louisiana's most vulnerable and food insecure families.

C. **Who benefits and how?**

According to Feeding Louisiana, food insecurity is a critical issue for the state, with a significant number of Louisiana residents and households facing a hunger crisis, particularly for our most vulnerable populations such as communities of color and single-women households with children. The report resulting from this summit provides recommendations intended to address the hunger crisis in Louisiana and would benefit those residents who suffer its effects.

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

Approximately 125 attendees, representing a variety of organizations in the public, private and charitable sector, participated in the virtual event. BONS and Feeding Louisiana staff noted a high level of engagement among participants and presenters. The final session of the day was an interactive session where attendees directly submitted policy ideas, action item recommendations, and any other relevant suggestions. This allowed for BONS Summit facilitators to capture all submitted ideas and ensure that they were included in this recommendation report.

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

Yes, it is part of BONS vision to reduce hunger and find ways to increase access to healthy foods.

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

No

Accomplishment #4: Interactive WIC Maps

A. **What was achieved?**

In an effort to increase accessibility of both clinics and vendors for Louisiana WIC participants, new interactive maps were developed and added to the Louisiana WIC website. The Vendor map includes WIC-approved vendor (grocery store) names, addresses, and self-checkout statuses. The Clinic map includes WIC clinic names, addresses, phone numbers, and linked google map directions to the location.

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

The interactive maps provide WIC Participants with the most up-to-date contact information for Vendors and Clinics in one easy to use interface.

C. **Who benefits and how?**

Louisiana WIC Participants benefit by having the information necessary to utilize their WIC Benefits at authorized grocery stores. Louisiana WIC Participants, and those residents of Louisiana potentially eligible for WIC, benefit by having the information necessary to schedule appointments, contact clinic staff with questions, etc.

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

Louisiana WIC hired a Business Analytics Specialist who was able to utilize Tableau to create and publish the maps.

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

Yes, the strategic plan includes an objective to investigate new technologies to provide high quality clinical services, food distribution, and shopping experiences to WIC and Commodity Supplemental Food Program (CSFP) participants.

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 use of technology, with the goal of improving efficiency and access, is a best management practice and should be a priority for every agency in the state.

Accomplishment #5: WIC Breastfeeding Rates Increase

A. **What was achieved?**

Louisiana WIC has seen increased breastfeeding rates among WIC participants. In July 2022, the post-partum breastfeeding rate was 62% compared to 41% in 2021. The fully breastfeeding rate was 20% and the some breastfeeding rate was 27% in 2022 compared to 11.5% and 19% respectively in 2021.

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

Breastfeeding is associated with reduced infant mortality and healthier women and children. Increasing breastfeeding rates is a National priority.

C. **Who benefits and how?**

Louisiana WIC families benefit from the increase in services provided by the Louisiana Breastfeeding Peer Counselor Program.

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

The Louisiana Breastfeeding Peer Counseling (BFPC) Program now has a total of 23 Peer Counselors (PC) and Designated Breastfeeding Experts. The Program has increased staffing of Peer Counselors throughout the state, thus increasing PC coverage of WIC clinics to 76%. This is an improvement of 33% more coverage in less than a year's time. This expanded coverage has targeted the more rural regions that have the lowest breastfeeding rates. In August 2021, to further expand the breastfeeding support services offered, the Louisiana BFPC Program launched a monthly virtual support group, which has steadily grown in participation with over 20 women/mothers participating each month. Lastly, the Louisiana BFPC Program now has six International Board Certified Lactation Consultants (IBCLC) on staff, including the Louisiana Breastfeeding Manager. The IBCLC is the highest certification and the only internationally recognized credential in the field of lactation.

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

Yes, a key part of our strategic plan is to continue to build upon and expand activities in the WIC State Agency's USDA-approved Breastfeeding Peer counseling Implementation Plan. Increases in program staffing is a major contributor to the increase in breastfeeding rates

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

agencies?

The Breastfeeding Peer Counselor Program is a Federal model.

OFFICE OF PUBLIC HEALTH LABORATORY

Accomplishment #1: Support of the Monkeypox Outbreak Response:

A. **What was achieved?**

The Office of Public Health Laboratory was the first laboratory in the State of Louisiana to offer testing for monkeypox using the LRN non-variola Orthopox real time PCR assay in response to the state's need to detect and vaccinate positive cases.

The Laboratory Response Network (LRN) is a network of state and local public health labs, the Department of Defense, veterinary labs, and federal and environmental testing laboratories, under the auspices of the CDC. The Office of Public Health Lab (OPHL) is a part of this network. The LRN has a Rash algorithm for the diagnosis of rash producing diseases including varicella zoster (VZV=chicken pox), Non-variola Orthopox, and Orthopox viruses. Orthopoxviruses cause diseases, which include smallpox (variola virus), cowpox, horsepox, camelpox, and monkeypox. The non variola Orthopox part of the Rash algorithm includes monkeypox and the orthopoxviruses except for the variola virus. Although the non-variola Orthopox is not specific for monkeypox, it does detect other orthopoxviruses except for variola (smallpox producing virus). Thus, the non-variola Orthopox PCR assay can be used as a screen in the detection of monkeypox virus. Presumptive positive results are followed up by confirmation by the CDC.

When the first case of monkeypox was confirmed by the Massachusetts Department of Public Health on May 17, 2022, it set in motion our laboratory to validate a method which could detect monkeypox. Although the LRN rash algorithm was available, our laboratory had not at that time validated any of the methods because of lack of necessity as no requests had been made for those in years. We decided that because of the short turnaround time needed that we would validate the portion that detects the non-variola Orthopox. We went into high gear to do this to get the method ready for use in less than two weeks. Our method went live on June 3, 2022. Our first positive was detected on July 2, 2022.

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

Although the impact of monkeypox outbreak is not at the level that COVID-19 was, with no deaths reported as yet in the US, the disease has the potential to spread widely to the general population. Having a test for the early infection can help in early treatment and hopefully prevention of spread.

C. **Who benefits and how?**

As there are effective treatments for monkeypox, treatment can reduce the risk of transmission, so the target population in Louisiana can benefit. Cost savings can be obtained by only treating those effected and prophylaxis focused on the target population.

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

When we began our validation of the non-variola Orthopox method there were only six confirmed cases in the United. States. Validations are required to confirm that analyses are accurate, precise, and sensitive as required for our clinical laboratory license by CMS (Centers for Medicare and Medicaid Services) in compliance with CLIA (Clinical Laboratory Improvement Amendments). The validation was a challenge in that there was a lack of available positive sample material. To create these, contrived samples were created by spiking swabs with positive control samples.

Our Method Review Committee, composed of Infectious Disease Emergency Preparedness (IDEP) manager and technical supervisor, the Quality Assurance manager and technical masters, along with laboratory information system (LIMS) program managers, the laboratory director, and the laboratory medical director was setup during the COVID-19 response. This team proved to be very beneficial to our process of getting new tests validated properly and insuring that all necessary procedures and processes are put in place in a timely manner. Included in the reviews are review and optimization of the validation protocol, review of the results of the validation, review of the Standard Operating Procedure, review of the web page test method information, notification of CLIA of the additional test to our test menu, setup and review of User Acceptance Testing of any LIMS additions or modifications, and review and final approval by the lab directors. Before any new test can be performed, the proper training and competency assessments must be put in place. Training/competency is a critical but laborious process as all must be performed within the BSL3 (Biosafety Level 3) lab, requiring PPE and masking for personal protection. In addition, courier transport needs to be arranged.

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

The OPH Laboratory was able to respond to this public health emergency by implementing testing as supplies and resources for testing were only initially allocated to LRN laboratories, the OPH Lab being the only one in the state. These actions contributed to the strategic plan of the laboratory by adding testing as needed to respond to public health needs across the State and by using technology to advance the mission in an efficient manner. In this case, the public health needs demanded increased laboratory testing which was sensitive, specific, and readily adapted to the need.

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 use of technology to expedite processes and supplement manpower effort was a best management practice noted during the OPH Laboratory's response to the monkeypox outbreak. Additionally, collaboration between the lab, ID Epi, the state medical officer, and the health units enabled the lab to move forward across the industry in an aligned manner.

Initially set up as a manual entry process, with report via an in-house Access database, we have since moved to being fully automated in our StarLIMS system via the Lab Web Portal.

Our accessioning processes with this addition should contribute to the laboratory's ability to maintain acceptable turnaround times even as specimen volume rapidly increases and as it approaches our surge capacity.

In addition, increased utilization of the recently implemented Qualtrax Compliance Software allowed for efficiencies and real-time tracking and monitoring of new and revised laboratory policies, protocols, and procedures, particularly in relation to the four (4) test methods implemented. This allowed for electronic editing, reviewing, and approving, as well as automated notification of appropriate staff.

An electronic process for requests of any type and control of documents are best management practices that the OPH Laboratory would recommend.

IMMUNIZATION

Accomplishment #1: Advancing Vaccine Equity:

A. What was achieved?

In FY22, we established the Vaccine Equity Unit (VEU), starting with hiring a Vaccine Equity Officer in January, and recruiting and hiring two Partnership Coordinators in April and May. The new Vaccine Equity Unit has developed partnerships within OPH, local government agencies and community-based organizations. The Vaccine Equity Unit has worked to gather better data on vaccine equity and identify where gaps remain in data, including data on people experiencing homelessness, people with disabilities, people living with HIV, and LGBTQ+ people, and strategized how to close these gaps. In FY 2022, the In-Home Vaccination Program received 1,483 new registrants, and administered 2,572 doses of COVID-19 vaccine, including 599 first doses, 687 initial series completed, and 1,286 booster doses. Registration has nearly doubled in calendar year 2022, which can be directly correlated to ongoing targeted outreach via multiple media and interpersonal channels, as well as creating a secondary mode of registration.

B. Why is this success significant?

This new team then built their operational capacity to effectively use our CDC Supplemental 4 grant to achieve increased vaccine equity and vaccine confidence. After significant outreach the VEU held its first virtual *Vaccine Confidence-Building Action Lab* with over 80 participants representing a cross section of partners to share lessons, align efforts, learn about impact, and disseminate best practices for increasing vaccine confidence. Although identifying where gaps exist may not be a standalone accomplishment, it is an essential part of the process of continuous quality improvement. An estimated 1.12 million adults in Louisiana (33% of the adult population) had at least one disability, and approximately 5% of the 65+ population in Louisiana is homebound. These groups are both more likely to experience vaccination barriers and comorbidities that leave them at a higher risk of dying from COVID-19. This program alleviates that risk by bringing vaccines to people where they are, and in FY 2022, it achieved traction that continues to grow.

C. Who benefits and how?

This unit promotes fair and just vaccination awareness, acceptance, and access for those groups that experience disparities in immunization and in health outcomes. Vaccine equity is a key part of achieving the vision that all people in Louisiana are valued equally and have the opportunity to be as healthy as possible, and that disparities in vaccination access and adoption by race, national or ethnic origin, gender identity or expression, age, ability, location, socioeconomic status, education, political affiliation, religion, sexual orientation, and housing status have been eliminated. Our approach to partnerships is to create a broader vaccine equity learning community to favorably impact the health and wellness of our community. Once we know where inequities persist, then we can better address them. All residents of Louisiana aged 6 months and above who are homebound or who have a disability can receive a free COVID-19 vaccination at their home via a mobile strike team.

D. How was the accomplishment achieved?

Efforts were led by the Bureau of Infectious Diseases (BID) to get unit established. We consulted with regional OPH offices, other departments in OPH, academic partners, and Community Based Organizations who had been activated in the COVID-19 response through Bring Back Louisiana. The Vaccine Equity Unit works with the Bureau of Health Informatics (BHI), the Immunization Data unit, and other partners that collect data that can be cross-referenced. Originally, registration for the In-Home Vaccination Program was solely available via a telephone hotline. In April 2022, a new online registration portal was created to encourage registrations from individuals experiencing barriers to conversing via telephone. New marketing materials advertising the registration method, including an ASL video, were released statewide to OPH regional offices, providers, and hundreds of community-based partner organizations. Additionally, over a million

households across Louisiana received postcards with booster reminders and information on the program.

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

Equity activities contributed to the LDH strategic plan Goal 1 to "increase operational capacity and infrastructure to ensure efficient and effective utilization of resources." This work also contributes to the LDH strategic plan Goal 3, "develop, maintain, and facilitate partnerships for the alignment of efforts and overall impact on health and wellness of individuals and communities" and aligns with LDH strategic Goal V, "Lead and continually improve a public health system that identifies and reduces inequities to improve health outcomes and quality of life in Louisiana" and Goal VI, **"**Leverage health information technology and maintain a modern IT infrastructure to maximize use and integration of data to drive decision-making.

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

These accomplishments can be considered a best practice, as they are effectively increasing vaccination equity among residents in underserved communities.

Accomplishment #2: Strike Team Support for COVID Vaccinations:

A. What was achieved?

In FY22: 4,445 Contract Vaccination Strike Team events occurred at 974 unique locations across the state, administering 140,000+ doses of COVID-19 and flu vaccines. Of these encounters, 522 team events included visits to homebound individuals and more than 3000 doses were administered to homebound or disabled individuals.

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

This was a remarkable number of mass vaccination events to execute in one year. Prior to COVID-19, each of the 9 OPH regions was required to host one mass vaccination event, usually during flu season. The events allowed the state to achieve greater equity and access in vaccinations.

C. **Who benefits and how?**

Individuals without transportation or without access to a traditional vaccine provider benefited from these mobile events. It allowed many individuals to more easily receive a vaccine; and for some it was the only way they could be vaccinated. The entire state also

benefited from increased vaccination rates.

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

In the fall of 2020, the Immunization Program formed vaccine strike team contracts with 7 vendors across the State (Ochsner, LCMC, Pafford, Acadian, LSUS, SWLAHEC & Health Heroes). These vendors collectively provided statewide capacity for the program, and each of the 9 OPH regions, to host a tremendous amount of mobile vaccination events.

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 continued activity has been an effective and successful public-private partnership.

Accomplishment #3: Support for LA Wallet:

A. **What was achieved?**

The OPH Immunization Program collaborated with ENVOC (LA Wallet vendor) to establish a streamlined consumer support process for obtaining COVID-19 vaccination status through the LA Wallet mobile application.

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

LA Wallet enabled Louisiana residents to access their COVID-19 vaccination status electronically, at any time. During the pandemic, accessibility to your immunization status was of the utmost importance to provide proof of vaccination for various purposes.

C. **Who benefits and how?**

Louisiana residents were able to access their COVID-19 vaccination status for work, travel, school and venue attendance/entry purposes. Entities that required proof of vaccination benefited from LA Wallet because they were able to quickly confirm status of vaccination by viewing an individual's status when it was presented to them.

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

The OPH Immunization Program developed and implemented a query interface between LA Wallet and LINKS to achieve this objective. This enabled the vaccination status from LINKS to feed into the LA Wallet Mobile application.

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

Yes, it enabled residents to obtain their COVID-19 vaccination status through the consumer access portal during the COVID-19 pandemic. Vaccination was required to gain entry to many venues during the pandemic. This directly aligns with LDH's strategic objective of helping to control or eliminate preventable diseases through June 30, 2028.

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 demonstrated a successful collaboration between private and public partners to respond to an emerging public health emergency within a restricted time frame.

Accomplishment #4: Vax Matters Podcast:

A. **What was achieved?**

The OPH Immunization Program has launched the Vax Matters podcast which features guests discussing the importance of vaccines and vaccine-preventable diseases. There are 36 episodes planned in the series, each about: 30 in length. Of these, 21 have been recorded and released on standard podcast platforms such as Apple, Spotify, Prime and others.

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

LDH has long had a goal of developing a podcast as a compliment to its online communication channels. Vax Matters represents the first podcast for the agency. The series will also add to the Immunization (IZ) program's public education efforts to improve vaccine confidence.

C. **Who benefits and how?**

Vax Matters is a public education promotion/activity designed to give the public a greater understanding of vaccines and why they are an important public health tool.

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

Vax Matters is a public education strategy that is a result of funding provided to the IZ

program for addressing health equity.

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

Yes. Each of the performance indicators in the IZ program's Strategic Plan are about improving the percentage of youth and adolescents who are up-to-date on their routine shots. Vax Matters is designed to instill confidence in vaccines, one component of driving these improvements.

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

This could possibly be shared as OPH is aware of only one other Executive Branch department (GOHSEP) that has an active podcast.

Accomplishment #5: Monkeypox Vaccine distribution:

A. **What was achieved?**

JYNNEOS vaccination for at-risk individuals is available in all nine public health regions in 15 Parish Health Units and 18 external partner sites. As of 08/12/2022, 3,510 doses have been distributed, with 2,549 doses administered. The Louisiana Office of Public Health Immunization Program has also utilized existing strike teams to execute vaccination events where approximately 1,500 doses of JYNNEOS will be administered between 08/08/22-08/13/2022. Approximately 77% of JYNNEOS have been administered in Region 1, which also has 77% of reported monkeypox cases in the state.

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

This is significant because getting Louisiana residents at increased risk vaccinated will help to reduce monkeypox disease infection and transmission. Getting these doses distributed statewide will provide access to vaccines and the best protection against getting sick from the disease.

C. **Who benefits and how?**

The residents of Louisiana benefit from having an effective vaccine available and accessible to them in their region. The vaccines are free and are the best way to help avoid monkeypox transmission.

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

The Immunization Program worked collaboratively with the federal government, other

state programs, and regional public health offices to distribute the vaccines to PHUs and providers throughout the state.

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

Yes. Fast, effective and equitable monkeypox vaccine distribution directly aligns with LDH's strategic objective of helping to control or eliminate preventable diseases through June 30, 2028.

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

Yes, working with federal, regional, and local partners during a public health emergency to quickly distribute vaccines to targeted providers and communities in an organized and equitable fashion, is considered a best practice in the eyes of the program.

Accomplishment #6: Childhood Immunization Public Awareness Campaign:

A. **What was achieved?**

The OPH Immunization (IZ) Program has launched a multi-media campaign promoting routine shots for children. The campaign which launched in August 2022, Routine Shots Make Kids Stronger, can be found on billboards in Baton Rouge and New Orleans and on digital and social media. Radio and television ads will follow in mid-August 2022.

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

This effort has only recently started, but it is designed to promote immunizations at the time that children are returning to school and must be up-to-date on their routine shots.

C. **Who benefits and how?**

The campaign is focused on families of youth and adolescents under age 18. As people in this audience respond to the public messages, higher vaccination rates are the anticipated result. OPH's IZ program will evaluate the campaign to understand its results/effectiveness.

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

This campaign is part of a broader Immunization Program grant deliverable for one of its CDC grants.

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

Yes. Each of the performance indicators in the IZ program's Strategic Plan are about improving the percentage of youth and adolescents who are up-to-date on their routine shots. This education and awareness campaign is designed to instill confidence in routine childhood vaccines, one component of driving these improvements.

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

The project will be worthy of sharing if the evaluation and outcome data show increased vaccination rates in the targeted population.

INFECTIOUS DISEASES – STD/HIV/Hepatitis Program (SHHP)

Accomplishment #1: Continued Progress on the Louisiana Hepatitis C Elimination Plan:

A. What was achieved?

Despite several COVID-19 surges and the impact of Hurricane Ida, the HCV Elimination Plan made progress in its third year on each of the six interconnected strategies as described below:

1. Innovative Payment Model to ensure Access to HCV Cure
   From the launch of the five-year Hepatitis C Elimination Plan July 1, 2019 through June 30, 2022, 11,687 people have accessed treatment for Hepatitis C (HCV) in Louisiana. This number includes 10,115 Medicaid participants and 1,572 incarcerated persons who are in the custody of the Louisiana Department of Corrections. Sixty-eight percent (68%) of the persons treated were able to access treatment because of Medicaid Expansion. Moreover, an amendment was executed in June 2022 to the innovative payment model agreement with Gilead's Asegua Therapeutics for covering Department of Corrections incarcerated persons housed in local/parish jails.

2. Educate the Public on Availability of the Cure and Mobilize Priority Populations for Screening
   SHHP launched *The Cure Is Clear* marketing campaign in FY22 to raise awareness about the importance of getting tested and treated/cured of HCV across Louisiana.

   The first phase of the campaign (April-December 2021) resulted in 9,548,929 impressions (amount of times an ad has been shown) and 14,734 visitors to the campaign website landing page (www.thecureisclear.org). A strong 0.15% click thru

rate (calculated by dividing number of times an ad appears by number of times it is clicked on) yielded 35,773 website activities and 232 conversions (number of individuals who clicked a specific page, link or button over the length of the campaign).

The second phase of the campaign from March 28-June 30, 2022 resulted in nearly 4.5 million impressions and over 6,200 visits to thecureisclear.org, resulting in a 12.6% click thru rate and yielded 14,236 website activities and 65 conversions. Search interest for hepatitis C is up 44% respectively compared to the same timeframe last year, which can be attributed to increased awareness of treatment availability. Year-over-year impressions served increased by 15% while clicks increased over 45%. Social media performance for this phase of the campaign increased each month. Social media impressions increased by over 150% and clicks by 85%.

Moreover, for Hepatitis Awareness Month (May 2022), SHHP commissioned a series of three testimonial videos to promote the HCV campaign. These feature two community members living with HCV and one of the state's most prominent hepatologists and champions of curing HCV, Dr. Gia Tyson. The videos continued to circulate through June 2022 and they have garnered 103,832 views combined thus far. All videos can be viewed at www.louisianahealthhub.org.

3. Expand HCV Screening and Linkage to HCV Care

   SHHP's 19 contracted community-based organizations continued to work with the Prevention Unit and Regional Coordinators to ensure quality improvement of integrated HCV, HIV, and syphilis testing and linkage through quarterly data reviews using a CBO-specific 'HCV Snapshot Report'. In FY22, mobile phlebotomists tested 3,247 persons incarcerated in DOC facilities. During this same time, 527 Dose Administration Aids (DAA) prescriptions were written. Screening of the incarcerated persons housed in the eight state Department of Corrections facilities was completed during this period as well. As a result, screening has commenced in local/parish facilities. The HCV Linkage to Treatment Program has reached 1,840 clients; verifying 19% of clients were already treated and assisted an additional 8% with linkage to treatment.

4. Strengthen Active Surveillance and Scale-up Data to HCV Cure Programs

   SHHP hired an HCV data analyst to better support data needs to drive the other five strategies. Filling this position enabled the completion of monthly matches with Medicaid to track treatment initiation and completion and further developed care continua to identify the proportion of people who initiated HCV treatment, who completed treatment, who were cured, and who were re-infected.

   Moreover, SHHP is working to upgrade disparate surveillance and programmatic data management systems to a state-of-the-art integrated system called EpiTrax. The adoption of this system will improve processes, thus making them more efficient, and consequently allow surveillance staff more time to spend on higher-level projects and analyses.

Of special note, Kristina Larson, SHHP's Hepatitis Surveillance Supervisor, presented at the 2021 NASTAD HIV/HCV Technical Assistance meeting and at the Annual 2022 CSTE conference on Louisiana's HCV surveillance activities, which were highly credited.

5. Expand Provider Capacity to Treat HCV
   A total of 934 providers have been trained to treat HCV via detailing, Project ECHO, and the HCV Champions series, resulting in 675 providers having written prescriptions for direct-acting antivirals for the first time.

6. Implement Harm Reduction and Complementary Treatment Strategies
   SHHP continued collaboration and braiding of funding through the Office of Behavioral Health's Louisiana State Opioid Response (LaSOR) Program and the Bureau of Community Preparedness' Opioid Program to support scaling programs related to HCV/ opioid use disorder (OUD) treatment and syringe service programs (SSP). This funding has helped to support four SSPs throughout Louisiana (New Orleans, Baton Rouge, Alexandria, and Shreveport) and has also been used to purchase the overdose reversal drug Naloxone for distribution across the state. Over the past year, these programs have provided combined HIV and HCV screening for a total of 697 people who inject drugs (PWID) across all four SSPs; connected a combined total of 45 clients newly diagnosed with HCV to treatment; referred a combined total of 160 clients to treatment for substance use disorder (SUD); distributed a combined total of 5,320 Naloxone kits to clients; and recorded 2,473 overdose reversals across all 4 SSPs.

B. Why is this success significant?

With the exception of COVID-19, HCV kills more Americans each year than all other infectious diseases combined. Moreover, the rate of new infections is on the rise as a result of injection drug use associated with the opioid epidemic. Louisiana continues to be leader for other health departments in the nation and aligns with national treatment guidance from the Centers for Medicare and Medicaid Services (CMS) and two of the leading medical authorities on HCV, the American Association for the Study of Liver Diseases (AASLD) and the Infectious Disease Society of America (IDSA).

C. Who benefits and how?

At the individual level, as more people receive HCV curative treatment and participate in harm reduction syringe services programs (SSP) for HCV prevention, the number of future HCV transmissions will decrease. With curative treatments near 100 percent efficacy and minimal side effects, people living with HCV now have an unprecedented chance to live virus-free, and avoid potential liver failure, cancer-causing cirrhosis, liver transplants, and other costly health complications which benefit not just the affected individuals but the healthcare system and society as a whole.

At the public health level, the cost savings associated with the modified subscription model for HCV treatment will benefit the agency and the state, allowing it to spend a fixed amount for unlimited access to an otherwise costly cure. Longitudinally, medical costs associated with HCV disease progression will be mitigated.

D. How was the accomplishment achieved?

The implementation of HCV elimination program interventions continues to be carried out by a large cross-unit team within LDH including the OPH Assistant Secretary's Office and the Bureau of Infectious Diseases, including the STD/HIV/Hepatitis Program (SHHP). LDH continues to collaborate with many community partners and intra-agency stakeholders to braid integrated funding.

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

Yes. This accomplishment is directly related to one of LDH, OPH and SHHP's major priorities: to eliminate hepatitis C. This is also the core outcome of the Department of Health and Human Services (HHS) *Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination 2021-2025.*

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

Two fiscal years ago, an overview of this subscription-based payment arrangement was shared with other departments and agencies as it may potentially be applicable to other therapeutic areas and health issues in the state.

Accomplishment #2: Increasing Awareness of STIs in Louisiana

A. What was achieved?

In November 2021, SHHP planned, created and launched *Just Check*, a Sexually Transmitted Infections (STIs) awareness campaign that emphasizes the importance of education, screening, and treatment for STIs, specifically syphilis, gonorrhea, and chlamydia. The goal of this digital campaign was to increase STI awareness and appointment booking for STI testing. The campaign ran in two phases: the first phase ran from November 18, 2021 to February 28, 2022 targeting adults 18-39 throughout central and northern Louisiana. The second phase ran from April to June 2022. Overall, the campaign exceeded expectations:

- Search Engine Marketing (SEM) yielded 2,980 impressions (amount of times an ad has been shown), 2,030 more than estimated. On Facebook/Instagram, the campaign garnered 2,180,000 impressions. The ads alone drove engagement. We had 2,540 clicks but also had 1,400 individuals engaging with ads through comments, shares, likes, and reactions.

- Display ads exceeded our estimate of 2.5 million impressions, achieving a total of 3.61 million impressions. Facebook/Instagram over-delivered by over 750,000 impressions with a total of 2.8 million impressions.
- The link to the *Just Check* website received 2,020 clicks, and the link to learn more about other STDs received 172 clicks and the link to testing locations received 145 clicks. The standard industry Click-Thru Rate (CTR, calculated by dividing number of times an ad appears by number of times it is clicked on) for medical-related paid search campaigns is 3.27%. Our STI awareness campaign ended with an overall CTR of 7.87%.
- We had 157 total conversions (number of people who clicked a specific page, link or button over the length of the campaign), 145 of which were directed to testing locations.
- Organic social media posts continued from March until June. A third phase of the campaign — a large-scale statewide multimedia marketing push — is currently being finalized to be launched in August 2022, and will include radio, billboard, and digital advertisements.

B. Why is this success significant?

Communications and marketing campaigns impact and amplify public health efforts. *Just Check*'s ability to exceed expectations for impressions, conversions and CTR suggests a notable increase in STI awareness, which is what is needed to address the STI epidemic in our state. While marketing is just one of several efforts to reduce new STIs, SHHP understands the value of speaking directly to communities through relevant, relatable and understandable messaging that motivates people to learn more and take action.

C. Who benefits and how?

STIs may cause adverse health outcomes. For example, syphilis, when left undiagnosed and untreated, can result in serious consequences such as blindness, deafness, long term neurological dysfunction, and of course congenital syphilis. Louisiana consistently ranks high in case rates for primary and congenital syphilis, gonorrhea, and chlamydia, so Louisiana residents certainly benefit from increased STI awareness, testing, and treatment. Currently, Louisiana ranks 2nd for both chlamydia and gonorrhea, 12th for primary and secondary syphilis, and 7th for congenital syphilis in the United States.

D. How was the accomplishment achieved?

In an effort to pilot the campaign in three key regions experiencing increases in syphilis, the SHHP marketing team conducted three discovery meetings in late September 2021 that consisted of Disease Intervention Specialists, community partners, and employees of Parish Health Units from region 6, 7, and 8. The purpose of these meetings were to investigate the values, behaviors, and needs of the communities SHHP aimed to reach with the STI Awareness Campaign. The information gleaned from these meetings contributed to the creation of the *Just Check* campaign. After the

pilot campaign was underway, the search began for a full service advertising agency to expand the campaign statewide in 2022. After a public solicitation of offer process, Octagon Media, an agency based out of Baton Rouge, was selected by a group of SHHP staff as the campaign partner in December 2021, and the contract is now underway. The statewide campaign is set to have a formal launch by the end of August 2022.

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

Yes. This accomplishment is directly related to one of LDH, OPH and SHHP's major priorities: to reduce new cases of STIs, particularly syphilis, gonorrhea, and chlamydia. This is also a key outcome of the CDC's *Sexually Transmitted Infections National Strategic Plan for the United States: 2021–2025*. Insofar as awareness of STIs leads to testing and treatment, Just Check supports the aims of the national strategic plan and statewide goals to reduce new STI infection.

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

Part of the success of this campaign is attributed to early testing with stakeholders and representatives from the desired target audience. This is a practice that should be implemented as often as possible in any public health communications campaigns. SHHP recommends vetting messaging with prioritized communities in order to ensure campaign success across all public health efforts. This can be done by opinion polls, surveys, focus groups, and other marketing research tactics.

BUREAU OF FAMILY HEALTH (BFH)

Accomplishment #1: Awarded a five-year Title X Family Planning Grant

The Office of Public Health (OPH) Bureau of Family Health (BFH) was awarded a five-year Title X Family Planning Services Grant from the federal Office of Population Affairs to increase access to quality family planning and reproductive health services across Louisiana (April 2022):

A. What was achieved?

The OPH BFH successfully competed for a five-year federal award ($4.79 million annually) to support reproductive health services and projects that advance equitable, affordable, client-centered, and high-quality family planning services statewide.

B. Why is this success significant?

The award is significant because it provides continued support for reproductive health

services offered through the OPH Parish Health Unit statewide clinical service system as well as other critical access points. In addition, the award supports the OPH Bureau of Family Health Reproductive Health Integration Initiative (RHII), which provides financial resources, training, and technical assistance to help build the capacity of community health centers to increase access to high quality, client-centered reproductive health care services for low-income, under-insured and uninsured individuals.

C. Who benefits and how?

As a project that seeks to expand the availability of affordable high-quality reproductive health services statewide, all people in the state needing these services potentially benefit from OPH BFH being awarded the federal Title X grant.

D. How was the accomplishment achieved?

OPH submitted a competitive proposal for this award. Louisiana's successfully-funded project reflects extensive historical expertise and a commitment to innovate. In addition, the project reflects extensive partnerships with the OPH Bureau of Regional and Clinical Operations (BRCO) that oversee the OPH PHU clinical network, community health centers and clinical sub-recipient sites that provide services, and the Louisiana Public Health Institute (LPHI), which renders technical assistance to community health centers participating in RHII.

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

This accomplishment advances the OPH BFH strategic priorities, but is not connected to a specific agency 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?

The accomplishment was informed by the principles and processes of strategic management (Bryson, 2011 - Strategic Planning for Public and Nonprofit Organizations: A Guide to Strengthening and Sustaining Organizational Achievement)

Accomplishment #2: Awarded a five-year Pediatric Mental Health Care Access Grant

OPH BFH was awarded a five-year Pediatric Mental Health Care Access (PMHCA) grant from the Health Resources Services Administration (HRSA) to establish the statewide Louisiana Provider to Provider Consultation Line (PPCL) (September 2021)

A. What was achieved?

The OPH BFH successfully competed for a five-year federal award to support the development and implementation of Louisiana's Provider to Provider Consultation Line (PPCL), a program which helps to build the capacity of Louisiana's pediatric primary care providers—especially those practicing in rural areas—to appropriately screen, diagnose, treat, and refer children and youth who present with behavioral health conditions and concerns.

B. Why is this success significant?

This award is significant because pediatric primary providers are often the first line of care and treatment for children and youth with behavioral disorders, yet often lack the training, confidence, and time needed to address the behavioral health needs of their patients. By providing training, mental health consultation, and care coordination support to pediatric providers, the newly funded PPCL supports the integration of behavioral health services into the pediatric primary care setting, thereby increasing the access of children and youth to comprehensive care. Furthermore, the PPCL is expected to strengthen the implementation of Medicaid's EPSDT (Early Periodic Screening, Diagnosis, and Treatment) benefit which allows for all children under age 21 who are enrolled in Medicaid to be eligible for comprehensive preventive and developmental services, including routine health, mental health and developmental screening and evaluation and treatment for illnesses, conditions or disabilities.

C. Who benefits and how?

PPCL has a Pediatric Mental Health Team consisting of licensed mental health professionals, psychiatry, and resource specialists that will use telehealth modalities to provide training, consultation, and care coordination support to pediatric providers statewide including pediatricians, nurse practitioners, family physicians, and physician assistants. All pediatric providers and their patients with behavioral health conditions and concerns potentially benefit from OPH BFH being awarded this federal grant. Pediatric providers benefit by having support to appropriately screen, diagnose, treat and refer patients. Patients and their families benefit by having increased access to comprehensive, quality healthcare services.

D. How was the accomplishment achieved?

OPH submitted a competitive proposal for this award. Louisiana's successfully-funded project reflects extensive historical expertise and a commitment to innovate.

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

This accomplishment advances the OPH BFH strategic priorities, but is not connected

to a specific agency 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?

In order to develop a model that is scalable and effectively meets the needs of rural health providers operating in grossly under-resourced areas of the state, this project will apply health improvement science in its work with a select group of Rural Health Clinics (RHCs) to develop, implement, and test an effective model approach to consultation, education, and technical assistance with RHCs, and then will scale this model to work with additional RHC's and other pediatric providers operating in rural areas of the State.

Accomplishment #3: Launched a Caregiver Perinatal Depression Clinic Pilot

The Louisiana Perinatal Quality Collaborative (LaPQC), a program within OPH BFH, launched a Caregiver Perinatal Depression Screening Pediatrics Clinic Pilot (CPDS) in May 2022.

A. **What was achieved?**

The OPH BFH launched a new LaPQC pilot initiative to develop and test approaches to integrating caregiver perinatal depression screening in outpatient, primary care pediatric clinics. The four participating clinics represent diverse demographics, geographies, and communities. Similar to other LaPQC initiatives, the pilot was launched with a "change package" of evidence-based best practices for participants to implement and a measurement strategy to assess progress. In addition, the pilot utilizes an expert faculty to guide and inform change, and encompasses a comprehensive collaborative learning plan for participating practices.

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

Perinatal depression is the most common obstetric complication in the United States. In the US it is estimated that more than 400,000 infants are born annually to birth parents who are depressed. Perinatal depression is not only detrimental to maternal health but can have long-lasting negative consequences on the developing child, having been linked to reduced sensitivity and responsiveness in caregiving and poorer social-emotional, cognitive, language, motor, and adaptive behavior development in their children. Additionally, there is evidence that fathers, partners, and other primary caregivers of infants can struggle with mental health following the delivery of an infant in their close circle. Additionally, Act 188 of the 2022 Louisiana Regular Legislative Session now requires that, among other things, pediatric healthcare providers screen for "postpartum depression or related mental health disorders…" This pilot will be essential in laying the groundwork in helping pediatric providers screen their patients, and provide important linkages to resources and empathetic and trusting

communication.

C. **Who benefits and how?**

The work of this pilot directly benefits outpatient pediatric providers, their staff, patients, families, and communities they serve. Screening caregivers for perinatal depression can not only provide for important and, in some cases, life-saving linkages to resources, support, and care, but also build important bonds of trust between the family and provider. This is particularly important in communities of color where trust in healthcare providers and healthcare systems have been eroded. Trust in providers will lead to greater engagement – for both child and caregiver – with preventative medicine, care coordination, and specialty services.

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

This accomplishment is grounded in OPH BFH's extensive expertise in using improvement science to achieve system change, and a commitment to innovate.

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

This accomplishment advances the OPH BFH strategic priorities, but is not connected to a specific agency 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?**

The LaPQC utilizes a modified approach to the Institute for Healthcare Improvement (IHI) Breakthrough Series model, the Model for Improvement, and other proven improvement science methodologies. This approach has applications outside of public health and healthcare and can be used to improve programs and program outcomes.

Accomplishment #4: Continued implementation of the Louisiana Perinatal Quality Collaborative (LaPQC) Safe Births Initiative

The LaPQC, a program within OPH BFH, continued implementation of the Safe Births Initiative (SBI) with a focus on safe reduction of low-risk first-time Cesarean sections (launched in January 2021 and wrapping in December 2022)

A. **What was achieved?**

The OPH BFH LaPQC Safe Births Initiative is demonstrating substantive improvements in maternal care. In March 2022, among Safe Births Initiative-participating facilities reporting data:

i. The NTSV C/S rate was 27.4% (39/44 reporting)
    1. This is down from our baseline of just over 33% in Q3 of 2020, the time period immediately preceding the Safe Births Initiative.
ii. The quantification of blood loss measurement rate was 92.1% (41/44)
    1. This means that over 9 out of every 10 birth parents who come in for a delivery are having their blood loss measured through quantitative means. This is a best practice because it allows care teams to respond more quickly and effectively to blood loss.
iii. The risk assessment at admission rate was 91.9% (41/44)
    1. Hemorrhage risk assessments allow obstetric care teams to have the appropriate medications and equipment prepared prior to a delivery. A risk assessment, conducted at admission, allows them to do this in advance and communicate with patients and appropriate care team partners.
iv. The postpartum risk assessment rate was 84.0% (38/44)
    1. Should a patient's hemorrhage risk change following a delivery, this postpartum risk assessment allows nurses and doctors to prepare accordingly.
v. The timely treatment of hypertension rate was 76.1% (42/44)
    1. This is the percent of patients treated within 60 minutes of a severe range blood pressure (with a confirmatory severe-range pressure within 15 minutes), using a treatment algorithm approved by the American College of Obstetricians and Gynecologists (ACOG).

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

Louisiana has some of the worst maternal and neonatal outcomes in the country, placing at the bottom, or near the bottom of every health ranking list available. The OPH BFH LaPQC Safe Births Initiative is a key action arm for Louisiana's Pregnancy Associated Mortality Review; as such, many of the recommendations that are tied to inpatient obstetric care find their way through the Safe Births Initiative. Any progress in the Safe Births Initiative is a direct reflection of the efforts to address recommendations related to pregnancy-related causes of death in Louisiana.

C. **Who benefits and how?**

While the full benefits have yet to be seen – this phase of the Safe Births Initiative is

not yet complete – patients are the greatest beneficiaries of increased stability of hemorrhage and hypertension intervention processes and decreased first time, low-risk cesarean deliveries. Hospitals are more prepared to effectively assess and respond to hemorrhage and hypertension events during a delivery admission, thereby decreasing the incidents of severe maternal morbidity events. Similarly, preventing a first time, low risk cesarean delivery can reduce not only the likelihood of future cesarean deliveries, but also maternal and neonatal complications. Beyond the benefits to patients, hospitals report greater confidence by staff in responding to obstetric events, and better communication between obstetric care teams through participation in the Safe Births Initiative.

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

This accomplishment is grounded in OPH BFH's extensive expertise in using improvement science to achieve system change, and a commitment to innovate. Furthermore, the accomplishment was achieved through extensive partnerships with Louisiana's birthing facilities and maternal health champions. The LaPQC works with birthing facilities to implement evidence-based best practices using the Model for Improvement and IHI's Breakthrough Series as a foundation. This approach involves the implementation of best practices using Plan-Do-Study-Act cycles, data collection and analysis, and collaborative learning. In addition to providing the structure and tools for implementation, the LaPQC facilitates two collaborative learning calls per month, in-depth Learning Sessions, trainings, and other collaborative learning events to increase both practical and clinical knowledge as well as quality improvement capacity.

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

This accomplishment advances the OPH BFH strategic priorities and the LDH 2022 Business Plan.

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

The LaPQC utilizes a modified approach to the Institute for Healthcare Improvement (IHI) Breakthrough Series model, the Model for Improvement, and other proven improvement science methodologies. This approach has applications outside of public health and healthcare and can be used to improve programs and program outcomes.

Accomplishment #5: LaPQC Louisiana Birth Ready Designation system

The LaPQC, a program within OPH BFH, designated the first hospitals in Louisiana under the LaPQC Louisiana Birth Ready Designation system, with 27 hospitals achieving designation in the inaugural year (January 2022)

A. **What was achieved?**

Over half (n=27) of Louisiana's birthing hospitals (48 as of August 2022) are Designated Birth Ready (19) or Birth Ready+ (8); 16 of the 27 facilities were first designated in August of 2021, and the remaining 11 were designated in February of 2022. Facilities must apply for Birth Ready Designation annually. To achieve designation, facilities had to meet requirements across five dimensions drawn from existing reporting and accreditation requirements:

i. Participation: collaboration is a key element of sustained improvement; as such, hospitals who wish to be designated will have to be active participants in LaPQC collaborative learning and planning.
ii. Health Disparity and Patient Partnership: evidence-based equitable care and patient-centered improvement are fundamental to the work of the LaPQC's mission to reduce disparities.
iii. Policy and Procedure: written policies and procedures assure standardization of care and contribute to readiness.
iv. Structure Measures and Education: commitment to persistent education of staff and patients elevates knowledge and opportunities for communication.
v. Outcome and Process Measures: regular reporting of data is essential to tracking improvement and understanding disparities in care.

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

The work of achieving Birth Ready Designation is difficult and, while many of the requirements align with work from the LaPQC's Safe Births Initiative and the Joint Commissions perinatal requirements, many hospitals had to put new processes in place while also managing COVID-19 response, 2 active hurricane seasons, and staffing shortages. Birth Ready Designation is a concrete way to acknowledge facilities for sustained, quality improvement work related to the implementation of evidence-based best practices known to improve readiness and response to some of the known antecedents to maternal mortality and morbidity. Birth Ready Designation is also the second quality improvement designation offered by the LaPQC for birthing facilities, which is an added incentive to engage in quality improvement work through the collaborative.

C. **Who benefits and how?**

Hospitals benefit not only from being able to share and celebrate the designation with their staff, patients, and community, but also benefit from the confidence and preparation that comes from the consistent quality improvement work connected to designation efforts. Patients also benefit from evidence-based practices that are more stable and sustainable, which contribute to systems of safe, equitable, and dignified birth at the hospital level. Most importantly, the health equity practices implemented through the Birth Ready Designation process are expected to contribute to care that is

ultimately more trustworthy, patient-, and family-centered.

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

This accomplishment is grounded in OPH BFH's extensive expertise in using improvement science to achieve system change, and a commitment to innovate. Furthermore, the accomplishment was achieved through extensive partnerships with Louisiana's birthing facilities and maternal health champions. The LaPQC developed Birth Ready Designation Requirements in 2020, formally launching the offering to hospitals in January 2021. For facilities already performing at a high level, the LaPQC offered an initial Designation review in August 2021, then again in February 2022. Hospitals will have to apply for (re)designation annually.

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

This accomplishment advances the OPH BFH strategic priorities, but is not connected to a specific agency 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?**

The LaPQC utilizes a modified approach to the Institute for Healthcare Improvement (IHI) Breakthrough Series model, the Model for Improvement, and other proven improvement science methodologies. This approach has applications outside of public health and healthcare and can be used to improve programs and program outcomes.

Accomplishment #6: Update to The Louisiana Commission for the Deaf (LCD) statue

The Louisiana Commission for the Deaf (LCD), program within OPH BFH, worked with advocates and legislators to inform the first substantive update to the LCD authorizing statue in over 40 years.

A. **What was achieved?**

Modernization of the authorizing legislation for the Commission for the Deaf, which was enacted prior to the federal American,'s with Disabilities Act (ADA).

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

This success is significant because it will advance efforts to achieve equitable communication access for individuals who are d/Deaf, DeafBlind, and hard of hearing in the state. Specifically, the Act clarifies the role of the department and the role of the board and expanded representation of important roles and constituencies on the board.

The Act also eliminated references to certain areas of LCD's historical responsibilities that are no longer applicable or need to change in order to support effective implementation of the requirements of the ADA. Lastly, the Act will support important improvements to interpreter services in the state.

C. **Who benefits and how?**

Individuals who are d/Deaf, DeafBlind, and hard of hearing benefit from expanded representation on the LCD board and from the efforts to improve equitable communication access to all systems in the state.

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

This accomplishment is grounded in OPH BFH's extensive expertise in communication access and a commitment to innovate. Furthermore, the accomplishment was achieved through extensive, productive partnerships between the department, the board, legislators, leaders in other state agencies and systems, and other constituencies.

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

This accomplishment advances the OPH BFH strategic priorities and LCD strategic priorities, but is not connected to a specific agency 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?**

This accomplishment represents the application of a systematic policy process with extensive engagement with constituencies and partners affected by the legislation.

BUREAU OF CHRONIC DISEASE PREVENTION AND HEALTHCARE ACCESS

Accomplishment #1: Well-Ahead Louisiana increased and supported the healthcare workforce in rural and/or health professional shortage areas:

A. What was achieved?

Well-Ahead Louisiana increased the healthcare workforce in rural and/or health professional shortage areas and supported the existing healthcare workforce in those areas. More specifically:

- The Rural Health Scholars Program placed 17 students pursuing a career healthcare into rotations in rural healthcare sites.
- The State Loan Repayment Program supported 53 providers in rural or health professional shortage areas.

- The Conrad 30 program supported 37 providers in rural or health professional shortage areas.
- The National Health Service Corp program supported 216 primary care health professionals in health professional shortage areas.
- Well-Ahead Louisiana helped rural health clinics with job vacancies connect with health professionals seeking employment and developed a comprehensive recruitment and retention plan for healthcare facilities in Louisiana, both through 3RNet.

B. Why is this success significant?

This success is significant because it serves the more than 724,000 rural Louisianans[1] and the 2.5 million Louisianans who live in primary care Health Professional Shortage Areas (HPSAs)[2]. Rural Louisianans and Louisianans living in HPSAs have poor access to healthcare services. This success is also significant because it incorporates program level successes. For example, the Rural Health Scholars Program was implemented for the first time in FY 22 and was able to successfully build partnerships with clinics and educational institutions to identify and place students in rotations in rural healthcare sites.

C. Who benefits and how?

Rural Louisianans and Louisianans living in primary care (HPSAs) benefit from this accomplishment through increased access to quality healthcare.

D. How was the accomplishment achieved?

The accomplishment was achieved through the design and implementation of new programs, such as the Rural Health Scholar Program, as well as successful implementation of existing programs such as the Conrad 30 program, which successfully sponsored the maximum number of providers allowable through the program.

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

Yes, this accomplishment contributes to the success of the Bureau's strategic plan by contributing to strategy 11.1 which is to, "Sustain and increase access to primary care provided in rural communities and increase rural communities' capacity to make

[1] USDA Economic Research Service: https://data.ers.usda.gov/reports.aspx?StateFIPS=22&StateName=Louisiana&ID=17854

[2] Designated Health Professional Shortage Areas Statistics: https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport

informed health-related decisions" and strategy 11.2 which is to, "Support recruitment and retention of primary health care providers in health professional shortage areas (HPSA) across 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 methodology and training content are aligned with national best practices around increasing access to health care in underserved areas.

Accomplishment #2: Well-Ahead Louisiana connected tobacco users in Louisiana to tobacco cessation services through the Louisiana Quitline:

A. What was achieved?

2,836 tobacco users in Louisiana registered for Quitline's tobacco cessation services.

B. Why is this success significant?

This success is significant because over 18%[3] of Louisianans smoke and smoking is risk factor for chronic diseases such as many cancers and cardiovascular disease.

C. Who benefits and how?

Louisianans who smoke tobacco and have registered for the services offered by the Louisiana Quitline have benefited by receiving the support they need to quit smoking. Those exposed to second and/or third hand smoke also stand to benefit from successful cessation of those registered for cessation services.

D. How was the accomplishment achieved?

The accomplishment was achieved through successful campaigns that promote the Quitline, such as the Quit With Us, Louisiana Campaign that encouraged residents to quit tobacco and resulted in more than 60,000 visits to the Quitline website, www.quitwithusla.org, and over 6,700 calls to the Tobacco Quitline. Additionally, more than 60 healthcare professionals were trained through the Well-Ahead Provider Education Tobacco Intervention training and resource referral, resulting in over 1,200 referrals to the Quitline from healthcare professionals.

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

[3] Americas Health Rankings: https://www.americashealthrankings.org/explore/annual/measure/Smoking/state/LA

Yes, this accomplishment contributes to the success of the Bureau's strategic plan by contributing to strategy 12.1 which is to, "Reduce disease, disability and death related to tobacco use by increasing statewide initiatives, cessation programs, school programs, media campaigns/marketing, and educational programs."

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

The methodology and training content are aligned with CDC's best practices as they relate tobacco cessation.

Accomplishment #3: Well-Ahead Louisiana expanded access to care through community based chronic disease prevention programs.

A. **What was achieved?**

Well-Ahead Louisiana provided training and resources to community partners to help establish and support community based self-monitoring blood pressure programs and National Diabetes Prevention Programs to help prevent heart disease and diabetes and connect residents to care.

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

This success is significant because 14% of Louisiana have diabetes and 11% of Louisianans have cardiovascular disease[4] .

C. **Who benefits and how?**

Louisianans at risk for diabetes and/or heart disease stand to benefit from this success through increased access to preventative screenings in their communities and linkage to care to help manage their health.

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

This accomplishment was achieved by first building partnerships with community based organizations and clinics. Well-Ahead Louisiana then provided training, resources, and ongoing technical assistance to individuals in community based organizations and clinics to help ensure proper screening, tracking of data, and linkage to care.

[4] Americas Health Rankings: https://www.americashealthrankings.org/explore/annual/measure/CVD/state/LA

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

Yes, this accomplishment contributes to the success of the Bureau's strategic plan by contributing to strategy 12.2 which is to, "Reduce disease, disability, and death from chronic diseases by increasing statewide initiatives in schools, worksites, communities, and healthcare settings."

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

The methodology and training content are aligned with CDC's best practices as they relate to community based prevention of diabetes and heart disease.

Accomplishment #4: Well-Ahead Louisiana successfully worked with schools and early education centers to promote the health of Louisiana's kids.

A. **What was achieved?**

Well-Ahead Louisiana successfully worked to promote the health of Louisiana's children by:

- Providing free dental screenings to 826 students through the Seals Smiles School Sealant Program.
- The Well-Ahead Healthy Schools Training Krewe developed four new workshops for schools: Engaging Students in an Active Classroom, Nudging Healthier Choices, Building Partnerships Through Social-Emotional Learning, and School Staff as Healthy Role Models and trained educators.
- 940 child care centers are participating in GO NAPSACC, which is program that works to build healthy eating and physical activity habits in children.
- 282 child care centers are designated as WellSpots
- 590 schools are designated as WellSpots

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

This success is significant because promoting health in children and encouraging health promoting behaviors in childhood can help prevent the development of chronic disease and ultimately decrease morbidity and mortality.

C. **Who benefits and how?**

Well-Ahead works with schools and educators to create health promoting environments for students. Ultimately, Louisiana's children benefit from this success through exposure to health promoting environments and access to dental screenings.

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

The accomplishment was achieved by creating training content, partnering with schools, and delivering trainings.

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

Yes, this accomplishment contributes to the success of the Bureau's strategic plan by contributing to strategy 12.1 which is to, "Reduce disease, disability and death related to tobacco use by increasing statewide initiatives, cessation programs, school programs, media campaigns/marketing, and educational programs" and strategy 12.2 which is to, "Reduce disease, disability, and death from chronic diseases by increasing statewide initiatives in schools, worksites, communities, and healthcare settings."

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

The methodology and training content are aligned with CDC's best practices as they relate school health and oral health initiatives.

BUREAU OF COMMUNITY PREPAREDNESS

Accomplishment #1: COVID-19 Response – LDH Emergency Operations Center:

A. What was achieved?

The Bureau of Community Preparedness was engaged in COVID-19 response since January 2020. On June 30, 2022, the LDH Emergency Operations Center was deactivated. Over the past 2 ½ years, response activities evolved from monitoring to include testing, mitigation efforts, and vaccinating. During this time, the EOC fulfilled a total of 1,385 resource requests related to COVID-19.

LDH EOC provided the planning, logistical, operational, and financial support for LDH COVID-related efforts. Specific areas of support have included daily situational updates, data collection and reporting, resupply of medical equipment and supplies, medical oversight of field sites (isolation/quarantine camps and medical monitoring station), and PPE request fulfillment for health facilities. Key functions of the response have included *Medical Monitoring Station, Surge Testing, Nursing Facility Safety and Testing, and Vaccination Clinics*. Additionally, the LDH EOC staffed a Public Informational Call line and supported the 211 Call Center. Approximately 200,000 calls have be answered related to COVID-19.

B. Why is this success significant?

The duration and nature of the LDH EOC's response to COVID-19 required staff to pivot in ways that had not previously occurred and also respond at times when skilled staff were limited. LDH EOC response efforts afforded staff the opportunity to further hone response skills while developing increased efficiency in response practices.

C. Who benefits and how?

All residents of the state of Louisiana as well as visitors who were impacted by COVID-19 during their time in the state benefited from the LDH Emergency Operations Center. LDH EOC coordinated activities that directly impacted the public and supported COVID-19 prevention and education including *Medical Monitoring Station, Surge Testing, Nursing Facility Safety and Testing, and Vaccination Clinics.*

D. How was the accomplishment achieved?

LDH EOC coordinated activities that directly impacted the public and supported COVID-19 prevention and education including *Medical Monitoring Station, Surge Testing, Nursing Facility Safety and Testing, and Vaccination Clinics.*

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

Yes, this accomplishment contributes to the success of Commitment 1: Improve the health and well-being of Louisianans with an emphasis on prevention; Initiative 6: Increase and strengthen service delivery for vulnerable 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, this accomplishment represents a Best Management Practice that should be shared.

Accomplishment #2: COVID-19 Health Disparities Grant Year 2:

A. What was achieved?

Now in its second year of funding, BCP continues to monitor and support the objectives under the grant titled "National Initiative to Address COVID-19 Health Disparities among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities." In the first year, BCP saw success largely in sustaining existing and developing new partnerships with key stakeholders. Additionally, six HBCUs received funding totaling approximately $4.5 million to support LDH Business Plan Initiative 13 (Support efforts to increase diversity in the state's healthcare workforce). The goal for this initiative is to increase the number of

clinicians of color who provide healthcare in Louisiana. Among the successes are the following:

- Implementation of the *Rainbow of Short White Coats* program to inspire head start students to become healthcare professionals, one day. Thirty-five students from the Incarnate Word Head Start and Early Head Start operated by the Catholic Charities of New Orleans (CCANO) were given short white coats as a symbol of a commitment to lifelong learning in healthcare, which they will keep as a memento.
- Enabled five (5) pre-med students from Dillard University to attend the Student National Medical Association (SNMA) national conference in Orlando, FL. This was the first time in five years that Dillard University had the capacity to support student learning in this manner.
- Established a Clinicians of Color Working Group that engaged university, community, and governmental stakeholders to work collaboratively to increase clinicians of color in Louisiana.
    - To date, 279 students are engaged in Health Disparities initiatives or pursuing degrees or that can lead to health care careers as doctors, nurses, allied health professionals and public health practitioners. Break down by school:
        - Dillard University (17 students)
        - LSU Health Sciences Center at Shreveport (53 students)
        - Southern University Baton Rouge (52 students)
        - New Orleans (22 students)
- SU System Foundation (100 students)
- Xavier University of Louisiana and Grambling State University (35 students)

B. Why is this success significant?

The impact of COVID-19 was felt immediately throughout the state of Louisiana as the pandemic shed a spotlight on health inequities particularly in vulnerable populations. Through this funding opportunity, Louisiana has been able to enhance public health programs that provide services for individuals with access and functional needs, as well as support diversity in the healthcare workforce through promotion of the Clinicians of Color Working Group.

C. Who benefits and how?

The residents of and visitors to the state of Louisiana benefit as a result of the successes of the *National Initiative to Address COVID-19 Health Disparities among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities* grant.

D. How was the accomplishment achieved?

This accomplishment was achieved by building upon pre-existing partnerships while also seeking opportunities to new partnerships with relevant stakeholders.

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

Yes, this accomplishment contributes to the success of Commitment 1: Improve the health and well-being of Louisianans with an emphasis on prevention; Initiative 6: Increase and strengthen service delivery for vulnerable residents and Commitment 3: Enhance customer service, partnerships, and community relations; Initiative 13: Support efforts to increase diversity in the state's healthcare workforce.

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

Yes, this accomplishment represents a Best Management Practice that should be shared.

Accomplishment #3: Recruited and Hired Nurses to conduct Door to Door COVID-19 Education and Vaccination:

A. **What was achieved?**

The Bureau of Community Preparedness continues to expand the vaccination sand outreach initiative statewide. The Bureau of Community Preparedness has managed a Strike Team since July 2021. To date, the team has administered 4,191 CV-19 vaccinations. Since January 2022, 1,634 have been administered to individuals at various sites.

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

LDH has employed a unique approach to COVID-19 vaccination efforts. The Strike Team Initiative is designed to meet people where they are in an effort to vaccinate a larger portion of the population who may otherwise avoid vaccination due to hesitation, lack of transportation or other reasons.

C. **Who benefits and how?**

Louisiana residents benefit directly from this initiative.

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

This accomplishment is achieved through the leveraging of the LAVA program and available nursing volunteers.

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

Yes, this accomplishment contributes to the success of Commitment 1: Improve the health and well-being of Louisianans with an emphasis on prevention; Initiative 6: Increase and strengthen service delivery for vulnerable 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, this accomplishment represents a Best Management Practice that should be shared.

BUREAU OF REGIONAL AND CLINICAL OPERATIONS

Accomplishment #1: COVID-19 Pandemic response

A. What was achieved?

Louisiana residents had greater access to COVID testing and vaccinations by:

a. Administered COVID-19 vaccinations in Parish Health Units statewide
b. Utilized BHI-driven Social Vulnerabilities Index map for COVID-19 community vaccine events
c. Coordinated community-based COVID-19 testing and community distribution of self-administered test kit
d. Strengthened public health workforce via the Health Disparities and Workforce grant (regional health-disparity strategists and social workers
e. Covid-19 Youth Ambassador Program was developed and operationalized in Region 9 and expanded statewide
f. Assisted with coordinating homebound vaccinations
g. Participated in media interviews and Tele-town halls

B. Why is this success significant?

Regional public health teams focused their efforts on reaching communities who traditionally have no or poor access to healthcare services. Vaccinations, testing and outreach were offered in Parish Health Units across the state and mobile/pop-up events occurred in every parish at churches, community centers, libraries and parks.

C. Who benefits and how?

This benefits Louisiana residents who face greater health inequities. Our Parish Health Units serve residents who are under or uninsured and our outreach efforts also focus these communities.

D. How was the accomplishment achieved?

Regional teams used data, such as the Social Vulnerability Index (SVI), and community partnerships to identify low resource communities. Partnerships with our program offices, contractors and increased staff allowed regional teams to conduct increased outreach activities. LDH Bureau of Media and Communication **(**BMAC) helped to promote these events via various media channels and provided educational materials for public consumption.

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

Yes. It is part of the Bureau of Regional and Clinical Operations continuous focus on increasing access to healthcare in the *underserved* communities.

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

Yes this should be shared.

Accomplishment #2: Parish Health Units continued access to services

A. What was achieved?

Louisiana residents continued to have access to services in the Parish Health Units, despite the COVID-19 pandemic. Operations became more efficient with the EHR (Electronic Health Record) interfaces and we were able to continue to offer telehealth services to those who preferred that over in person services.

a. Implemented State Vaccine Registry and Lab Interface with Electronic Medical Record in all Parish Health Units
b. Coordinated regional Sexual Assault Response Plan
c. Maintained all Parish Health Program Services throughout COVID response and Hurricane response (WIC, STI testing/treatment , Adult/Pediatric non-COVID Vaccines, Children Special Health Services, Tuberculosis program, Vital Records, Refugee Screening).
d. Expanded Family Planning and STI services to include Telehealth video visits and self-administered option for birth control.
e. Operationalized Mass Flu Vaccination Events

B. Why is this success significant?

Regional public health teams services reach under and uninsured communities throughout the state increasing access to healthcare services for vulnerable residents. These services are a safety net and OPH worked to continue to provide high quality services during the pandemic. We were able to increase our efficiencies by interfacing our Electronic Health Record with the lab and vaccine registry, as well as increase our reproductive health visits via the use of telehealth video visits.

C. Who benefits and how?

This benefits Louisiana residents who face greater health inequities. Our Parish Health Units serve as a safety net healthcare provider.

D. How was the accomplishment achieved?

Partnerships with our program offices, contractors and increased staff allowed regional teams to conduct increased outreach activities.

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

Yes. It is part of the Bureau of Regional and Clinical Operations continuous focus on increasing access to healthcare in the *underserved* communities.

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

Yes

Accomplishment #3: Collaborated between OPH regions and Human Services Districts and Authorities on Opioid overdose prevention strategy, education and distribution of Narcan.

A. What was achieved?

As a public health response to the opioid epidemic, Louisiana residents now have access to Narcan in all Public Health Units (PHUs). Parish Health Unit staff are able to distribute Narcan to individuals when the need arises. OPH staff have been trained and educate individuals on how to use Narcan.

B. Why is this success significant?

With PHUs located across the state, this ensures that residents can access Narcan in all areas of the state, especially in our more rural communities.

C. Who benefits and how?

Individuals in crisis situations and at risk for overdose will benefit from greater access to Narcan.

D. How was the accomplishment achieved?

Regional teams worked in partnership with their Human Services Districts and Authorities for Narcan. BRCO Medical Director developed a Standard Operating Procedure for PHU distribution of Narcan. Staff were trained on distribution.

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

Yes. It is part of the Bureau of Regional and Clinical Operations continuous focus on increasing access to healthcare in the *underserved* communities

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

Yes.

Accomplishment #4: Community Health Worker program, Community HealthWays

A. What was achieved?

Louisiana residents have access to Community Health Workers (CHWs) in the Parish Health Units who will assist individuals in assessing and meeting health related social needs. In addition, the CHWs continued to conduct community outreach activities to support COVID-19 response efforts. CHWs provide resource coordination to individuals diagnosed with COVID-19 and referred by contact tracers. The CHWs assist these individuals in obtaining resources, such as food and PPE, necessary to quarantine or isolate, as recommended by CDC.

a. Expanded community health worker workforce from 28 to 40
b. Started Community HealthWays program in 6 Parish Health Units

B. Why is this success significant?

Social and environment factors like absent or low-quality housing, food, transportation, and other unmet health-related social needs (HRSN) drive more than 60% of health outcomes but are heavily under supported. Community HealthWays was launched by the Office of Public Health to support systematic screening for HRSN (housing, food

security, transportation, education, employment, utilities, and behavioral health), provide individualized navigation services to health address unmet needs, and to convent community-level public and private sector leaders to address structural factors fostering poor health through data-driven investments in new partnerships and organizations. Community HealthWays seeks to improve the quality of life for Louisiana residents by helping to address individuals' HRSN and the community health factors that drive them.

C. Who benefits and how?

This benefits Louisiana residents who face greater health inequities**,** specifically clients of our Parish Health Units and other individuals referred to the program by partners.

D. How was the accomplishment achieved?

Federal funding allowed the expansion of CHWs across the state, as well as training for CHWs in collaboration with LSU Health Sciences Center New Orleans and the Louisiana Community Health Worker Outreach Network (LACHON). CHWs work out of Parish Health Units and are located in parishes with poorer health outcomes and greater needs.

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

Yes. It is part of the Bureau of Regional and Clinical Operations continuous focus on increasing access to healthcare in the *underserved* communities.

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

Yes.

BUREAU OF EMERGENCY MEDICAL SERVICES

Accomplishment #1: Administration:

A. What was achieved?

The small staff of the Bureau of EMS has accomplished many great achievements during fiscal years 2022. In addition to continuing with COVID-19 vaccines through the second quarter, a significant number of state and federal surge ambulances were placarded and assistance was provided at the EMS Tactical Operations Center for sixteen days/nights during the response of Hurricane Ida.

In addition to pandemic and disaster response, the Bureau of EMS engaged with EMS Stakeholders to celebrate EMS week and engaged with EMS Practitioners in safeguarding their health, safety and wellbeing as well as the community that they serve. Also, nineteen (19) EMS Practitioners were honored at the EMS memorial.

Bureau of EMS Director, Susan Bailey, represented Louisiana, the Bureau of EMS, and the EMS profession on the national level at various activities and on several social media platforms.

B. Why is this success significant?

Networking with EMS stakeholders, EMS Practitioners and national EMS Industry Leaders provides visibility and a positive image of the Bureau of EMS staff, Louisiana and the EMS Profession.

C. Who benefits and how?

Through the efficiency of the Bureau of EMS staff, Louisiana's EMS profession benefits immediately and the citizens and visitors of Louisiana benefit in the long term as the Bureau of EMS ensures that education program meet quality standards, that EMS providers meet the standards set forth by rule and statute, and that the Louisiana Scope of Practice is progressive and meets the needs of the communities that are served.

D. How was the accomplishment achieved?

All accomplishments of the Bureau of EMS are due to the hard work and dedication of the staff. Each individual staff member has a statutorily defined job function as well as several ancillary job functions. Nevertheless, the Bureau of EMS staff continues to provide excellent customer services.

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

The improvement of customer service is at the heart of The Bureau of EMS' strategic plan. Each staff member has worked extremely hard to ensure this is achieved.

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

No, there is not another regulatory agency within the executive branch. The Bureau of EMS accomplishes the regulatory functions in the most efficient manner possible. These functions are exclusive to EMS.

Accomplishment #2: EMS Certification Commission:

A. What was achieved?

a. EMS Certification Commission conducted all six of the regular scheduled meeting with a quorum.
b. EMS Certification Commission reviewed and processed 247 disciplinary/complaint determinations that were reviewed, prepared, presented and processed by the Deputy Director.
c. 178 disciplinary/complaint cases were closed after review, preparation, presentation to the EMS Certification Commission and processed, all by the Deputy Director.
d. 172 new disciplinary/complaint cases were received, reviewed and processed to the most appropriate phase by the Deputy Director.
e. The EMS Compact legislation was enacted on July 1, 2022 requiring criminal history reports for initial EMS practitioners as well as facilitate the day-to-day movement of EMS personnel across state boundaries among Compact member states.

B. Why is this success significant?

a. The Commission was able to conduct the business of the Commission and the Bureau by meeting the quorum requirements. In previous years, this did not happen on a regular basis. This is a success due to the impact of the Deputy Director maintaining effective and timely communication with Commissioners and facilitating productive meetings so that the Commissioners feel like they are positively impacting change regarding EMS practitioners.
b. 247 disciplinary/complaint case determinations are a significant amount of cases for one staff person to oversee and process. The cases increased this year due to the implementation of Compact law and the number of practitioners who did not disclose previous criminal histories.
c. 178 case were closed by the Deputy Director after processing. This is a significant amount of cases for one staff person to oversee and process while having additional duties.
d. 172 new disciplinary/complaint cases are significant for one staff person to oversee and process while having additional duties.
e. The implementation of the Compact legislation, specifically criminal history reports has been challenging at best due to the delayed response from Federal Bureau of Investigations as well as Louisiana State Police. The Deputy Director remained persistent in communication in the pursuit of the finalization of the process.

C. Who benefits and how?

In all aspects above, EMS practitioners and the public within the State of Louisiana benefit from the Commission conducting business in a timely manner, conducting

disciplinary hearings against EMS practitioners to assure that the public is treated appropriately and remain safe from harm or potential harm due to an EMS practitioner, implementing scope of practice changes as well as holding the EMS practitioners accountable. The EMS Compact also assists in seamless patient transport across state boundaries of Compact member states.

D. How was the accomplishment achieved?

The Deputy Director implemented process improvement changes to assist in processing of the 247 determinations, closing 178 cases and processing 172 new cases. Again, this is a significant number of cases for one staff person to handle who also has other duties including management. The Deputy Director was able to accomplish this level of success due to her organizational skills, time management, and effective communication with the EMS Certification Commission. The number of cases due to affirmative criminal backgrounds increase exponentially due to the Compact Law.

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

Yes, it does contribute to the success of the Bureau's strategic plan as the success of the EMS Certification Commission and the processing of applications with disclosures and complaints support the role of the Bureau's regulatory functions.

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

No. There are no other agencies who oversee a State Commission who have regulatory functions associated with licensing, applications with disclosures and complaints related to EMS practitioners as these functions are specific in nature.

Accomplishment #3: Education:

A. What was achieved?

The Bureau of EMS was able to maintain high-quality education and training for EMS personnel.

B. Why is this success significant?

Louisiana licensed practitioners received higher-quality education, which in turn leads to safer and improved service to the public.

C. Who benefits and how?

EMS educators and education programs are better suited to meet the instructional needs

of students. This in turn leads to higher-quality and more competent practitioners which are capable of providing better service to the public.

D. How was the accomplishment achieved?

Collaboration with stakeholders via workgroups and town hall meetings. In addition, ongoing QA ensures that education programs are adhering to the strictest standards of quality.

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

No.

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

No.

Accomplishment #4: Examination:

A. **What was achieved?**

We were able to offer psychomotor exams to four levels of certification I EMS so that candidates would be eligible for licensure.

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

Louisiana as well as the rest of the United States has a current shortage of EMS providers, by offering psychomotor exams and working with educational programs with onsite testing we were able to keep up with most of the demand for providers. If Louisiana had followed the same trend as other states, we would have an extreme shortage in providers and emergency response would have suffered.

C. **Who benefits and how?**

The citizens of Louisiana benefit by having more EMS providers available to respond to emergencies. Offering psychomotor exams around in all regions of Louisiana benefits the communities by keeping their providers in the area they live and work, cutting down on travel time.

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

We were able to offer exams in Baton Rouge as well as around Louisiana by having contract examiners to provide needed work force.

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

Yes, we are contributing to our strategic plan by offering exams to different areas of Louisiana and developing a pool of skilled EMS providers to help be examiners as well as instructors and mentors for new providers.

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

Yes, best management practices are followed. Being a small office with limited personnel to cover tasks, we work well together and are willing to assist. This attitude should be widespread.

Accomplishment #5: Credentialing:

A. **What was achieved?**

Successful recruitment and retention of 12,062 EMS practitioners. The Bureau of EMS has a standard processing rate of seven business days for approving license applications. During FY22, license applications were processed on average within four days.

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

There were many challenges faced during FY22 including Hurricane Ida in addition to COVID-19. Despite all odds, over 500 more EMS practitioners were licensed in FY22 than in the previous year.

C. **Who benefits and how?**

Both the licensed EMS practitioner and the communities they serve benefit from the success of the Bureau. Licensed EMS practitioners serve their communities and workforce, ensuring patient care, safety, and rapid response times. During FY22 EMS practitioners have continued to provide essential services to hospitals and community facilities in the wake of staffing shortages due to COVID-19.

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

Educational programs and NREMT testing were able to adapt and continue in Louisiana without interruption. During the FY22, Bureau of EMS continued to issue provisional licenses following NREMT's licensing guidelines. Louisiana also allowed for an extension of the EMR expiration date of 9/30/2021 to 12/31/2021, following the devastation from Hurricane Ida.

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

Yes, the licensing accomplishments by the Bureau of EMS to contribute to the success of our strategic plan by continuing to being adaptive while growing our EMS workforce.

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

Our licensing process allows for growth and progress as laws, statutes, and NREMT licensing guidelines change. The Bureau of EMS uses an Information Management System that can communicate with NREMTs licensing software and allows for the tracking of educational courses. This makes the licensing process more efficient and seamless as changes occur over time.

Accomplishment #6: Ambulance Standards:

A. What was achieved?

- Increased usage of the information management system for EMS provider license renewals.
- Drafted and implemented surge unit policy and procedure, made changes to the surge unit forms, and began the process of obtaining a CEA for alternate ambulance processing sites.

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

- Use of the Information Management System (IMS) for provider license renewals requires less time to process applications, provides an organized digital databank for documents, decreases the amount of paperwork stored, and streamlines the inspection process.
- Implantation of a surge unit policy and procedure ensures that the correct process is being followed, minimizes mistakes, and provides guidance for other personnel to perform tasks as a secondary function of their job duties.
- Obtaining a CEA for alternate ambulance processing sites gives the Bureau of EMS the flexibility to use a site that is more conveniently located for surge ambulance response and acts as a backup location in cases of damage to primary site.
- Changes to the surge unit forms addressed issues identified during Hurricane Ida, i.e. increased processing time due to forms being submitted to the wrong email

address, non-credentialed personnel responding to the ambulance processing site, and redundant information being collected.

C. **Who benefits and how?**

- There are multiple benefits of using IMS for provider license renewal. The providers benefit by not having to submit the same paperwork every year, only needing to submit the items that have expired or changed. BEMS benefits because it requires less time to process applications. This benefits LDH and the citizens of Louisiana because more time is available for other tasks and projects.
- Changes to the surge unit process benefits the citizens of Louisiana by reducing the response time of surge ambulances in a disaster.

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

- An instructional PDF document was distributed with every license renewal notification. This document provides step-by-step instructions, with images, on renewing a provider license in the information management system.
- A post hurricane hot wash meeting was held with disaster response stakeholders. This meeting identified processes that worked well and areas of improvement. The feedback was used to make the changes necessary for a better response in the future. Once the changes were made, stakeholder feedback was encouraged and a round table exercise was conducted to test the changes.

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

Yes. The strategic plan identifies education on the information management system and a streamlined workflow as two areas of improvement. Both of those goals have been accomplished with these simple changes.

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

No.

SANITARIAN SERVICES

Accomplishment #1: Conducted Post Disaster Surveys and Disaster Shelter Assessment inspections in response to Hurricane Ida using the electronic database.

A. **What was achieved?**

Sanitarian Services is tasked with conducting inspections of disaster shelters as well as affected food establishments within disaster areas, pre and post disaster. For Hurricane Ida, Sanitarian Services conducted over 2000 electronic post disaster inspections of retail food establishments as well as over 200 electronic shelter inspections.

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

In FY21, Sanitarian Services completed adding the Post Disaster Survey and Shelter Assessment forms to our electronic database, Digital Health Department (DHD), using funds from a CDC grant. Post disaster surveys are conducted on affected Retail Food Establishments to make sure they are safe to re-open. Shelter assessments are conducted to ensure the shelters are setup properly for housing evacuees in regards to public health. Having these forms electronically proved to make the process more efficient for Sanitarian Services. This electronic system provided us with instant counts of inspections conducted and eliminated the need for inspectors to scan in or take pictures of hand written inspections. The inspections themselves were much more understandable and easily emailed to those who required access to them.

C. **Who benefits and how?**

Sanitarian Services benefitted from the inspections being captured electronically as reports were more accurate and quickly accessible. It was a huge time saver for San Services administration as the inspectors did not need to be contacted to send copies to central office. It was also a time saver for inspectors as they just had to submit inspections online, in the DHD database, and no further action was required of them. Those individuals who were purchasing/receiving food from permitted establishments within the affected area and using the Shelters also benefitted from those inspections as they were served safe food and sheltered in a safe environment.
Louisiana citizens who are purchasing/receiving food from permitted establishments within the affected area, knowing the product they are getting is safe. Also, those Louisiana Citizens that need access to a safe shelter.

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

The inspection forms being digitized were accomplished through a CDC grant which allowed us to develop and build the forms within our current DHD database. By using the same database that we use for our routine inspections, our field Sanitarians adjusted their scheduled routine inspections to accomplish these inspections without disrupting their normal activities. There was also extra help from sanitarians in unaffected areas to get these crucial inspections conducted.

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

Yes, this accomplishment helps to keep us on track and not fall behind on our routine inspection schedule, through streamlining these extra, unplanned/unscheduled inspections.
It also improves and advances our services to the citizens of Louisiana who rely on the Office of Public Health to keep them safe.

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

Yes, streamlining actions through existing technologies is an efficient way to use already available resources to maintain plan goals.

BUREAU OF PLANNING AND PERFORMANCE

Accomplishment #1: Completing a Community Engagement Process for the State Health Assessment

A. What was achieved?

The Office of Public Health conducts a State Health Assessment (SHA) every five years to provide an overview of the health status of Louisianans and to highlight where health inequities and disparities exist. This is used to inform statewide public health planning and collaboration and helps identify resources in the community that can be mobilized to achieve better health outcomes. Specifically, the SHA is used to support the creation of the State Health Improvement Plan (SHIP), a multi-year plan for addressing priority areas to improve health in Louisiana.

In this fiscal year, the Bureau of Planning and Performance partnered with the Governor's COVID-19 Health Equity Task Force and the Louisiana Public Health Institute to lead a statewide process to engage community members and partner organizations and to hear directly from Louisianans about their health concerns, to inform the SHA and SHIP. This is to complement the health data that was published on our SHA dashboard (www.LouisianaSHA.com) in 2021. The community engagement process included two rounds of virtual regional meetings in each OPH region, a statewide survey, community leader interviews, and public health system stakeholder interviews. Over 5,000 Louisianans from every region of the state were engaged in this process.

LDH staff and their advisory committees used the data to prioritize health-related issues to be addressed by the SHIP. The four priority areas identified are: **behavioral health**,

chronic disease, **community safety**, and **maternal and child health.** Over the coming year, community members and partner organizations will be engaged to develop and begin implementation of the SHIP around these priority areas.

B. Why is this success significant?

While examination of secondary data is critical for understanding the health status of Louisianans, conducting a truly robust and equity-centered SHA requires a strong community engagement process that involves direct feedback from partners and community members. A robust SHA will be the basis for priority setting, planning, program development, policy changes, coordination of community resources, funding applications, and new ways to collaboratively use community assets to improve the health of the population. Having a strong SHA with meaningful community engagement sets the stage for development of a SHIP that is not just an LDH plan, but a shared plan among communities and partners across the state. LDH can now move forward with developing a State Health Improvement Plan that addresses the most pressing health concerns for Louisianans. In addition, this type of community engagement process is a best practice and will enable us to meet certain requirements for reaccreditation of our health department by the Public Health Accreditation Board.

C. Who benefits and how?

The residents of Louisiana benefit from a public health system and statewide public health improvement plan that addresses the most pressing health concerns across the state. In particular, this effort is designed to benefit residents of Louisiana who experience health inequities, by highlighting the health inequities that exist and developing a collaborative plan to address those inequities. In addition, the public health system as a whole benefits as it is able to be more effective due to increased collaboration, communication, and coordination.

D. How was the accomplishment achieved?

This activity was achieved with financial support from the U.S. Centers for Disease Control and Prevention and from the Governor's COVID-19 Health Equity Task Force. The Health Equity Task Force had recommended the development of a health equity dashboard and provided funding to the Louisiana Public Health Institute (LPHI) to collaborate with Bureau of Planning and Performance to design, manage and implement this activity. Individuals from the Bureau of Planning and Performance and LPHI engaged in project planning throughout the year to design and conduct the regional meetings and to collect, analyze and report on the findings of the various methods employed, which included virtual meetings, a statewide survey, and 1:1 interviews with community leaders and public health system stakeholders. OPH's Regional Medical Directors were instrumental in engaging community members and organizational partners in their respective regions and helped to lead the regional

meetings.

In addition, two advisory committees provided invaluable guidance for this project:

- **LDH SHA/SHIP Core Group**: A committee of experts across LDH was tapped to advise this process. These individuals represented LDH-OPH, the Office of the Secretary, the Office of Behavioral Health, and Medicaid.
- **Review, Advise, Inform Board**: Through a selective application process, LDH convened this board of community members and health equity experts from across the state to advise LDH's health equity efforts, including the SHA/SHIP process.

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

Yes. This activity directly relates to OPH being valued as a leader in public health in Louisiana, and facilitating partnerships for the alignment of efforts and overall impact on health and wellness of individuals and communities. It also directly relates to OPH leading and continually improving a public health system that identifies and reduces inequities to improve health outcomes and quality of life in Louisiana.

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

While completion of a State Health Assessment and a State Health Improvement Plan is a best practice for health departments in particular, the community engagement methodologies used could certainly be adapted by other executive branch departments or agencies.

Accomplishment #2: Establishing an Employee Mentorship Program

A. **What was achieved?**

OPH established an employee mentorship program to provide opportunities for employees to engage in meaningful conversations, connect with others outside of their own team, exchange information and gain professional development with experienced health department colleagues. In the fall of 2021, we guided 21 mentor-mentee pairs along a series of six one-on-one meetings as part of this program.

Following the program, we conducted a participant survey and found that:

- 100% of participants rated the program as valuable.
- 82% of participants said this mentoring relationship has been beneficial to them.

- 78% reported all or some goals discussed in the mentorship pair have been completed at this time.
- 78% felt more connected to others as a result of this mentorship program.
- 67% had an increased understanding of others' roles at our agency.
- 63% reported feeling energized by this mentoring experience.

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

We have long been aware of the need to offer more professional development opportunities for staff and to engage in practices that support job satisfaction and improve retention. The COVID-19 pandemic put significant additional strain on the workforce, leading to overwhelm, burnout, and disconnection. Offering this type of program helped to support our workforce and increase morale and a sense of connection to others, which is critical now more than ever. This contributes to overall employee success, happiness, and retention.

C. **Who benefits and how?**

The OPH workforce, and particularly, the participants in the program, are the primary beneficiaries, as they receive mentoring that helps them with their professional development and helps them feel more connected to others within the organization. OPH as a whole benefits from having employees who are more likely to experience career satisfaction and less likely to leave the organization. The people of Louisiana benefit from having a stronger public health workforce.

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

We engaged the services of a mentorship platform called Together. We invited all OPH staff to apply for the program through the Together platform. The Together platform suggested mentor-mentee matches. The OPH workforce team then finalized the pairs prior to kicking off the program. The OPH workforce team hosted a webinar for participants to orient them to the program and provided supporting resource materials.

We asked the mentor-mentee pairs to meet at least six times within a six-month window. We provided optional agenda templates for both mentors and mentees to guide individual interactions. We checked in with mentors and mentees over the course of the program to ensure everything was going smoothly and to troubleshoot any issues that came up. Also, during the program, the OPH workforce team hosted a series of video calls and webinars to increase communication and resource sharing among mentors and to provide additional professional development support and networking opportunities for all participants.

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

Yes. This activity directly relates to OPH attracting and retaining a competent and diverse staff throughout our workforce to maximize productivity, deliver high quality service, and improve outcomes.

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

Yes.

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

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

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

Overall, OPH has been making great progress towards its agency goals. As the examples in the prior section show, our work is resulting in measureable improvements in health-related behaviors and outcomes for the people of Louisiana.

- **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:

Two areas where we have been making significant progress include facilitating partnerships to increase our impact on health and wellness of individuals and communities, and leading and continually improving a public health system that identifies and reduces inequities to improve health outcomes and quality of life in Louisiana. These strategies are reflected in the accomplishments described in the previous section.

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.

We have worked consistently over the years to build partnerships and develop collaborations focused in improving health outcomes with an equity lens.

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

We expect that, should the required resources remain available, this work will continue to result in significant progress over the coming years.

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

None

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

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

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

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

The Office of Public Health (OPH) did revise its 5-year strategic plan to build on

successes and accomplishments previously stated. We also participated in the planning and implementation of the LDH Business 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.

Regular leadership meetings are held across the agency to review, update, and ensure implementation of plans.

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 COVID-19 pandemic response has challenged the Office of Public Health's (OPH) infrastructure in unpredictable ways. One challenge in particular has been developing and maintaining the infrastructure to manage large sums of federal funding. The lack of infrastructure has necessitated handing over additional responsibilities to staff in middle management positions, which has led to overload, turnover, and loss of critical leadership at this level.

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

   The first goal of OPH's strategic plan is to "Increase financial stability by more efficient utilization of resources and increased revenue." With over $880 million in federal grants now available, OPH has certainly increased the availability of resources. However, without the adequate infrastructure in place to manage the grants or their deliverables it is increasingly difficult to meet the requirements of

the grants and efficiently leverage those resources.

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

   This is experienced across the entire agency.

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

   This affects external customers and the public at large as it is a barrier to more effectively addressing public health needs, which impacts public health outcomes. It is an obstacle to providing excellent customer service levels. Internally, it taxes our managerial capacity and staff morale as existing staff continue to be stretched and overworked. Typically, it is our more tenured staff who are tasked with more activities within their current schedule requiring many hours of K-time and lack on any work life balance. When low morale leads to staff turnover, the agency loses institutional and job-related knowledge and capacity which is costly to replace. In most technical areas, there is a two-year training period to train new staff. In the highly specialized areas, that training period can be up to five years to fully replace the knowledge lost.

5. How long has the problem or issue existed?

   Expanding staffing to meet new initiatives is not a new challenge; however, the number of tasks and the workload from a pandemic has meant that the number of staff needed to accomplish the work is far greater than ever experienced before. However, though OPH's budget and responsibilities have quadrupled, its staff has increased by a small fraction of that.

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

   The problem has been caused by the lack of TO and JA positions, and the risk has been highlighted by the ongoing pandemic, and the influx of federal funds. Attempts to address the gaps using contract positions have not been sustainable, and it has been difficult to attract workers willing to accept temporary positions, nor does contracting build infrastructure for the long term. State positions are more attractive to potential applicants than contract positions. In addition, contracting or outsourcing the work requires another process of procurement, oversight, management and auditing, i.e. more work, that is not required when using state positions.

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

   With regard to emergency response, a consequence is that we are restricted in our ability to mobilize our staff to engage in emergency response efforts. The burden

of emergency response falls unevenly on our staff members, with permanent TO positions required to be activated but not most contract positions, which affects morale of those who are required to respond.

OPH has utilized external contracted positions and internal temporary positions to meet the need for these programs and services, but that is not sustainable, nor does it provide a long term solution. It also handicaps the agency's ability to compete with private industry for top talent in these forward initiatives.

There is also the risk of financial consequences due to the lack of a grants management infrastructure. Without proper management of funds we not only limit our the ability to efficiently and effectively implement federal grant requirements, but we also run the risk of losing the funding and handicapping future attempts to obtain 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?

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

Report #1:

1. Title of Report or Program Evaluation:
   Extreme Heat in Louisiana: Staying Protected

2. Date completed:
   Published: 05/03/2022

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

   The Environmental Public Health Tracking Program (‘Tracking’) is required to generate projects in their Annual Work Plans which support one or more core activities of the CDC National Tracking Program. Additionally, projects are

developed to align and support the strategic priorities of the Health Agency.

As part of the Work Plan focus area of Data/Science, Project 6: Expansion of Community Health and Environmental Modules to Better Respond to Community Concerns:

- Activity 3. Tracking Data will be applied, evaluated and interpreted to inform the development and evaluation of public health actions.
- Activity 4: Tracking staff will generate short, informative and community-interest topic reports written in plain language, in new presentation format. Topic reports will be reviewed, published to the project website, and shared with the public as part of a communication strategy.

As part of the Work Plan focus area of Data/Science, Project 9: Creating Climate Change Products that Inform the Program:

- Activity 1. Staff will a. complete an update to existing Climate Change reporting to inform the program, and b. update the climate content on the website, including a review from the State Climatologist

Previous project work under this Cooperative Agreement, including partnerships have increasingly implicated heat and heat illness as priority health datasets which should be provided to the public and available internally for analysis.

- LDH Tracking partnered with the State Climatologist and SEET Occupational Health and Indoor Air Programs to analyze heat illness and extreme heat in November 2019 as part of the Louisiana Morbidity Report
- SEET has been collaborating for several years with internal and external partners to raise awareness about extreme heat and heat-related illnesses and to promote heat safety to Louisiana's residents. Products have included heat safety messages and participation in a heat awareness campaign
- Heat Illness data are required to be submitted to the CDC annually and to be published and shared on the state data explorer with information and metadata.

4. Methodology used for analysis or evaluation

- SEET Staff were provided Data Visualization training which assisted in the translation of science through maps, graphs and charts in promotions and publications.
- Staff provided literature review of federal, state and other sources, provided descriptive statistical analyses, summarized current parish and state data, summarized available data and images from the previous LMR, 2019, met with scientists and partners, and generated maps utilizing Geographic Information Systems (GIS) for the promotional material
- Staff partnered with the Occupational Health, IAQ Program and State Climatologist to analyze and summarize data, including temperature data, air quality and worker hospitalizations and emergency department visits.
- A Technical Advisory Group provided feedback on the contents and format of the initial template document, which is used in future Topic Summaries

- Graphic design, images and content review was provided by the Bureau of Media and Communications staff

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

Cooperative Agreement funding from the CDC
Data Visualization Training: $16,000

6. Major Findings and Conclusions

- Males Aged 20-44 and 45-64 were the most frequent visitors to the Emergency Room (2010-2018) in Louisiana
- Wetlands and naturally occurring bodies of water in South Louisiana actively regulate outdoor temperatures as they absorb heat through evaporation. This process of evaporation leads to high humidity and trends of high heat indexes, but lower actual temperatures during periods of extreme heat in South Louisiana.
- North Louisiana experiences high heat indexes coupled with an equally high temperature. Unlike South Louisiana, it is not equipped with the same naturally occurring, insulating bodies of water. This results in a higher average monthly maximum temperature and far more days where the maximum temperature is greater than 95°F or even 100°F.
- Identified vulnerable populations
- Provided Prevention Tips

7. Major Recommendations
Heat-Illness Prevention Strategies were shared.

8.Action taken in response to the report or evaluation

Extreme Heat Awareness was promoted by LDH through Social Media on Meta and Twitter during Tracking Awareness Week in July 2022.

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

Electronic file, website: Environmental Public Health Tracking > Resources > Reports: https://ldh.la.gov/assets/oph/Center-EH/envepi/LDH_Tracking_Heat.pdf

10. Contact person for more information:

Name: Alexis Williams
Title: Environmental Health Scientist Coordinator
Agency & Program: Louisiana Department of Health, Office of Public Health, Section of Environmental Epidemiology & Toxicology-Tracking Program
Telephone: (504) 568-2898

E-mail: Alexis.Williams3@la.gov

Report #2:

1. Title of Report or Program Evaluation:
   Performance Management Collection Tool (PCMT). Reporting Period 2/1/2021-1/31/2022.

2. Date completed
   Submitted: April 26, 2022

3. Subject or purpose and reason for initiation of the analysis or evaluation
   To report to the CDC Tracking Program on annual performance measures for program evaluation.

4. Methodology used for analysis or evaluation
   Internal reporting to include performance and evaluation reporting for 29 required core and advanced project activities. A Performance Measures Worksheet aligns with the Focus Areas of the Cooperative Agreement. These include Science and Content Performance Measures, Technology and Informatics, Communications and Program Services. The Program reported data sources, quantitative and qualitative measures, including counts and lists with accompanying descriptions of deliverables met over the previous project year.

5. Cost (allocation of in-house resources or purchase price)
   100% federally funded, with in-kind resources (Program Manager and Section Chief are state funded provide contributions to the report and review).

6. Major Findings and Conclusions
   Louisiana's Tracking Program continues to successfully meet the requirements of the Louisiana OPH-US CDC Cooperative Agreement, which includes demonstrating program success at achieving 29 Core and Advanced Activities (2/10) each year. These activities are outlined in the Program Work Plan. The application included cumulative year activities and findings.

7. Major Recommendations
   Not applicable

8. Action taken in response to the report or evaluation
   Not applicable

9. Availability (hard copy, electronic file, website)
   Hard copy/e-file, internal

10. Contact person for more information, including
    Name: Kathleen Aubin

Title: Program Manager
Agency & Program: Environmental Public Health Tracking Program
Telephone: 504-568-8144
E-mail: Kathleen.aubin@la.gov

Report #3:

1. Title of Report or Program Evaluation
   Anti-Hunger Summit Recommendations Report
2. Date completed
   May 22, 2022
3. Subject or purpose and reason for initiation of the analysis or evaluation
   Senate Resolution 77 (SR 77) called on the Louisiana Department of Health (LDH) to convene a Summit and develop a recommendations report to address the increase of hunger across the state of Louisiana by sharing information, expertise and resources to better coordinate public, private, and charitable sector efforts to abate hunger across the state. The Bureau of Nutrition Services (BONS) in the Office of Public Health (OPH) took the lead on the Summit and report with assistance from Feeding Louisiana.
4. Methodology used for analysis or evaluation
   The Summit was held virtually on Thursday, December 2, 2021, from 9 a.m. to 4 p.m. The Summit consisted of 12 sessions, with six of them being concurrent (where attendees could attend two of six sessions). The breakout/concurrent sessions included topics such as the challenges of rural hunger, the role of food banks in food insecurity, health disparities in hunger, emergency feeding, and how to reach vulnerable populations. Approximately 125 attendees, representing a variety of organizations in the public, private and charitable sector, participated in the virtual event. BONS and Feeding Louisiana staff noted a high level of engagement among participants and presenters. The final session of the day was an interactive session where attendees directly submitted policy ideas, action item recommendations, and any other relevant suggestions. This allowed for BONS Summit facilitators to capture all submitted ideas and ensure that they were included in the recommendation report.
5. Cost (allocation of in-house resources or purchase price)
   There was no cost associated with the summit or the recommendations report other than LDH/OPH staff time and effort.
6. Major Findings and Conclusions
   According to Feeding America's State of Senior Hunger in 2019, Louisiana ranks in the top five states for having the highest senior food insecurity at 9.9%, significantly rising to 18.1% for seniors who are marginally food insecure. The New Orleans-Metairie area had the highest rate of senior food insecurity of any large metro area (>1,000,000 persons) in the entire country where 20.6% of the population qualify as being marginally food insecure, low food insecure or very low food insecure. At the other end of the life cycle, the Agenda for Children estimated that in 2020, 24% of children in Louisiana lived in poverty. Louisiana consistently has the second highest rate of childhood hunger. In 2020, Save the Children ranked Louisiana poorly when compared to the remaining 49 states and the District of Columbia based on the

childhood poverty level, child hunger rates, teenage pregnancy, and child death due to homicide and suicide. In addition to public health programs and federal feeding programs, food banks have long played a vital and established role in reducing hunger in Louisiana. This critical role was instantaneously highlighted beginning in March 2020, when the impact of the COVID-19 pandemic created an incredible increase in food insecurity across Louisiana, as well as new challenges to distributing food in an efficient and safe manner. Additionally, natural disasters compound the already high rates of hunger in Louisiana. Based on historical weather trends, the state of Louisiana is amongst the top states frequently affected by natural disasters.

7. Major Recommendations
   The final recommendations to reduce hunger in Louisiana are summarized in the report and include:
   i. Creating a statewide coalition to address reducing hunger in Louisiana;
   ii. Synchronizing federal programs to make program enrollment and retention less burdensome;
   iii. Increasing access to universal breakfast and lunch for all Louisiana school children;
   iv. Encouraging state agencies to work together to utilize a single point of entry application process; and,
   v. Addressing the root causes of hunger in Louisiana by focusing on reducing health and hunger disparities and implementing long-term solutions.
8. Action taken in response to the report or evaluation
   The statewide coalition is under development. OPH meets at least quarterly with the Department of Child and Family Services (DCFS) and the Department of Education (DOE) to share resources and develop plans for program collaboration.
9. Availability (hard copy, electronic file, website)
   Available via electronic file by request.
10. Contact person for more information:
    Name: Jennifer Nicklas, MS-MPH, RDN, LDN
    Title: Director
    Agency & Program: Louisiana Department of Health, Bureau of Nutrition Services
    Telephone: 225-342-7988
    E-mail: Jennifer.Nicklas@la.gov

Report #4:

1. **Title of Report or Program Evaluation**
   Louisiana Commission for the Deaf Governance Training Report

2. **Date completed**
   January 4, 2022

3. **Subject or purpose and reason for initiation of the analysis or evaluation**
   From July 1, 2021 through December 31, 2021, Innivee Strategies, Inc. provided consulting services for the Louisiana Commission for the Deaf (LCD) with the intention

of improving the commission's understanding of the board structures, roles, and governance responsibilities and mechanisms through which to improve governance. This project was built off of the strategic planning consultation provided to LCD by Innivee Strategies from December 1, 2020 to June 30, 2021.

4. **Methodology used for analysis or evaluation**
LCD's governance training was a multi-phase process over the period of six months. This process began immediately after Innivee Strategies and LCD completed the organization's strategic planning process on July 1, 2021. A total of six workshops were conducted with LCD board and staff, along with regular weekly check-ins with LCD staff. An anonymous culture survey was provided to all board members and data was collected and provided in a comprehensive survey result report.

5. **Cost (allocation of in-house resources or purchase price)**
Total cost for consulting services- $17,500

6. **Major Findings and Conclusions**
Commendations:
    1) LCD has an impressive range of professionals and individual experiences on the board
    2) LCD has committed and competent staff members
    3) LCD demonstrates collective investment in the organization's success
    4) LCD shared general consensus on valued leadership qualities

    Areas for Development
    1) Board-level strategic alignment has yet to be fully integrated
    2) Significant uncertainty and disparities pertaining to board members understanding of roles, expectations and recommendations
    3) Uncertainty of leadership structure between board, staff, and other state government departments
    4) Formalized leadership development plan or mechanism for cultivating and recruiting future board and/or staff has yet to be established
    5) No formal organizational culture defined nor goals for fostering
    6) Process for decision-making (when and how board should participate) is not clearly defined
    7) No formal established system in which the board can evaluate the Director

7. **Major Recommendations**

    1) To improve the commission's board-level strategic alignment, LCD is encouraged to:
        - Hold an orientation for all existing commission board members and all future incoming members to review the role, expectations (once defined), and share examples of the types of strategic insights they should be offering.
        - Establish a schedule and system to regularly review LCD's strategic priorities as a board and with staff leadership.

- Similarly, regularly review and discuss LCD's mission, vision, and values to ensure the organization is adhering to them, and if it is still relevant. Commission board members should know the mission, vision, and values by heart.

2) To improve the commission board members' understanding of their roles and responsibilities, LCD is encouraged to:
    - Hold an orientation for all existing commission board members and all future incoming members to review the role, expectations (once defined), the commission board's responsibilities as a governing board, and all issues raised below. Regularly provide this orientation to the commission board thereafter, at least annually.
    - Clarify and explicitly define what is considered acceptable "advocacy" as a Commissioner and as a private citizen who happens to be a commissioner.
    - Determine how much of a role the commission board and/or staff will play in the Legislative process; from there, detail what commission board members can and cannot do within the legislative process. Encourage staff to consider adding Legislative awareness training as part of their efforts to fulfill the "community engagement" strategic priority.
    - Produce a "job description" or similar document which summarizes the Commission board's expectations, roles, and responsibilities; have each member sign the document at the beginning of each calendar year.
3) To formalize leadership structure, LCD is encouraged to:
    - Establish and formalize a direct relationship between the commission board and BFH; modify the expectation that the (Interim) Director liaises between each.
    - Determine when the commission board will engage BFH and vice versa, especially in regards to staff oversight and evaluation, but also in relation to the Legislative process, decision-making, program/service oversight, et cetera.
    - Strategically assess how LCD could benefit from other government departments/bodies, specifically in regards to the furtherance of its strategic priorities, and work with staff members to determine the appropriate course(s) of action in establishing/strengthening those relationships.
4) To cultivate leadership, LCD is encouraged to:
    - After defining the role, ask each board member to identify 2-3 individuals who fit the expectations the organization has set for its board members, then have these Board members cultivate relationships with each and gauge their level of interest in serving on the commission in the future.
    - Put leadership development on meeting agendas, and consider establishing a dedicated subcommittee to champion leadership development efforts.
    - Formulate a leadership development strategy that articulates how the Commission board will sustain its efforts to identify prospective board

members, provide leadership opportunities to those individuals (such as through sub-committees, volunteer roles, etc.), as well as providing leadership opportunities to the community at large (possibly through staff instead of board), actively recruit commission board members, and take a larger role in advising the governor on his selection and approval of appointed members. Examples of leadership development activities are listed on Slide 5 of the document,"2021.11.05 LCD Governance Workshop #3."

5) To define and support organization culture, LCD is encouraged to consider:
    - Culture blossoms when people come together. Create opportunities for the Board, staff, and community to get to know each other. In addition to building rapport between groups, this will give the board and staff an opportunity to promote and explain LCD's new mission, vision, values, and strategic priorities. By having more direct access to constituents and a better understanding of what staff members face daily, commission board members will be able to make more fully-informed decisions
    - Make it a habit to acknowledge and celebrate collective and individual contributions, for instance, by setting aside a few minutes at each meeting to acknowledge someone or an email to the board from the chair to congratulate someone on a life occasion.
    - Maintain a habit of self-evaluation in order to ensure that everyone feels engaged in the organization.
    - Establish positive reinforcement mechanisms that encourage commission members to uphold desired culture as part of the board's collective commitment to creating change; determine how the organization will handle situations where the desired culture is not upheld.
    - Communicate frequently and openly. Establish an expectation of regular communications between different groups and stick to it.

6) To better define the board's decision-making process and authority, LCD is encouraged to:
    - Clarify what merits a discussion, dissemination, or a decision: not everything requires a vote.
    - Establish a governance committee to review the biggest disruptors or drags on progress.
    - Explore alternative voting mechanisms. Robert's Rules of Order, while commonly used at the organizational level, requires specific sequential protocols to participate, and thus is not inclusive to most who are unfamiliar with the process, including the Deaf and hard of hearing community that LCD serves. Such alternatives include consent-based decision-making1, Martha's Rules of Order2, and many more that can be found online and in books.
7) In order to define and evaluate the director of LCD (Interim or otherwise), LCD is encouraged to:

- Establish an understanding of how the commission board will partake in the executive evaluation process and how their input will be incorporated into BFH's evaluations.
- Develop a refreshed (Interim) Director job description. Work with the current (Interim) Director to evaluate their performance and skills and provide additional support (e.g. professional development, funding for a new hire, reallocation of time spent) to ensure the organization as a whole has what it needs to be successful

8. Action taken in response to the report or evaluation

1) Commission's board-level strategic alignment
   - Orientation established and reviewed with all existing commission board members on January 27, 2022
   - Orientation established and conducted on all incoming members to review the role, expectations, and share examples of the types of strategic insights they should be offering.
   - Director report process to include regular review of LCD's strategic priorities, action steps and progress at LCD's quarterly public meetings
   - Organization's mission, vision and values added to LCD website and publicized via listserv and social media; Mission recited by board at beginning of each public meeting
2) Board members' understanding of their roles and responsibilities
   - LCD successfully implemented revisions to statute RS 46:2351-2356 which was proposed as SB98 by Senator Sharon Hewitt and is now Act 128 of the 2022 Regular Legislative Session. Revisions included current board make up, expectations, and clarity for LCD's overall purpose.
   - Additional definitions and descriptions for board expectations are under draft and shall be included in LCD's Administrative Code (Title 67) via rule-making- expected date Spring of 2023
   - Orientation established and conducted with current board members; established process for incoming board orientation
   - In progress- better define acceptable "advocacy" a commissioner and as a private citizen who happens to be a commissioner in LCD Admin Code- expected publication, Spring 2023
   - Established one-pager of board member's role, responsibilities, and expectations.
   - Established LCD board "page" on website to include meeting information, board pictures and bios, and roles and responsibilities one pager https://ldh.la.gov/page/LCDBoard
3) To formalize leadership structure
   - LCD is currently under contract with Innivee Strategies (July-Oct 2022) to conduct a formal "Organizational Assessment" of the current and potential future structure of the LCD organization.
4) To cultivate leadership
   - LCD plans to contract with Innivee Strategies for 2023 to provide a year-long Leadership Development cohort (up to 12 individuals) to support and

cultivate upcoming leaders within the Deaf, DeafBlind and hard of hearing communities.
- LCD is seeking trainings and workshop opportunities, along with internal program position opportunities (such as internships or other methods) for supporting leadership.

5) To define and support organization culture
   - LCD staff began providing snacks for LCD commissioners and encourages them to arrive early and meet in green room for casual conversation prior to meeting and during breaks
   - LCD staff has committed to regular communications via email to all board members informing/celebrating individuals with permission
   - LCD created an exit interview for all LCD board members facilitated by the LCD (Interim) Director, to collect information on board member's experience and provide recommendations, along with the board chair, on how to improve (and celebrate what is being done well)
6) To better define the board's decision-making process and authority
   - Current board discussions are being had on implementing clear agenda goals outlining business items as a discussion, dissemination, or a decision. To be managed by Chairperson
   - Current considerations for supporting an expert on Robert's Rule of Order (parliamentarian) on board
7) To define and evaluate the director of LCD
   - LCD is currently under contract with Innivee Strategies (July-Oct 2022) to conduct a formal "Organizational Assessment" of the current and potential future structure of the LCD organization, to include the Ex Director position and future evaluation processes.

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

10. Contact person for more information
Name: Amy Zapata
Title: Director
Agency & Program: Office of Public Health/Bureau of Family Health
Telephone: 504-568-3506
E-mail: amy.zapata@la.gov

Name: Jana Broussard
Title: Interim Director
Agency & Program: Office of Public Health/Bureau of Family Health/ La Commission for the Deaf
Telephone: 225-219-1668
E-mail: jana.broussard@la.gov

Report #5:

1. **Title of Report or Program Evaluation:**
   RFA-PS21-2103 Integrated Viral Hepatitis Surveillance and Prevention Funding for Health Departments

2. **Date completed:** March 31st 2022

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
   Annual progress report required by federal funding agency and notice of award.

4. **Methodology used for analysis or evaluation:**
   The STD/HIV/Hepatitis Program is fortunate to have a longstanding Research and Evaluation Unit that works across all units and is available to assist in evaluating all interventions and funded program efforts including hepatitis elimination strategies outlined in RFA 21-2103. Hepatitis evaluation efforts are described in their SHHP-Wide Evaluation Plan. This tool is designed to act as a comprehensive reference for internal monitoring, evaluation, and research related to SHHP interventions, programs, and projects, consolidate and describe monitoring and evaluation activities, as well as function as tool for supervisors and managers to monitor program performance and anticipate grant reporting deadlines. Additional required and optional evaluation projects and studies are outlined in the Louisiana HCV Evaluation and Performance Monitoring Plan submitted as a CDC grant requirement. HCV surveillance and treatment data were used to compute all indicators and performance measures and assess progress towards all grant objectives and goals.

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:**
   The major findings of this report showed that the activities conducted by the STD/HIV/Hepatitis Program under this award:

   - Increased HCV testing and detection of current infection at settings that service populations at high risk for HCV in Louisiana;
   - Increased number of settings that participate in the implementation of interventions to increase HCV testing and detection in Louisiana;
   - Increased ability to link newly diagnosed patients with HCV to appropriate medical care and treatment through workforce development for hepatitis care coordinators in Louisiana; and
   - Increased monitoring of effective policies implemented to maximize report of HCV testing in Louisiana. In addition, the report documents the successful completion of all program objectives and meeting or exceeding all proposed target indicators and performance measures.

7. **Major Recommendations:**
   Due to the fact that this report was only recently submitted, no major revisions or

recommendations have been returned by funder.

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

9. **Availability (hard copy, electronic file, website):**
   Electronic file available on request

10. **Contact person for more information:**
    Name: Samuel Burgess, Director, STD/HIV/Hepatitis Program and
    DeAnn Gruber, Director, Bureau of Infectious Diseases
    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 and deann.gruber@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department:	**Louisiana Department of Health (LDH)** 09-330 Office of Behavioral Health
Department Head:	**Dr. Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Assistant Secretary:	**Karen Stubbs, J.D.**

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: COVID-19 Emergency Response for Suicide Prevention

A. **What was achieved?**

Louisiana Department of Health, Office of Behavioral Health (OBH) continued collaboration with our partner, Louisiana Mental Health Association (LAMHA) to provide the Fisher Project statewide. The original Project Period was 7/31/20 – 11/30/21. A No Cost Extension was granted (11/3/2021) which the extended through May 30, 2022. Through the continuation of this partnership, LAMHA established a case management intervention model utilizing Peer Support Specialists (PSSs) and has two Peer Support Specialists employed with the Fisher Project. The case managers' supervision is being provided by a Licensed Mental Health Professional. The case management includes the following elements: suicide screening, assessment, safety planning and lethal means restriction, discharge planning, transition care, and warm hand offs to treatment or community organizations as needed, and information sharing. Contact and communication with the participant proceeds for 6 months following the initial intake.

During this Fiscal Year 2021-2022 the Fisher Project in collaboration with Southeastern Louisiana University, Discovery/Renew Family Resource Projects enrolled 111 participants. Overall, during the grant period of July 1, 2020 through May

30, 2022, the COVID-19 Emergency Response for Suicide Prevention Grant enrolled 168 individuals into their case management program which exceeded the targeted goal of serving 160 participants.

In collaboration with the Tulane Parenting Education Program (T-PEP) Family Resource Center and the Louisiana Coalition against Domestic Violence (LCADV), Discovery Renew developed a 26-week curriculum to provide support to domestic violence survivors. Discovery Renew conducted three weekly groups with domestic violence survivors. One group was conducted on site at the Capital Area Family Justice Center (CAFJC). CAFJC is a multi-disciplinary team that works together in a centralized location to provide coordinated services to victims of domestic violence. Discovery Renew also provided individual therapy, group therapy and connections to community recovery supports. During the grant period of July 1, 2020 through May 30, 2022, Discovery/Renew enrolled a total of 72 individuals into their case management program. Individuals that were identified as at risk for suicide were referred to LAMHA to participate in the 6-month Case Management program (Fisher Project). The following services were provided by Discover/Renew:

1. Therapeutic Services include: Individual and Group Counseling
2. Case Management includes: Crisis Intervention, Risk Assessment, Safety Planning, Needs Assessment, Advocacy, Psycho-Educational Information
3. Collaboration and Referrals include: Shelters, Law Enforcement Agencies, Substance Abuse, Mental Health, Hospitals, Victims Assistance Coordinators, other domestic violence agencies.
4. Discovery/Renew provided additional support to clients by connecting them to suicide prevention resources, safety planning, trauma treatment providers, housing assistance and working closely with DCFS to aid in addressing additional basic need
5. Discovery/Renew modified the services and curriculum for clients with cognitive delay to meet their needs.

The Louisiana Department of Health, Office of Behavioral Health (OBH), will continue to partner with the Louisiana Mental Health Association (LAMHA) to support the Fisher Project statewide. The goal is to sustain the COVID-19 ERSP program/Fisher Project and continue to expand the services to support our communities in reducing suicides and suicide attempts.

LAMHA in collaboration National Suicidology Training Center (NSTC) and American Foundation for Suicide Prevention (AFSP) provided training to 820 individuals, including mental health providers, clinicians, first responders, military service members, veterans and their families (SMVF) and university personnel.

The National Suicide Training Center (NSTC) provided a 6-hour training program in suicide prevention and postvention strategies.

The American Foundation for Suicide Prevention (AFSP), Louisiana Chapter provided

ASIST, safe TALK, and Talk Saves Lives trainings.

LAMHA's contract with NSTC and AFSP officially ended November 30, 2021; however, NSTC and AFSP continued collaborations with LAMHA and OBH to support suicide prevention initiatives.

B. **Why is this success significant?**
The program supported the state/communities during the COVID-19 pandemic in advancing efforts to prevent suicide, suicide attempts and provide support to domestic violence survivors. The program utilized Peer Support Specialists to provide case management, follow-up and transitional care to individuals receiving the case management intervention. Peer Support is an evidenced-based practice for individuals with mental health conditions or challenges. Peer support improves quality of life, increases and improves engagement with services and increases whole health and self-management. Providing statewide suicide prevention, intervention and postvention trainings increased the awareness of suicide and warning signs of someone who may be experiencing a mental health crisis and connecting them to services. The program provided support for individuals at risk for suicide and domestic violence survivors due to high rates of suicides and domestic violence incidents.

C. **Who benefits and how?**
Individuals ages 25 and older who have attempted suicide or experienced a suicide crisis will benefit from the program. The continued partnership with LAMHA will expand services to include individuals ages 18 and older. LAMHA employed 2 case managers utilizing Peer Support Specialists with supervision provided by a Licensed Mental Health Professional. The case manager interaction includes the following elements: screening, assessment, safety planning and means restriction, discharge planning, transition care, warm hand off to treatment or community organizations as needed, information sharing and caring contacts.

D. **How was the accomplishment achieved?**
OBH was awarded the SAMHSA grant for COVID-19 Emergency Response for Suicide Prevention authorized under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Protocols were developed based on best practices in suicide care to provide rapid follow-up and care transitions.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
- Yes, this accomplishment contributes to the agency's strategic plan:
  Contributing to the strategic plan to expand the use of peers to keep individuals at risk for suicide connected and engaged over a continuum of care.
- Providing education and increased awareness of the risks and warning signs of an individual experiencing a mental health or suicide crisis and how to support someone after a suicide loss by offering statewide suicide prevention, intervention, and postvention trainings.

F. **Does this accomplishment or its methodology represent a Best Manag**ement Practice that should be shared with other executive branch departments or agencies?
No.

Accomplishment #2: Zero Suicide:

A. **What was achieved?**
LDH/OBH provides leadership to decrease suicide deaths and suicide attempts of adults aged 25 or older within behavioral healthcare systems through the following objectives:

- LDH/OBH has continued to collaborate with 4 (four) designated Local Governing Entities (LGE) and 2 (two) state psychiatric hospitals to implement a Zero Suicide framework into their behavioral healthcare systems. The Zero Suicide framework is defined as a way to improve suicide care within health and behavioral health systems through the following 7 components: leadership development, healthcare workforce training, identification of suicide risk factors, patient engagement, and access to treatment, health system transition, and health system quality improvement.
- Representatives from the 4 LGEs and 2 state psychiatric hospitals attended the Zero Suicide Workshop on June 6th 2022 and June 7th 2022. During the workshop, attendees were introduced to the Zero Suicide framework and engaged in presentations and discussions that offered resources for beginning implementation and ways to overcome barriers. Additionally, attendees learned how to incorporate best practices into their organizations and processes to improve care and safety for individuals at risk. The next step of the implementation process is to attend the Zero Suicide 2-day academy which is tentatively scheduled for September 2022. During the 2-day academy, attendees will learn about the Zero Suicide framework and seven elements, begin strategic implementation planning, and prepare for commonly faced challenges.
- Another element is completing the Organizational Self Study which is to assess what components of the comprehensive Zero Suicide approach are currently in place and the degree to which the components are embedded within key clinical areas. The Organizational Self-Study also helps to assess organizational and clinical area-specific strengths and opportunities for development across each component. The providers are currently working on completing their Organizational Self Study and will submit to OBH by September 2nd, 2022.
- The goal of the Train component of the Zero Suicide framework is to train a competent, confident, and caring workforce. During FY21 (July 1, 2021-June 30th, 2022), the Zero Suicide Providers trained a total of 235 employees in evidenced based practices such as ASIST, Safe TALK, Dialectical Behavior Therapy, Suicide Safety Planning, First Aid for Clinicians, Crisis Intervention, Mental Health First Aid, and Suicide Screening for Direct Care.

B. **Why is this success significant?**
Zero Suicide is a transformation Framework for health and behavioral health care systems. The foundational belief of Zero Suicide is that suicide deaths are preventable for individuals under the care of health and behavioral health systems. By addressing all elements of the Zero Suicide Framework, health care providers will transform their health system to one that is ready to identify, treat, refer, and ensure continuity of care for individuals at risk for suicide and suicidal behaviors. Organizations that have used this approach found a 60-80% reduction in suicide rates among those in care.

C. **Who benefits and how?**
The program implements suicide prevention and intervention programs for individuals who are 25 years of age or older. The program is designed to raise awareness of suicide, establish referral processes and improve care and outcomes for such individuals who are at risk for suicide. Through this transformation, the involved behavioral healthcare systems will benefit greatly from implementing the framework and ultimately, the individuals served through the behavioral health systems will benefit from the safer suicide care.

D. **How was the accomplishment achieved?**
The aforementioned accomplishments were achieved through collaboration and partnership with the Educational Development Center and Louisiana Center for Prevention Resources in planning for the Zero Suicide workshop and 2-day academy.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.**)
Yes. The goal of the state suicide prevention plan is to reduce the incidence of suicide in Louisiana through system-level implementation of strategies in criminal justice and health systems throughout Louisiana, including behavioral health systems. Office of Behavioral Health (OBH) is tasked to establish the Zero Suicide initiative statewide to bring awareness to suicides, and enhance awareness by creating and administering focus on zero suicide.

F. **Does this accomplishment or its methodology represent a Best Managem**ent Practice that should be shared with other executive branch departments or agencies?
Yes. The Zero Suicide model is a key concept within the 2012 National Strategy for Suicide Prevention (NSSP), a priority of the National Action Alliance for Suicide Prevention.

Accomplishment #3: 988 Implementation:

A. **What was achieved?**
The 988 Implementation Planning Grant allowed LDH/OBH to plan for the implementation of a new nationwide three-digit number for mental health crisis and suicide response (988). The goal of the plan was to develop and address key coordination, funding, capacity, operational and other key considerations which were

necessary to implement 988 by July 16, 2022. The plan focused on a long-term plan to improve in-state answer rates for Lifeline calls, texts and chats. The 988 Implementation plan allowed for the planning of LDH/OBH to establish a robust call system in which two (2) certified Lifeline call centers serve as back-up to each other to increase the in-state answer rate for Lifeline calls, texts and chats. With the 988 Implementation Planning grant support, OBH identified stakeholders and developed workgroups to evaluate the needs of the current system and demand for 988-related services, create a roadmap to fill any system/community gaps, and build a crisis response system to deliver focused crisis resources for those in need. OBH conducted a landscape analysis of the 2 certified Lifeline call centers in Louisiana and it was determined that the crisis centers required more funding and resources in order to continue operating and growing. Through the 988 Implementation Grant, OBH developed a statewide routing structure that was approved by Vibrant and SAMHSA. OBH also developed a 988 Coalition which has since transitioned to a Crisis Coalition. The Crisis Coalition will continue to work to integrate 988 with the broader Crisis Care Continuum Response System.

In May 2022, OBH was awarded a 988 State and Territory Cooperative Agreement to build local 988 Capacity. The grant is funded through SAMHSA and the grant period is April 30, 2022 through April 29, 2024. The Louisiana 988 Cooperative Agreement focuses on the following areas: 1) recruiting, hiring and training behavioral health workforce to staff local 988/Lifeline centers to respond, intervene, and provide follow-up to individuals experiencing a behavioral health crisis; expanding the crisis center staffing and response structure needed for the successful implementation of 988.

Through funding from the MHBG and newly awarded 988 SAMHSA grant, the Office of Behavioral Health (OBH) has developed Cooperative Endeavor Agreements (CEAs) with VIA LINK and LACG to answer calls for the Lifeline. OBH intends to improve in-state answer rates by providing MHBG funds and 988 SAMHSA funds to the crisis contact centers to build infrastructure and capacity to respond to Lifeline calls statewide. Funds allow Louisiana to have statewide geographic primary and back-up coverage which will increase the number of calls answered in-state. The goal is to increase the number of calls answered by local crisis centers that are familiar with the culture and resources in Louisiana to best address the needs of the caller. Funding also allows the crisis contact centers to recruit, hire and train new and existing staff.

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

On July16, 2022, 988 became the national three-digit code for the Lifeline, replacing the current phone number of 1-800-273-TALK (8255). The 988 Implementation Planning Grant allowed for the development of clear roadmaps for how LDH/OBH would address key coordination, capacity, funding and communication strategies that were foundational to the transition to 988. With an easy to remember and dial number like 988, the Lifeline hopes to reach many more people in emotional crisis. 988 represents a long past due opportunity to shift from a law enforcement and justice system response to one of immediately connecting to care for individuals in suicidal, mental health and substance use crises. The number is the first step to make a

fundamental shift in how people in crisis are engaged and connected to services in our communities. 988 is an important entry point to a broader Crisis Care Continuum Response System that is being built to connect callers to community-based providers who can deliver a full range of crisis care services (such as mobile crisis and crisis stabilization centers). The transformation of this system means that more individuals with be served by the least restrictive intervention. The newly awarded 988 SAMHSA Cooperative Agreement will continue to build upon the work that was accomplished through the 988 Implementation grant in which a 988 Implementation Plan and routing structure has been established for Louisiana. The 988 SAMHSA grant is providing for the workforce development and sustainability of the crisis contact centers over the next two years.

C. **Who benefits and how?**

The Lifeline is the nation's public safety net for all American residents in emotional distress or suicidal crisis. Specifically, Louisianans will benefit by being served by their local crisis centers. Expanding the call system to include a second certified Lifeline Contact Center will establish a robust call system with two (2) certified Lifeline contact centers serving as back-up to each other, which will increase the number of calls answered in-state. Callers to the National Suicide Prevention Lifeline are better served by their local crisis centers. The plan will also expand the state's capacity to answer text and chat for the Lifeline. Local Lifeline crisis centers reduce the burden on our emergency rooms, police, and emergency responders, as well as our behavioral healthcare providers, who often must step in when emotional crises escalate. The centers also provide a safety net in the absence of other affordable community resources. A 988 Crisis line that is effectively resourced and promoted will be able to:

- Connect a person in a mental health crisis to a trained counselor who can address their immediate needs and help connect them to ongoing care.
- Reduce healthcare spending with more cost-effective early intervention.
- Reduce use of law enforcement, public health, and other safety resources.
- Meet the growing need for crisis intervention at scale.
- Help end stigma toward those seeking or accessing mental healthcare.

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

The 988 Implementation Plan was developed as part of a technical assistance grant that was received from Vibrant Emotional Health, who is the administrator of the National Suicide Prevention Lifeline. The Louisiana 988 Implementation Plan was developed in collaboration with a multi-stakeholder coalition. The 988 Coalition began meeting monthly in May 2021. Membership in the coalition represented a wide range of stakeholders including Lifeline contact center staff, providers, advocates, peers, and representatives from the state 911 administrators. The initial meetings were an opportunity for OBH to present information about the new three-digit number and for the current certified Lifeline centers and the 211 providers to present critical information on how the centers currently operate. Workgroups were developed to focus on drafting and finalizing the Louisiana 988 Implementation Plan.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes. Lifeline centers reduce suicidal and emotional distress in callers. Numerous studies have shown that most Lifeline callers are significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful after speaking to a Lifeline crisis counselor. People in crisis can easily use hotlines to access help when other mental health, substance abuse, and social services have eligibility restrictions, are unavailable in rural areas, are inaccessible during late-night hours, or no longer operate because of budget cuts. The new 3-digit dialing code to reach the Lifeline provides an easy to remember number which makes for easier access to life-saving resources for individuals in crisis. Local crisis centers can resolve approximately 80-90% of crisis contacts without the need of escalating the call to a higher level of response such as an active rescue or dispatch of mobile crisis. Increasing the number of calls answered in-state by local crisis centers helps to connect individuals in crisis to the most appropriate resources and provide a more person-centered, community based response which can defer from higher levels of response such as emergency departments and a criminal justice response.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
No.

Accomplishment #4: Peer Support Specialists (PSS) Expansion

A. **What was achieved?**
During SFY22, an additional 84 peers successfully completed the two-week long Peer Employment Training (PET) to become Recognized Peer Support Specialists (RPSS). Due to the COVID-19 Pandemic, all Peer Trainings continued to be conducted virtually via Zoom. On March 1, 2021, the first phase of Medicaid reimbursement for Peer Support Services as a standalone Medicaid service was initiated. With this initial phase, the local governing entities (LGEs) are the provider type allowed to bill Medicaid for this service in the initial phase. While there has been low initial utilization of the Peer Services as a stand-alone billable service during SFY22, 20% of providers were active in that SFY. The utilization of Peer Services was also expanded by inclusion within the crisis services developed within the Louisiana Crisis Response System.

Another accomplishment for Peer Services in SFY22 was the passage of House Bill 334 of the 2022 Regular Legislative Session to become Act 151, which allows exceptions for Peer Support Specialists working in LDH licensed behavioral healthcare settings with specific criminal offenses listed on criminal background checks. Act 151 is an initial step to alleviating some employment barriers for Peer Support Specialists. HB 334 / Act 151 passed with unanimous bipartisan support from

the House, Senate and Governor. Rep. Royce Duplessis authored the bill, and six (6) additional representatives of Democratic, Republican and Independent parties joined as co-sponsors of the bill. Act 151 allows for exceptions to limited criminal background histories if a minimum of three (3) years has passed since successfully completing the sentence for the criminal offense. The criminal offenses where this exception are allowed include:

- R.S. 14:38.1 – Mingling Harmful Substances
- R.S. 14:67 - Theft
- Distribution or possession with the intent to distribute controlled dangerous substances as listed in Schedules I through V of the Uniform Controlled Dangerous Substance Act

Information obtained from the Peer Stakeholders Workgroup established in 2020 and responses from a Request for Information (RFI) released in September 2020 have provided valuable feedback and information with structuring the Medicaid service definition and phases of implementation for Medicaid reimbursement of Peer Support Services. During SFY22, LDH/OBH continued discussions with national subject matter experts, Peers, partners and other stakeholders to obtain input to guide next steps in the statewide expansion of peer services. LDH/OBH has continued to work closely with national subject matter experts (SMEs) and engage in discussions with several other states to obtain additional feedback regarding how the expansion of peer services has occurred in other areas of the country and to help shape the future of this service in Louisiana. In SFY23, LDH/OBH intends to continue engagement with Peer Stakeholder Workgroups to obtain additional feedback as the next steps with enhancing and expanding Peer Programs and Services are developed and implemented. Regular meetings have been scheduled with the Louisiana Peer Action Advocacy Coalition (LaPAAC) as part of this strategy to increase engagement with the Peer Profession to obtain their feedback. Stakeholder workgroups are also planned for the coming year to continue to obtain feedback from the Peer Support Specialists professionals and other stakeholders as plans for further expansion and enhancement of Peer Support Services are planned.

During SFY22, LDH/OBH also implemented the Peer In-Reach Specialist Team with ten additional Peer Support Specialists positions with the My Choice Louisiana initiative that was developed in response to the Department of Justice (DOJ) agreement. These ten additional positions included a Peer Supervisor and nine (9) regional Peer Support Specialists to support the target population of the DOJ agreement with successfully transitioning from a nursing facility to the community.

While there have been many challenges with the transitions needed during the COVID-19 Pandemic, the transition to virtual trainings has been beneficial to increased participation and allowing flexibility for training participants in comparison to the previous years when all trainings were conducted in-person. Please see data below regarding Peers trained and active in Louisiana. Active Peers refers to those trained Peer Support Specialists who have continued to obtain the minimum of ten

continuing education units annually and submit their annual training reports to LDH/OBH. While less Peers were trained in SFY22 in comparison to SFY21, it continues to represent a growth when compared to previous fiscal years. There were challenges with Training Facilitators during SFY22 that resulted in fewer trainings hosted, which impacted the total number of Peers trained.

- Peers Trained in SFY20 – **67**
- Peers Trained in SFY21 – **112**
- Peers Trained in SFY22 - **84**
- Total Peers Trained to Date - **788**
- Total Active Peers - **275**

Since 2008, LDH/OBH has utilized the Peer Training Curriculum developed by RI International of Arizona. Through an agreement with RI International, selected Peers have been selected and trained as Advanced Facilitators to conduct trainings within Louisiana. During SFY22, LDH/OBH was informed by RI International of their plans to transition to only allowing their staff to conduct the trainings beginning in SFY23. In response to this notification, LDH/OBH consulted with other states and researched other training curricula for Peer Support Specialists to approve another initial training model to utilize for Peers wanting to become trained as Recognized Peer Support Specialists. After consulting with national experts and other states, LDH/OBH selected the Appalachian Consulting Group (ACG) as the entity to work with to assist with developing another peer training that is customized for Louisiana and complies with the SAMHSA Core Competencies of Peer Support and CMS guidelines. Appalachian Consulting Group was highly recommended by national SMEs and other states as having decades of expertise and knowledge in Peer Training. The training curriculum currently used for the OBH contract program, Target Health, is also based on the Whole Health Action Management (WHAM) curriculum developed by ACG; therefore, LDH/OBH had the experience of utilizing one of their training curricula and successful implementation in Louisiana. The ACG training model is scheduled for implementation in SFY23, with the "train the trainer" series scheduled to begin in August 2022. The RI International Peer Employment Training (PET) model will continue to be recognized as an approved training curriculum for Peers in Louisiana, and anyone interested in this training may contact RI International directly to register for their training. The ACG Peer Training model will be coordinated through the LDH/OBH contractor, Extra Mile Region IV.

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

This success is significant for numerous reasons. Peer Support Services are recognized by the federal Substance Abuse Mental Health Services Administration (SAMHSA) as a best practice in the provision of behavioral health services. These additions of Peer Support Services are critical to compliance with Senate Concurrent Resolution 84 (SCR84) of the 2019 Regular Legislative Session, which requested the Louisiana Department of Health take all steps necessary to approve peer support services as a Medicaid covered service. These steps also comply with the federal Department of Justice (DOJ) Agreement, which requires Louisiana to expand PSS to the target

population identified in the Agreement. While many states have recognized that criminal backgrounds are often a barrier to employment for Peers, Louisiana is one of a few states to have successfully passed legislation to address this barrier. Other states that have passed legislation have included Florida, Arkansas, and Georgia. The addition of another approved training curriculum for Peers also expands training options and access to trainings for Peers. During SFY22, the LDH/OBH contractor managing the Peer Trainings, Extra Mile Region IV, began to have a waiting list of Peers applying for the initial Peer Training. With the approval of the training model developed with Appalachian Consulting Group (ACG), this expands access to the required initial training for Peer Support Specialists.

C. **Who benefits and how?**

The expansion of Peer Support Services (PSS) benefits those served through behavioral health programs. Peers can relate to others in a non-clinical, more personal way as they have a similar lived experience. Peers are positive role models and offer hope to others, demonstrating by their own life that recovery is possible. As PSS is recognized by SAMHSA as a best practice, research studies have demonstrated improved engagement and retention of service recipients when PSS are a part of the treatment team.

The transition of the initial Peer Support Specialist training to virtual to comply with COVID-19 safety protocols has continued to demonstrate the benefit of increased participation in the training, as participants are not required to leave their homes and families for a two-week period. The LDH/OBH contractor that manages the Peer Trainings has reported that the most common reason for "no-shows" with the in-person training has historically been the inability to coordinate childcare arrangements for a two-week period. The virtual trainings have allowed for more flexibility with supporting Peers to obtain the training necessary to become an approved Peer Support Specialist. The transition from in-person to virtual trainings has also reduced the costs for the training and will allow LDH/OBH to increase the number of trainings offered. The goal was to provide a minimum of nine trainings in SFY22, which would have allowed LDH/OBH to train a minimum of 110 Peers. This goal fell short, with seven (7) trainings provided in SFY22 due to the loss of many trainers, which resulted in 84 Peers trained. In SFY23, in partnership with the contractor, The Extra Mile Region IV, LDH/OBH intends to implement the additional training curriculum and conduct a "train the trainer" for this added model, which will expand the training opportunities in Louisiana for Peers.

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

These accomplishments were achieved through collaborative efforts with leadership, the Governor's Office, legislators, partners, stakeholders and contractors. Support from community partners, stakeholders, legislature and LGEs led to the passage of HB334 (2022 Regular Legislative Session), which will help to alleviate some employment barriers for Peer Support Specialists. During SFY22, LDH/OBH also continued to work closely with national subject matter experts on a strategic plan for further development of Peer Programs and the Peer Profession in Louisiana. National subject matter expert in the field of Peer Services, Dr. Peggy Swarbrick, has continued to assist Louisiana

with further development of training curricula and growth of Peer Programs and Services.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, this accomplishment contributes of the agency's strategic plan by:
- Contributing to the plan to expand Peer Support Services;
- Complying with the DOJ Agreement;
- Complying with legislation;
- Act 151 (2022) has helped to remove some employment barriers for Peer Support Specialists;
- Expanded access to Peer Support Services for those who would benefit from the service within the behavioral health services network;
- Expansion of the trainings available to Peers who are interested in becoming Recognized Peer Support Specialists (RPSS); and
- Further development and implementation of SAMHSA recognized best practices with 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; while the utilization of Peer Support Specialists is primarily associated with behavioral health programs, the use of Peers has also been identified as helpful with many populations and programs, such as Veterans/service Members, individuals with chronic health conditions, parents of children with behavioral health conditions, and child welfare systems.

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

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

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

The Office of Behavioral Health (OBH) is on target. OBH is committed to the efficient and effective use of the state's scarce behavioral health resources to adequately provide for the peace, health, safety, and general welfare of the public. OBH will continue to develop goals, objectives, and priorities for the creation of innovative programs that promote and improve the behavioral health of the citizens of the state and seek to achieve increased access to services and for underserved groups, increased quality of services and better outcomes, cost-effectiveness and efficiency of services and programs, interagency collaboration, and

promotion of emerging best practices and increased quality of care in the delivery of behavioral health services.

There are areas that due to fluctuating trends of the current pandemic have been or may still be affected. The public health emergency and/or weather-related incidents that have occurred impacted particular areas of implementation of some of our initiatives relative to our agency's strategic plans. Nonetheless, we are moving in a forward direction anticipating positive outcomes regarding any impacted initiatives. We have resumed all operations of our office. Our strategies appear to be effective and are rooted in evidence-based techniques and practices.

- **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:

Continually Increasing Access to 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 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.

OBH will continue to lead efforts to increase access to behavioral health services by promoting early identification of behavioral health concerns. Examples of some strategies that OBH is employing are efforts in supporting primary care physicians through behavioral health consultation, as well as increasing access to high-quality evidence-based behavioral therapies for young children. Additional strategies employed to address the increased volume on the behavioral health system with Medicaid Expansion and long term effects of the COVID-19 pandemic will be the integration of Peer Support throughout the system of care. The use of trained, credentialed peers is a critical component to a recovery-oriented system of care and results in improvements in client engagement, treatment outcomes, and recovery. As an enhancement to traditional treatment services, peer support services allow for more effective and targeted interventions resulting in improved care and an increased capacity of the system to serve a broader array of individuals. To increase access to effective behavioral health supports and services, OBH will work with Medicaid, advocates, providers, and Healthy Louisiana managed care partners to implement strategies to retain and increase the behavioral health workforce. Workforce development efforts will include training and support for providers of evidence-based therapies addressing issues emerging in early

childhood, trauma exposure, and other psychiatric and addictive service needs. OBH will lead efforts to provide training and support for providers of peer recovery supports, including mentoring and coaching opportunities. Expanding the workforce of providers of behavioral healthcare may also include further utilization of provider types such as provisionally licensed social workers. Finally, all of the aforementioned will assist the strengthening of the Louisiana Crisis Response System (LA-CRS) that will ensure that the behavioral health system of care is evolving and meeting the needs of the citizens of Louisiana.

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

This progress is expected to continue, and continually evolve to increase access to- and availability of behavioral health services.

- **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:

Progress is continuing. The LDH/DOJ project will continue through 2023. The first phase of implementation ran through December 6, 2018 and Phase Two was released in December 2019 along with a crisis plan, diversion plan, and a housing plan. Annual implementation plans will be updated and released each December moving forward for the duration of the project. Staff are currently implementing critical activities necessary to move the programs forward and outlining activities for future years, 2022 and beyond.

The COVID-19 public health emergency impacted certain initiatives. Specifically, though COVID-19 had impacted the ability of Transition Coordinators to go into Nursing Facilities to transition individuals into the community. We have restarted these activities with the number of transitions occurring increasing steadily. Additionally, OBH has spearheaded the attainment and utilization of technology intended to further improve in-reach activities within nursing facilities, which enable additional transitions into the community. These impacts continue to be felt through SFY22.

While the scope of the project is vast, with multiple moving parts, OBH is working diligently to adhere to timelines within the implementation plans; onboarding and enlisting the assistance of staff and outside consultants to ensure targets are achieved.

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.

OBH is not significantly behind on any individual component related to the implementation of activities associated with the DOJ Agreement. OBH has worked diligently to ensure activities are kept current. As indicated earlier, hiring of additional staff will allow for a more focused and targeted approach to implementation of the various components of the Agreement.

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?

As noted above, the multiple external barriers hopefully a single set of circumstances with the pandemic contributed to the delays in progress of some efforts.

- **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.

OBH continuously reviews the strategic plan and meets regularly to discuss the implementation progress and/or needs.

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 tedious and laborious process of entering into contracts via the Division of Administration protocols has been, and remains to be an obstacle in implementing services and initiatives in a timely and efficient manner. While the OBH obviously recognizes the necessary levels of review, communication and ultimately approval, in discussions internally within the LDH, we recognize that there is a lack of efficiency, operational ease, cohesion and communication amongst the contracting process. Numerous parties are involved in the development, submission, review and approval of a State contract. This has recently been extended with the development of the Office of the Secretary's, Office of Management and Finances' Office of Contracts and Procurement. While the intent is positive, the end result has not resulted in any improvement or efficiency in the contracting processing. OBH's concern is that there is a lack of progress in streamlining the contracting process.

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

The inability of OBH to secure contracts in a timely manner absolutely 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 of the Budget. Interagency Agreements are required between the State (OBH) to simply flow out funds to our Local Governing Entities, 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.

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

All units within OBH have been impacted by the impediments that have resulted from this inefficiency. Administration is faced with prioritizing submission of contracts to the OS/OMF, Legal, Civil Service and the Division of Administration in order to cause the least harm to the recipients in need of behavioral health assistance. While direct care often takes precedence, there are daily requests for prioritization of contracts, amendments, RFIs, RFAs, RFPs and CEAs, based on the most current need and the political environment. This results in our Health Plan Management and most notably our clinical unit, having difficulties in implementing the goals and objectives per the grants and initiatives supported and developed 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 services needed by the citizens of Louisiana in need of behavioral healthcare.

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.

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

Inefficient processes; antiquated forms that aren't user friendly or reflective of any technological advances, overly cumbersome routing processes that are duplicative and inefficient. There is a lack of a Department wide tracking process or prioritization methodology, and there is a lack of transparency across each phase of the contracting process.

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

Consequences include inability of staff to ensure completion of the goals and objectives of initiative, grants, programs and or strategic plan assigned tasks and inability of OBH to respond to our goals of initiatives.

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 begun to pursue the use of Monday.com in order to more effectively and transparently allow for the tracking of our contract documents, internally.

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?

      Training will occur throughout FY23. We have implemented a single entry email for all contract related documents as of 7/1/22, and the Monday.com tracking is in a pilot phase of development. We are currently revamping our shared drive to ensure the ease and completeness of the use and availability of contract documents 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 is in place, as is the pilot phase of the tracking system. Our intent is that, within the first quarter of SFY23, the training and newly revamped shared drive resources will be ongoing and/or in place.

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're using existing resources and licenses at this point, in order to achieve our objectives.

☐ 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 c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

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

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive 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, including:
    Name:
    Title:

Agency & Program:
Telephone:
E-mail:

Report #1:

1. Title of Report or Program Evaluation:
   Prevention Management Information System Reporting on Prevention Services (Quarterly and Annual)

2. Date completed:

   July 1, 2021 – June 30, 2022. Data for this report was pulled on July 26, 2022.

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 SAPT 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.

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 2022, Prevention Services provided evidence-based services to 79,988 enrollees.

   In addition, during FY 2022, block grant funded one-time services were provided to the general population and reached 13.1 million participants. This number

reflects the number of individuals that are impacted by PSAs, billboards, and other media campaigns. This number included the combined services provided by Prevention Staff and Prevention Contract Providers.

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

Report #2:

1. Title of Report or Program Evaluation

   Synar Report: Youth Access to Tobacco in Louisiana

2. Date Completed:

   December 21, 2021

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 $62,400.00 ($100.00 per compliance check x 624 checks). The total cost to prepare and complete the Annual Synar Report was $70,000.00.

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 18. 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 2021 is 14.2%.

7. Major Recommendations:

   OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2022 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. Our goal is to continue implementing current strategies since they've proven to be successful.

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

   The FFY 2022 Annual Synar Report is available by hardcopy, and may be

accessed online at http://ldh.la.gov/index.cfm/newsroom/detail/1390

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

Report #3:

1. Title of Report or Program Evaluation:

SAMHSA Block Grant Annual Reporting (SAPT and CMHS)

2. Date completed: In progress

Louisiana's CMHS and SAPT Behavioral Health reports must be submitted to SAMHSA no later than December 1st of each year. Some components of reporting are completed quarterly with an annual review prior December 1. If OBH misses the statutory date for submitting the reports, it will not receive any federal Block Grant funds for that federal fiscal year.

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 SAPT funds were expended, recipients of grant funds, authorized activities funded, and services purchased with such funds. CMHS and SAPT 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 August of each year.

OBH Analytics staff problem solve, plan, and develop methodologies for data report analysis. OBH Analytics staff analyze performance/outcome data and prepare and disseminate monitoring and performance reports/dashboards.

Additionally, they produce standard URS (Uniform Reporting System; Client Level Data Uploads) tables, performance indicators, and reporting tables. In order to complete data based reports, OBH Analytics staff maintain the operation of the OBH Data Warehouse, maintain the OBH Client Level Data Manual, and oversee LGEs' EHR data submissions. LGE data submissions are continuous, and are sent to the OBH Data Warehouse on a semi-monthly basis.

Most components of the December 1 reporting are submitted via SAMHSA's online portal, Web Block Grant Application System (WebBGAS). Other submissions are completed through their respective SAMHSA sponsored online portals.

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 client level data reporting available to the public in PDF format. The Annual Report from SAMHSA's WebBGAS system is distributed via email to the Louisiana Behavioral Health Advisory Council and upon request.

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

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department: **Louisiana Department of Health (LDH)**
09-340 Office for Citizens with Developmental Disabilities

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Asst. Secretary (or Ex. Director): **Julie Foster Hagan**

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

Accomplishment #1: Planning for Home and Community Based Waiver in a Post-Public Health Emergency Environment:

A. **What was achieved?**

During the COVID-19 Public Health Emergency (PHE), the Centers for Medicare and Medicaid Services (CMS) allowed certain exceptions to the regular waiver rules in order to protect the health and safety of participants, their families, and the direct support professionals (DSPs) who care for them. The Office for Citizens with Developmental Disabilities (OCDD) held focus groups with parents and stakeholders to identify their concerns and their anticipated needs after the COVID-19 Pandemic exceptions end. OCDD focused on three particular topics of concern during individual focus group meetings:

- The 16 hour rule, which prohibited direct support professionals (DSP) from working more than 16 hours in a day;
- Family as paid caregivers, to allow family members living in the same home to work as a DSP, and legally responsible relatives to work as a DSP; and
- Utilization of virtual visits in lieu of in person visits.

In response to these focus groups, OCDD adjusted waiver services to address stakeholder concerns including:

- Parents and persons living in the same household will be allowed to provide

services to a family member after the PHE ends with some guardrails put into place;
- Parents will be allowed to provide services for their own child so long as the child's needs are extraordinary compared to a child of that same age;
- Monitored In-Home Caregiving (MIHC) was added to the Residential Options Waiver (ROW);
- Virtual services were added as an option to vocational services;
- DSPs can be shared across waivers;
- The 16 hour rule was eliminated;
- Allowing virtual visits for some of the required support coordination meetings throughout the year.

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

OCDD strives to ensure a system that offers flexible and responsive supports to meet the needs of person's with intellectual or developmental disabilities (IDD). Listening and learning about the needs of participants, families, and those who provide support are important components toward this assurance. Holding these focus groups allowed OCDD to learn about impacts from the PHE, and how these lessons could be used to enhance the network of support post-PHE.

OCDD has submitted waiver amendments to allow family members living in the home to be paid staff beyond the public health emergency when it is in the best interest of the individual and with some guardrails in place, per CMS requirements. While listening to the concerns of participants and their families at the beginning of the public health emergency, we worked on guidance to allow this to continue post-public health emergency. We will further define legally responsible individuals and extraordinary care in our provider manuals.

OCDD allowed telehealth visits by support coordination agencies under the public health emergency. Participants and families were pleased that we addressed their concerns related to support coordinators coming into their homes. Support Coordinators have continued to contact families on a monthly, quarterly and annual basis for planning.

OCDD implemented sharing across waivers to allow flexibilities to families with different waivers to share the same support staff.

OCDD strives to address the needs of participants wanting to access dental services. This approval will allow more individuals to access comprehensive dental coverage through the expansion of services.

OCDD promotes independence for individuals requesting technology supports with remote features. This will broaden an individual's access in their home or community.

C. **Who benefits and how?**

Participants and families benefit because the changes are responsive to their needs and take into account their wishes for their own services. By allowing family as paid caregivers, for example, families have greater flexibility for their loved ones.

Support coordinators and direct service professionals benefit because the flexibilities will help ease, to some extent, workforce crisis by increasing the pool of workers to

include family members. It also allows support coordinators to make some visits virtually, easing the burden of making multiple in-person visits to spread out locations.

OCDD benefitted from the stakeholder feedback because it allowed OCDD to hear and be responsive to the needs of the stakeholders. By being more responsive and listening to stakeholders, OCDD can help improve satisfaction of its participants, and ultimately improve the quality of our services.

Participants will benefit from the approved waiver amendments allowing access to comprehensive dental care for adults 21 years of age and older with developmental or intellectual disabilities who are receiving the Supports Waiver (SW), Residential Options Waiver (ROW), or New Opportunities Waiver (NOW). Comprehensive Medicaid coverage for dental care include coverage for dental and oral health services.

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

OCDD established cross-sectional stakeholder groups which included representatives family members, Home and Community Based Providers, Support Coordination Agencies, Local Governing Entities and stakeholders —making sure that each workgroup had as much varied representation (geographical, stakeholder type) as possible. This allowed OCDD to hear perspectives across all stakeholders, and allowed each stakeholder group the opportunity to learn from and share information across groups. Through this diverse composition, OCDD was able to identify opportunities to strengthen the system of support for persons with IDD.

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

Yes. This accomplishment contributes to the success of the strategic plan in several ways. In listening to stakeholders and being responsive to their needs, OCDD is increasing access to information about services and supports that are available. By making the process collaborative, OCDD ensures that the service delivery system is meeting participants' needs and families' needs to enable people to live in the most integrated settings, and to receive services in a way that focuses on their needs, goals, and desires.

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 practice represents a best practice that other departments or agencies can use. Increasing community engagement and involvement increases satisfaction with the system. Increased community engagement also improves self-determination by allowing people within the community an opportunity to have a say in their services, and to say what is in their own best interests. Additionally increased community engagement helps improve health outcomes—by giving people a voice in the system OCDD is able to ensure that we are meeting people where they are and acknowledge the importance of their voice within the system.

Accomplishment #2: Study and report on the feasibility and viability of implementing a system for tracking the location of children with intellectual and developmental disabilities (IDD) including autism (HCR 45).

A. **What was achieved?**

The 2021 Regular Legislative Session House Concurrent Resolution 45 required the Louisiana Department of Health (LDH) to engage, collaborate, and obtain information and perspective from stakeholder groups that advocate for children with developmental disabilities and their families. OCDD was asked to consider information on tracking the physical location of children with developmental disabilities, the types of global positioning system (GPS) trackers available, the cost of these devices, duties and responsibilities related to the tracking system, and other important considerations that would inform the policymaking body prior to implementing an electronic tracking device (ETD).

Workgroup findings revealed the following:

- There is no right approach for everyone: consideration of needs and preferences of the individual/family are critical toward assuring good match between chosen ETD and individual. Access to a variety of options that maximize choice is an important consideration.
- There is no one ETD that will eliminate all instances of wandering. Although an ETD may help reduce risk of harm and facilitate location of a missing individual, a comprehensive approach that integrates various support methods and integration across response agencies is needed.
- Cost of equipment and/or monthly monitoring fees are major concerns for families.

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

Children, youth and adults who experience IDD, including autism are at greater risk of becoming lost, walking away from supervision, or sometimes intentionally leaving an area in order to get access to something or some activity. In addition to these risks, there are also incidents and situations that place these individuals at greater risk for exploitation (including human trafficking). ETDs may play an important role in preventing risk of harm by more quickly locating these individuals if they wander. The study and report offer a preliminary understanding of feedback received from Louisiana families of children and adult children with developmental disabilities related to their preferences, opinions, experiences, and knowledge about ETDs. And while the scope of the language in HCR 45 limited the study to individuals diagnosed with IDD including autism, there is the potential for ETDs to have life-span benefit for typically-developing children and youth, elders diagnosed with dementia or Alzheimer's disease, and others, as this technology may play an important role in preventing risk of harm to or more quickly locating individuals.

C. **Who benefits and how?**

While the required focus was on children with IDD including autism, ETD options

could potentially be used to compliment services and supports for anyone who experiences challenges related to wandering, eloping, or a propensity to get lost. OCDD participants, families, support coordinators, and direct support professionals could all potentially benefit from the addition of an ETD to one's array of identified supports.

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

The workgroup held nine meetings beginning on August 5, 2021 and ending December 16, 2021, reviewed federal/state-specific legislation, technical summaries of electronic options, grant-funded opportunities and peer-reviewed literature, and sought input from two subject matter experts. The workgroup developed and conducted a 16-question survey to obtain information directly from families about their interest in using ETDs, as well as engaged in many in-depth discussions about life experiences and all aspects of the study.

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

Yes. OCDD has specific goals to increase capacity for opportunities to live, work, and learn in integrated community settings, to focus on person-centered practices, and to increase capacity of community providers to support individuals. Additionally, the OCDD strategic plan recognizes that promoting stakeholder engagement and advocacy efforts is an important component of our overall 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. OCDD reviewed federal/state-specific legislation, technical summaries, grant-funded opportunities and peer-reviewed literature, as well as sought input form two subject matter experts to inform study activities and report findings. Additionally, using stakeholder workgroup input and surveys are a Best Management Practice according to CMS.

Accomplishment #3: Pilot with Case Management on Certification of Person-Centered Tools:

A. **What was achieved?**

OCDD clinical services partnered with an identified Support Coordination agency to pilot implementation within agency training and supervision activities of the core onboarding training series with certification requirements for all new support coordinators and supervisors. The 10 modules developed in last year's Person Centered initiative were used for the didactic training component.

- Modules 1-3: Person-centered thinking and tools to aid in discovery,
- Module 4: Preparing for planning discussions and using PC tools,
- Modules 5-7c: Facilitating planning discussions and building a PC plan,
- Module 8: Plan review and quality outcomes.

Modules were delivered via recording to all newly hired support coordinators. These

onboarding modules were built into required onboarding training for all new support coordinators. A two-tiered certification process was developed for both new support coordinators and for supervisors. Completion of the first tier of certification for PC tools was completed this FY with 100% of the supervisors achieving certification and 91% of all new support coordinators. Some turnover occurred but was minimal compared to previous rates in previous initiatives – 1 supervisor resigned (10% turnover since total supervisors was 10 at the start of the project) and 3 support coordinators resigned (21% turnover rate). Completion of the supervisor certification allows for in house training and certification in new support coordinators by the agency which assures a higher degree of quality services and efficiency in onboarding and training.

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

National experts, federal regulation agencies, and LDH/OCDD leadership have long recognized that person-centered practices represent a best practice approach to supporting individuals with intellectual or developmental disabilities (IDD). Implementation to scale of person-centered practices take years and multiple efforts. Multiple large state-operated facilities existed between 1960 and the early 1990s due to the large imbalance in Louisiana's support system; consequently, OCDD's initial efforts were linked to reforms associated with the impact of the Olmstead decisions and the Americans with Disabilities Act (ADA). The effort was initially focused on its Supports and Services Center (SSCs), with primary goals of supporting individuals to be more involved in the local community, and to move from larger congregate living situations to smaller, more community-based living. The Office achieved success in these efforts beginning with the initial accreditation of Greater New Orleans (GNO) SSC (formerly Metropolitan Developmental Center) by the Council on Quality and Leadership, and continued its success during the Department of Justice (DOJ)-informed improvements at two of its SSCs (NLSSC achieved an increase from 0-42% of individuals moving to work or educational activities daily within the local community between 2003 and 2007; achieved 98% of individuals participating in preferred community recreational activities at least monthly by 2007; and transitioned individuals to smaller living arrangements—ultimately downsizing to closure via privatization in 2012).

Between 2003 and 2012, OCDD successfully downsized and closed 9 larger congregate SSCs, and achieved a significant rebalancing of supports with more individuals receiving supports via Home and Community Based Services during this time. Due to the increased demand for services in community-settings, and the growing costs within the comprehensive waiver, mid-way through the transitional efforts OCDD also turned its attention to resource allocation—another nationally-growing effort. Between 2005 and 2008 OCDD convened a large stakeholder group and worked with national consultants to develop an approach to balancing the need to allocate resources effectively with the need to attain important positive outcomes for individuals. OCDD was recognized nationally for its development of the *Guidelines for Support Planning,* which combined a person-centered approach to planning and the delivery of supports with the important consideration of a more equitable distribution of resources to support the most people with available dollars. By implementing an intensive training and monitoring approach to planning, OCDD successfully implemented resource allocation within its New Opportunities Waiver (NOW) and decreased the annual average waiver cost per

participant (section A refers to some of this data) while serving more people—with no increases in critical incidents and no individuals losing their ability to live in a home and community based setting (HCBS) due to this implementation. Additionally, plan goals shifted to:

- Support for independence (32% of plans to 71%);
- Supports for desired community involvement (44% of plans to 84%);
- Planned supports to maintain social connections (22% of plans to 54%);
- Involvement of natural supports (56% of plans to 80%) and
- Use of typical community or technology supports (9% of plans to 52%).

These efforts were recognized at the 2015 National Association of States United for Aging and Disabilities (NASUAD) HCBS conference. The growing waiting list for the New Opportunities Waiver (NOW) shifted OCDD's focus to effectively reforming the waiver screening and implementation process following the 2012-2014 system transformation input. An evaluation of the Request for Services Registry (RFSR) occurred, and stakeholders engaged in planning changes to the waiver screening and access process. These changes were implemented beginning in 2017, and OCDD successfully moved to a prioritized process where individuals no longer wait for currently needed services. OCDD presented this success at the 2019 ARC National Convention. The significant turnover in support coordination agencies, new requirements to allow additional support coordination agencies to enroll to provide OCDD case management services, and the growing numbers of individuals being supported across multiple OCDD waivers, drew a new focus to the need for additional person-centered practice reforms.

The National Association of State Directors of Developmental Disabilities Services (NASDDDS) data suggests that all states continue to struggle with bringing person-centered practices to scale system-wide. Person-centered practices have been shown to improve the planning process and waiver recipient outcomes within specific providers– both as noted above in some Louisiana efforts and in recent presentations nationally from specific providers (for example, a Minnesota provider presenting at the HCBS conference related to person-centered organizational changes noted positive impacts on satisfaction of recipients with services and improved outcomes along with decreased injuries/incidents, decreases staff turnover and staffing needs, and decreased emergent situations). One challenge in taking these practices to scale has been the lack of shared expectations, core competencies and outcome measures. The National Center for Advancing Person-Centered Practices and Systems (NCAPPS) was launched in 2019 and the collaborative recently published self-assessment and core competency areas for plan facilitation and implementation. Additionally, the increased adoption of technology to adapt during the COVID-19 emergency as a means of engagement and education has offered OCDD a new opportunity to leverage limited existing expertise within the state to initiate this effort in a way that improves sustainability. This initiative focuses on developing competency-based core onboarding modules for support coordination, and the merging of data on plan quality and individual outcomes into existing support coordination monitoring with a co-occurring provider tool-kit and competency approach at the supervisory level within provider organizations. This effort represents the next step in the foundational stage of scaling up person-centered practices in the state of Louisiana's IDD system. This success sets the stage for OCDD to move ahead in future

years to the use of meaningful outcome data to guide both evaluation of service provision, and areas for improved quality aimed at supporting independence, social and community connections, employment, and varied social roles. It serves as a model for implementation in other support coordination agencies and can be a component of required quality services OCDD expects from support coordination agencies.

C. **Who benefits and how?**

Self-advocates, families, providers, and advocacy groups all acknowledge OCDD has good person-centered planning resources (e.g. guidelines for support planning). However, they have also shared that there needs to be a way to ensure person-centered practices are being implemented at the planning level, that providers are exposed to person-centeredness at the service delivery level, and that person-centered practices are reflected in key performance measures.

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

OCDD's clinical services division partnered with a support coordination agency seeking to implement quality initiatives to improve hiring and retention as well as recipient outcomes. The previously developed 10 core module recordings were built upon to merge the person centered training into the routine onboarding within the agency. A two-tiered certification process was developed including training and certification of supervisors to assure in house capacity for implementation and quality outcomes in the future.

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

Yes. OCDD's has specific goals to increase the use of community-based care (and decrease reliance on institutional care), focus on person-centered practices, and to increase the capacity of community providers to support individuals.

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 approach OCDD is undertaking is consistent with national standards and trends using the NCAPPS resources and guidance.

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

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

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

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 resources are allocated 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 CARES Act and American Rescue Act funding allowed OCDD's progress on objectives to remain steady despite setbacks posed by the COVID-19 Public Health Emergency. OCDD continues to build on successes in the areas of customer responsiveness, waiver reform, person-centered thinking, early intervention, supports for people with complex behavioral needs, and employment. The success of these initiatives in FY 2021-2022 has moved the Office toward goals/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 polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
     - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?

- Other? Please specify.

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

Supporting Individuals with Complex Behavioral Health Needs to Live in their Community

The OCDD Resource Center has continued to shift to supporting 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. A performance indicator (#24259) is included in OCDD's Strategic Plan and Operational Plan 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 350-500 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 over 97% 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?

   Progress is expected to continue. The Resource Center staff has implemented triage initiatives, and they have been able to provide services to a greater number of individuals and provider agencies. 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 time-frame that increases the likelihood of diversion to the most integrated setting.

Enhanced Training for Community Professionals and Providers to Improve Capacity to Support Individuals with Complex Needs

The OCDD Resource Center uses the professional expertise of staff to develop and conduct training and technical assistance activities with community providers and professionals to enhance the ability of these providers and professionals to support

individuals with complex medical and behavioral support needs. These activities are initiated by the office and by provider/professional request. A performance indicator (#24696) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative. The Resource Center was able to conduct 360 training activities in FY 22, with the majority of these being focused on medical/nursing related activities impacted by the public health emergency. The Resource Center was also able to continue *Operation House Call* activities in both New Orleans and Shreveport locations before year's end. Additionally, during this fiscal year OCDD's Resource Center Team collaborated with two other states/territories to continue to share resources for educating behavioral health professionals on the efficacy of existing behavioral health evidenced-based practices (EBPs) for individuals with IDD and co-occurring behavioral health needs.

OCDD's clinical director participated as a member of the virtual conference committee for the National Association on Dual Diagnosis (NADD)'s annual conference. The clinical director and deputy assistant secretary for community programs also presented at the conference. With regard to dental needs, OCDD continued formal outreach and coordination with Medicaid health plans and stakeholder groups and served as a member of the dental task force.

1. To what do you attribute this success?

   OCDD employs clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral and medical support needs. OCDD and the Office of Behavioral Health (OBH) have developed more formal partnership approaches to address the needs of individuals with co-occurring needs.

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

   Progress is expected to continue. The OCDD Resource Center and Clinical Staff have adapted trainings by offering virtual alternatives to in-person training, and learning from the virtual options have allowed for planning of hybrid approaches to maximize providers/professionals the Resource Center can reach and impact. Feedback is obtained from customers at the time of each training event; this feedback and suggestions for additional training allow OCDD to be responsive to customers' training needs. Professional continuing education and discipline-specific outreach events will continue, with planning done each fiscal year.

Redesign of Day and Employment Services to Promote Integrated Community Settings

Over the course of the last three years, OCDD collaborated with the State Employment Leadership Network (SELN), a small workgroup of thirteen day and employment providers from around the state and larger stakeholder groups to add two small group services into Appendix K and then into each of the adult waivers (New Opportunities Waiver, Support Waiver, and Residential Options Waiver). Those amendments were effective as of July 1, 2022. Virtual delivery of day habilitation, prevocational services, and individual supported employment follow along services were included. A direct

support professional (DSP) rate increase occurred in October 2021, meaning the rate increased for all of the new services.

OCDD added new services, which include:

- **Community Life Engagement**—a service that was added to meet the goal of integration into the community in a small group of 2-4 individuals. This service involves participation in integrated community settings, in activities that include persons without disabilities and with people who are not paid or unpaid caregivers. This service promotes opportunities and support for community inclusion; building interests and developing skills and potential for not only meaningful community engagement but also it can help the individual in figuring out areas of interests that could lead to possible competitive integrated employment in the community. Services should result in active, valued participation and engagement in a broad range of integrated activities that build on the participant's interests, preferences, gifts, and strengths while reflecting their desired outcomes related to community involvement and membership. OCDD expects this service to result in the individual developing and maintaining of social roles and relationships; building natural supports; increasing independence; increasing potential for employment and/or experiencing meaningful community participation and inclusion. Volunteering is expected to be a part of this service as well.
- **Career Planning Services**—a service that is delivered in a small group of 1:2-4 ratio in the community. OCDD designed the service to create a path to individual, integrated community based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Career Planning Services use the person-centered planning process to discover the various interest, skills, and general information about each person that will assist in developing a path to employment in the community. From the person centered planning, activities should be tailored for each person in preparing them for paid employment in the community. The outcome of this service is to create a 'Profile' that can be used to help each person create their own employment plan.
- **Virtual Delivery** of Day Habilitation, Prevocational and Supported Employment Job Follow Along services has been included as an option for delivering the typical service but allows the individual the choice in how they would like to participate.

1. To what do you attribute this success?

   The results generated would not have occurred without the collaboration of the SELN, workgroup, and OCDD. Because of the implementation of the new services, OCDD created new policies, generated rate codes, amended waiver applications, and amended rules for the NOW, SW and ROW waivers. OCDD made progress by working collaboratively with the workgroup to redesign services to ensure that community integration can occur.

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

   This progress was only the beginning of the expected redesign of the day and employment services. On July 7, 2022, the workgroup met to discuss the proposal for the individual Supported Employment service menu as this is our next group of services to work on.

EarlySteps Improvements: Overcoming the Program Impact of the COVID-19 Pandemic

EarlySteps has demonstrated progress in improving the referral rates and child count that were impacted during the pandemic and the hurricanes. The strategies that were used in 2021-22 resulted in a 16% increase in the referral rate and an 8% increase in the child count.

The EarlySteps service system is designed to support infants and toddlers with disabilities, and their families and caregivers, in *natural environment* settings. In Louisiana, 99% of service delivery occurs in these settings, typically family homes and child care centers. When the first COVID-19 restrictions were issued in March, 2020, EarlySteps staff worked with the LDH Office of Public Health (OPH) to design and implement a responsive hybrid service delivery model so that appropriate service delivery could continue regardless of the phase of the COVID-19 requirements. Staff also collaborated with the Louisiana Department of Education Early Care and Education (LDE) staff to monitor changing requirements for service delivery visits to child care center. Referral rates decreased beginning in March, 2020 when physician well-child visits were restricted and/or when families refused referrals to minimize exposure risks to their child and family.

1. To what do you attribute this success?

   Progress is due to the strategies that were implemented by EarlySteps and in conjunction with OPH through a joint business plan initiative:

   - Staff worked with state and national resources to explore options and implement strategies that were appropriate for use in Louisiana.
   - Referral, Child Count, and Service Data were constantly reviewed to monitor entry to (and exit from) the program, service utilization, issues with billing, and reimbursement.
   - Staff communicated regularly with the OPH epidemiologists as the COVID-19 phases evolved and the impacts of Hurricane Ida were resolved to ensure that service delivery could occur with minimum amount of risk to both families and providers.
   - Staff collaborated on a LDH business plan activity with the Office of Public Health initiative (Initiative 5, Goal 6: Strengthen Louisiana's Early and Periodic Screening, Diagnostic, and Treatment system by increasing the provision of necessary but underutilized preventive services in the following four areas of child health: developmental screening, immunizations, oral

health, and Adverse Childhood Experiences). The strategy focused on improving child health outcomes through improving developmental screening rates and linkage to diagnostic and intervention services. The deliverable for which EarlySteps was responsible was to "restore the referral rate to early intervention services following the 20% decreases experienced as a result of the impact of COVID-19 and hurricanes."

- Data from referrals was tracked monthly by parish and source of referral and reported at monthly staff meetings and quarterly to the State Interagency Coordinating Council, the advisory group responsible for advising the early intervention system. Results were also shared with the Community Outreach Specialists, who conduct outreach activities. The results of the review were used to target specific referral sources with EarlySteps materials to increase the referral rates with the goal of increasing the child count.
- EarlySteps participated in a technical assistance (TA) activity provided through a grant from the Pritzker Foundation. The grant is a cross-state department initiative and targets improvements to the early care and education system. A national TA center reviewed data, interviewed staff from other states, and conducted stakeholder focus groups to determine strengths and weaknesses of the referral process. A series of recommendations was presented to EarlySteps to consider additional improvement activities ongoing.

  The program would not have shown increasing numbers of referrals and an increase in the child count at the current rates without the strategies that were implemented. In addition, service providers would have left the program due to the financial impact of the limitations on home visits if the hybrid model had not been developed and implemented. Through the collaboration with the LDH epidemiologists, the hybrid model of service delivery was revised as the COVID positivity rates and phases evolved. Guidance was jointly reviewed and updated and requirements sent to providers to implement. Referrals by referral source were reviewed monthly and outreach was targeted to sources where numbers had decreased compared to previous years. EarlySteps worked closely with OPH epidemiologists and through the business plan initiative to address strategies for improvement. Collaboration with the LDE also contributed to continuing service delivery in child care settings as those requirements changed through the pandemic.

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

   The trend toward increasing referral rates and child count is expected to continue. The 2018-19 fiscal year (pre-COVID-19) had the highest number of referrals and child count in the history of the program. It is anticipated that the targeted rates will at least return to those levels. In addition, a rate increase was funded by the legislature, which has already had an impact on provider enrollment. With increased service availability, it is expected that the child count will continue to increase.

- **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 developing a full-scale data-driven quality database. OCDD must resolve many issues before the database is complete. One primary obstruction has been lack of resources for developing a full-scale data-driven process. Currently OCDD has one available programmer who has the full time responsibility for modernizing all of OCDD's databases. OTS is currently working on upgrading its Information Technology Structure, and this must be completed before OCDD can move forward with the database. Over the past year, OCDD has updated two of the databases that will become a part of the full-scale data-driven database. The implementation of SIMS took place in 2019, and staff are continuing to update and refine the system so it is complete and responsive to the needs of the users of this system. Finalizing the electronic Individual Support Plan (eISP) will also be tied to this system.

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 is 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. Modernization of all IT infrastructure has had a significant impact on progress.

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

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

Yes. OCDD has updated its Strategic Plan for FY 2023 through 2028. Updates included revisions to Office goals, program objectives, strategies and indicators to reflect Office direction, to build on successes, to provide strategies in areas where success has not been as substantial or where changes in program direction indicate such, and to improve performance assessment.

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

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

  Within OCDD, objectives are assigned to specific staff members who are responsible for management and oversight of the accomplishment of each objective and related performance indicators. A variety of management tools (i.e., databases, project charters, etc.) and task/initiative specific workgroups/committees are used to track, review, and provide feedback for use in decision-making and resource allocation. Progress, or lack of progress, (along with support/resources needed to achieve assigned objective) is reported to OCDD Executive Management. Performance data is also reported in Louisiana Performance Accountability System (LaPAS), and 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?

("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?

Problem/Issue #1: <u>Information Technology (IT) Upgrades/Modernization Project</u>

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 in need of system upgrade and modernization. Many applications/databases need redesign and/or major revision; equipment needs to be updated. Modernization is needed to allow for automation of processes requiring access by multiple internal and external users. The Office's system transformation efforts are being seriously thwarted by the lack of up-to-date IT equipment and programming.

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

   Yes, in some way all of the six goals are negatively impacted by OCDD's outdated IT system due to a need for resources to make improvements. Goal V (To implement an integrated, full-scale data-driven quality enhancement system) is especially hampered by this problem.

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

   This problem affects all units within the office to varying degrees. IT upgrades and modernization would improve the efficiency of all work units within the Office.

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

   The people supported by the Office and their families, providers, support coordination agencies, and other stakeholders are indirectly affected. The Office is unable to fully 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 OCDD Information Technology (IT) Upgrades/Modernization projection has been significantly hampered by the lack of funding. Although funding was requested for the IT Project during the state budgeting process, the project was not chosen as one of the Department's priorities.

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 the Office's Quality Enhancement system remain priorities and are critical to the OCDD's next steps in system transformation. These efforts will be delayed and will significantly affect progress in meeting established OCDD goals and objectives if additional funding is not secured.

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?

   Funding is needed to implement, test, correct, and maintain the data infrastructure necessary to implement the eISP, build a proposed electronic developmental disability health record, and re-design the current quality enhancement integrated database. The ability to fill the vacant full-time programmer and funding to replace older equipment is needed to address efficiencies. Funding to address larger systemic issues is needed to fully implement major initiatives related to the planning process for individuals with developmental disabilities being served in Home and Community-Based Services waivers.

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

   Yes.

4. Are corrective actions underway?

   Funding was requested in the FY 2022-2023 budget.

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 salary for another full-time programmer, and funding for equipment upgrades and system modernization are required. This cannot be managed with the current TO and budget.

Problem/Issue #2: <u>Community settings lack adequately trained professionals and direct support staff to deliver needed (1) behavioral services, including qualified persons to deliver applied behavior analysis to people with autism, and (2) services and supports, including skilled nursing service and community nursing service, to individuals who are medically fragile</u>

A. Problem/Issue Description

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

   There continues to be a lack of adequately trained professionals and direct support staff to deliver needed behavioral and medical/nursing services to individuals with complex needs in community settings, including a lack of qualified professionals to deliver applied behavior analytic therapies to persons with autism. There is a shortage of trained staff to provide services and supports for individuals with significant medical needs, including 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. Applied behavior analysis can be very effective and can significantly alter the course of autism for many individuals. Complex medical support needs, particularly those requiring nursing supports throughout significant periods of the day, can be managed in community settings; however, it is very difficult to locate and secure trained staff to meet these needs. Continued challenges in this area contribute to institutional admissions, hospital admissions, emergency room use, increased illnesses, increased medication usage and costs, and other negative health outcomes.

   There have been specific departmental and OCDD initiatives introduced during this fiscal year to continue addressing this barrier—and improvements have occurred in some areas—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. Lack of professional supports in community settings has continued to be the primary contributor to admissions to the supports and service center and other more restrictive settings. 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. The lack of trained autism professionals negatively impacts the ability to develop new autism services, which could prevent more severe negative developmental outcomes. The inability to adequately teach functional behavioral skills detracts from community participation objectives (i.e., that individuals with disabilities are participating fully in communities). The continued movement from Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) settings to community-based living arrangements is also hampered due to the challenges in securing needed behavioral and medical/ nursing supports for individuals with complex needs.

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

   OCDD and the Local Governing Entities have been impacted by the lack of professional support in the community for many years. The Office of Behavioral Health (OBH) and Medicaid are also experiencing some impact due to this problem.

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

   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 are all impacted by this problem. Hospitals are impacted when individuals with co-occurring needs present at the emergency room due to difficulty accessing other needed services. Behavioral health professionals and agencies are impacted because they are now receiving referrals for individuals with co-occurring needs for whom they may not feel adequately trained to deliver treatment. Managed care organizations are also impacted 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. Many 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 impact 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 positive behavior supports and medical/nursing needs.

Factors specific to fiscal year 2021-2022 include the continued impacts of COVID-19, additional major hurricanes disrupting services in the State, and historically significant workforce challenges being experienced within Louisiana and nationally. These public health disasters and workforce challenges affected the provision of community-based services and resulting in the temporary relocation of many people with developmental disabilities. Additionally, issues related to availability of direct service professionals is likely to continue or worsen due to changes in the general economy subsequent to COVID-19. 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 autism, other behavioral challenges and/or complex medical needs leading to increasing service costs over the course of their lifespan.

B. Corrective Actions

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

   ☐ 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 recommended actions to alleviate the problem:

- Continue evaluation of the benefits of the inclusion of behavioral and medical therapeutic respite options via the OCDD consolidated waiver, and research development of specialized shared living waiver models for individuals with complex medical and behavioral needs.
- Continue implementation of opportunities for partnering with university programs that provide training, as well as individual clinicians, resulting in additional needed professionals and growing the service provider pool.
- Continue OCDD developed and sponsored professional continuing education opportunities.
- 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.
- Continue collaboration with OBH on development of crisis framework and services and other opportunities for partnership with shared stakeholders.
- Complete contract with the Center for START services to conduct a systems analysis related to meeting the needs of individuals with IDD and co-occurring behavioral health needs.
- Complete the activities of the study groups in HCRs passed this year related to DSP workforce, nursing services within agencies and the needs of individuals with dual diagnoses (IDD and co-occurring behavioral health needs).

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. Some recommendations have been implemented, and new recommendations are included. Many of these recommendations require sustained implementation over a period of time to effect needed systems issues and improve outcomes.

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.
- OCDD has developed core training related to trauma-informed and wellness supports for support coordinators and providers and implemented trauma and wellness focused efforts this fiscal year.
- OCDD continues its statewide offering of Medical/Nursing DSP training via Money Follows the Person (MFP) Rebalancing Demonstration.
- OCDD continues to offer Board Certified Behavior Analysts (BCBA) continuing education opportunities, as well as other behavioral and psychological continuing education options.
- OCDD 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 continues to work with Medicaid to support Applied Behavior Analysis (ABA) services via the State Plan and has increased routine coordination with Office of Behavioral Health (OBH) related to mental health needs for individuals with intellectual/developmental disabilities.
- OCDD has initiated contact and secured as part of ARPA funding to contract with the Center for START services.
- OCDD continues to partner as part of the statewide Dental Taskforce and passage of funding to provide dental coverage has occurred in the last two FYs.
- OCDD continues collaborating with OBH, CSoc, and the Managed Care Organizations (MCOs) to address the co-occurring IDD and behavioral health needs of recipients who access services across systems.
- OCDD Resource Center staff have developed a liaison program with the two state operated psychiatric facilities.
- OCDD is in collaboration with Missouri and NASDDDS to develop additional training and educational materials for clinicians.
- OCDD participates as 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.

Most of these actions do not carry a cost. The training and capacity building efforts approved in the Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana) Operational Protocol are funded with federal demonstration dollars through fiscal year 2023. While other corrective actions could carry a cost insofar as additional clinicians and/or technical assistance staff are recruited into state service systems, they do not carry a cost as most new positions in OCDD are existing positions diverted from institutional services. They do not incur a cost when the focus is on community, non-public capacity building. Costs are associated with new services such as ABA, START and enhanced waiver services. However, those costs are likely offset by costs associated with failure to implement corrective actions such as: 1) failure to intervene at the community level can result in extensive additional institutional treatment costs, and 2) failure to intervene with persons with autism at an early age does result in extensive lifelong service costs that are estimated at over one million dollars per person and incurred by families and the taxpayer. Additionally, the initial funding for the START contract will occur through federal ARPA dollars.

☐ 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 #3: *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 sixteen 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,
- Ongoing, or legacy costs, including the employer share of group insurance benefits for retirees, and
- The supports and services offered through statewide Resource Center operations that formerly ran from each facility.

Some of these services have been refined to include the OCDD Programmatic Unit and Monitoring and Analytical Support activities. OCDD continues to be responsible for the maintenance of the grounds of North Lake Supports and Services Center facility, and the Leesville Residential and Employment Services. None of these expenditures are part of the cost reporting used to determine the per diem for the facilities. As these facilities either privatized or closed over the years, the expenditures were collapsed under the appropriation to the Pinecrest Supports and Services Center. The activities are funded from a combination of both a significantly reduced State General Fund appropriation and pooled Interagency Transfer (IAT) Revenues derived from any over-

collections that may be available from the Pinecrest Supports and Services Center operations. Pinecrest has continued to absorb the expenditures that were once spread across nine facilities and their respective revenue streams. As facility operating expenditures increase, the ability of Pinecrest to support these statewide non-facility activities is diminished or eliminated moving forward. During FY 2020, the Central Louisiana Supports and Services Center was transferred to OCDD at mid-year resulting from Act 411 of the 2019 Regular Session.

2. Is the problem or issue affecting the progress of your strategic plan?

   Yes. Although indirectly, this issue affects agency progress in implementing its Strategic Plan. Fiscal and human resources are necessary to manage vacated properties and to support critical, non-facility activities. These resources could be better used to further progress toward one or more of OCDD's Strategic Plan goals. The non-facility activities have no dedicated funding stream and require the use of funds earmarked for use by Pinecrest. Any available pooled revenues from Pinecrest are subject to reduction based on the operational needs of the facility. The amount of available pooled revenues to subsidize the non-facility activities has decreased significantly as these operational expenditures have increased at Pinecrest over the last several years.

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

   OCDD is managing the problem by continuing to allocate any available resources to the costs necessary to maintain the properties and fulfill both Office of Risk Management (ORM) and other state requirements.

4. Who else is affected by the problem?

   The Pinecrest facility budget is impacted. The mandated expenditures made through this appropriation from Pinecrest pooled revenues impact the cash flow at the facility. There are also additional indirect impacts of the required expenditures on participants/families because resources are diverted away from service delivery.

5. How long has the problem or issue existed?

   This issue was identified in 2010.

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

   The problem is caused by the mandatory expenditures associated with duties and costs for state-owned property insured by Office of Risk Management (ORM), mandated group insurance costs for retirees from now closed institutions, and statewide Resource Center operations. These costs, once funded from eight state-run facilities, which are no longer in operation, are now subsidized solely by the operation of the Pinecrest revenue stream. Though vacated or operating with significantly reduced occupancy, the properties require appropriate effort to keep the physical plant in good condition and to prevent theft or destruction of property. The retirement benefit absorbed in the Pinecrest revenue stream includes medical coverage for employees who retired under one of the qualifying retirement systems. The benefit paid by the state for participating retirees depends upon a number of

factors based on their participation in the Group Benefits program.

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 are no longer used by OCDD. These expenditures may cause cash flow shortfalls in future fiscal years.

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, including, but not limited to, the following: 1) the transfer of state-owned property to other state, parish, or local governing departments/offices for an alternative public good; and/or 2) the utilization of state-owned property as revenue generating property. If not, the state may propose to sell the properties. Note that sections of all facilities contain asbestos that will require abatement. All such actions 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. Similar recommendations have been made in this annual report since FY 2009-2010.

4. Are corrective actions underway?

   Yes. Corrective actions are underway.

   - Closed Facilities. With respect to ongoing facility maintenance and upkeep at closed facilities, in accordance with the ORM guidelines, OCDD is working to identify potential alternate uses for all properties not occupied or those planning to be vacated due to ongoing downsizing efforts.
     - During the fiscal year, action was taken on three closed facilities:
       - Leesville: OCDD continues expending toward the upkeep of this facility during the fiscal year upon expiration of a cooperative endeavor agreement with the Town of Leesville. Act 342 of the 2019 Regular Session of the Legislature authorized the transfer of certain parcels of land that include the former Leesville Residential and Employment Services facility to the Museum of America's Training Ground. However, the transfer and sale of the Leesville property did not occur. The property has storm and freeze damage. Claims for the repair of this damage were filed

with the ORM, and repairs are underway.

- Southwest: The responsibility for the property has been transferred from OCDD-Pinecrest Supports and services Center to OBH-Eastern LA Mental Health System (ELMHS). The property continues to be maintained by ELMHS for evacuation destination for its patients should the need occur.

- Belle Chasse: OCDD is responsible for the upkeep of property located at 251 F. Edward Hebert Blvd., Belle Chasse, Louisiana. The property and buildings had been part of the Metropolitan Developmental Center.

- Updates on previously reported efforts to find a proposed best use for former facilities:

  - Acadiana: Act 142 of the 2017 Regular Session of the Legislature authorized LDH to transfer land and improvements occupied by the former Acadiana Employment Services Center in Opelousas to the St. Landry Parish School Board. To date, this property remains under OCDD as no sale has taken place.

- Legacy Costs. Regarding ongoing 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. The appropriated amount represented the gap between the estimated ability of state facilities to meet these obligations from its own revenue stream and the mandated expenditure obligation.

5. Do corrective actions carry a cost?

☒ No. If not, please explain.

No. There are no anticipated direct costs related to researching and developing amendments to existing legislation, as these actions would be completed by existing staff. Failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings/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 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):

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

1. Title of the Report or Program Evaluation:

   National Core Indicators Survey. The National Association of State Directors of Developmental Disabilities Services (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.

2. Date completed:

   HSRI and NASDDDS made the final reports for the survey cycle that ended on June 30, 2021 available to the State in January 2022.

   The 2021/2022 survey cycle began in October 2021 with pre-survey activities. OCDD mailed survey packets for Family Surveys in March 2022 to 6,000 family members of individuals receiving OCDD services. OCDD sent electronic invitations via the NCI portal to Provider agencies for the Staff Stability Survey in mid-March 2022, when NCI opened the survey portal for responses. NCI extended the due date for final response entries for the Child Family and the Adult Family Surveys from June 30, 2022 to July 31, 2022. NCI also extended the final

response entries for the Staff Stability Survey from June 30, 2022 to July 31, 2022.

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

   The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and their families. Indicators address key areas of concern including employment, rights, support planning, community inclusion, choice, and health and safety. Surveys were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. Survey questions concerned satisfaction, quality of care and quality of life. Analyses compared Louisiana statewide results with results of other states participating in the National Core Indicators Project. During the 2021/2022 cycle, OCDD chose to conduct the Child Family survey, the Adult Family survey and the Staff Stability Survey. The Family Guardian survey and the In-Person Interview survey were not conducted for this cycle.

   OCDD participated in the 2020/2021 NCI Staff Stability Survey (NCI-SSS) for the fourth consecutive year. NCI instituted this survey to address the concerns surfaced in HSRI and NASDDDS about the instability of the direct care service work force across the United States. Concerns that are being explored center around wages, benefits, career opportunities, work environment and educational opportunities for the work force of care- givers. The NCI-SSS is an on-line survey through an NCI portal that is accessed by licensed service provider administrators of agencies supporting adults with DD/IID 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. Respondents participate on a voluntary basis, but are strongly encouraged by OCDD leadership 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:

   The primary tools used for the service participant satisfaction evaluation for the 2020/2021 cycle (prior year) was the Child Family and Adult Family Surveys. The analysis reports both the number and percentage of responses to each question. The NCI averages contained in the national report are “weighted” means; their calculations reflect the relative population sizes of all participating states, as well as the sample size. The weights used in calculations of this report were developed by NCI using each participating state’s number of survey respondents and its total survey-eligible population. NCI tests for statistical significance as well as effect sizes. Effect sizes are used in addition to statistical significance because statistical significance of a state’s result depends in part on the size of the state’s sample. Comparisons are compiled in an NCI national report that includes all of the participating states who submit a minimum of 400 surveys. NCI produces state reports for each participating state; if a state is not eligible to be included in the national report, that state will still have a state report available. NCI offers a web-based survey response site that provides families

who were participating in one of the family surveys the opportunity to respond via direct entry into the NCI database. OCDD provides a unique survey code on each survey for respondents to use to access the database to assure anonymity. OCDD has experienced a diminishing rate of return of surveys, which has resulted in this Office pulling larger samples and mailing more survey invitations in order to achieve the target of a minimum of 400 completed Family surveys per targeted population. OCDD did not conduct the In-Person Survey that directly interviews adults with a developmental disability participating in services through OCDD-managed programs. OCDD also did not conduct the Family Guardian survey this cycle. Final reports from NCI on the aggregated 2020/2021 data were available in January 2022.

Reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services and delivered to OCDD in January 2022:

National Core Indicators Louisiana Adult Family Survey 2021 Final Report: This report provides an aggregated summary of the results of the survey which was mailed to families of adult individuals living and receiving developmental disability services in the family home and provides comparisons between Louisiana and the national average of other participating states.

OCDD concluded the Child Family survey on July 31, 2022 and met the projected return rate for participation. The Adult Family survey also concluded on July 31, 2022 and met the projected return rate for participation. OCDD also met the targeted return rate for the Staff Stability survey.

OCDD made the NCI web-based survey response format available to respondents for the 2021/2022 surveys; hard copy surveys were also sent to the sample survey recipients to ensure equal access to everyone. The OCDD Quality section is continuing to explore ways to increase the on-line participation rate for NCI surveys.

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

   The Child Family mail-out letters were printed by State Printing for $5,985 for Child Family and $5,985 for Adult Family and mailed by Office of State Mail Operations $8,247. The cost of the business reply postage for postage-paid return surveys is projected to be $1,900.

6. Major Findings and Conclusions:

   Findings in the 2020/2021 Family Survey reports were limited due to the low response rate. OCDD has not completed a final analysis of the reports produced by NCI. Preliminary review suggests feedback from family members of service participants was affected by the challenges that families and service participants were experiencing because of the continued disruptions from COVID-19 pandemic restrictions. Findings for the 2021/22 NCI survey cycle will be available in January 2023.

7. Major Recommendations:

OCDD should consider contracting out the mail return processing of surveys and the In-Person Survey activities to an entity that would remove any conflict of interest concerns that occur with OCDD surveying its own services. OCDD is exploring proposals for contracting with outside entities for implementation no sooner than the 2023/24 survey cycle. OCDD should formulate strategies to promote on-line participation in the Family surveys for the 2022/23 survey cycle, with additional support for the use of the technology being made available to family members through phone contact, a dedicated email site, and web-based tutorials. Quality 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%.

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

   Information from the surveys was cross-walked to Centers for Medicare & Medicaid Services (CMS) measures for the Home and Community-Based Services (HCBS) Settings Rule, which addresses community participation and employment goals for persons with developmental disabilities who are receiving HCBS.

   OCDD's quality improvement process includes review of NCI data as well as data from other sources, such as data on regional performance indicators as part of the Human Services Accountability Plan and data from EarlySteps and HCBS waiver performance indicators. The data is reviewed by an OCDD workgroup consisting of programmatic and quality staff. When trends and patterns are noted, quality improvement projects are developed and implemented upon approval of the OCDD Executive Management Team

9. Availability (hard copy, electronic file, website):
   www.nationalcoreindicators.org

10. Contact person for more information, including:
    Name: Dolores Sarna
    Title: Program Manager 2
    Agency & Program: OCDD Quality Management Section
    Telephone: 225-342-5714
    E-mail: Dolores.sarna@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department: **Louisiana Department of Health (LDH)**
09-375 Imperial Calcasieu Human Services Authority

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Executive Director: **Tanya McGee**

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

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

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

Accomplishment #1: Collaboration with local partners to provide peer navigators to local hospitals

A. **What was achieved?**
Imperial Calcasieu Human Service Authority (ImCal) collaborated with local partners to provide peer navigators to local hospitals to help manage individuals entering hospital emergency departments with overdose and other substance use disorder issues, making harm reduction specialists available to individuals with substance use disorders upon discharge from hospital emergency departments.

ImCal HSA has entered into a Memorandum of Understanding (MOU) with Odyssey

House of Louisiana and Lake Charles Memorial Hospital to ensure continuity of care for individuals who are admitted to the emergency department(ED) due to a substance use disorder (SUD). The MOU provides hospital peer navigators to assist ED staff with discharge planning and conduct follow up monitoring of the patients. In addition to traditional discharge planning activities such as referrals for detox, inpatient/outpatient therapy, and medication assisted treatment (MAT) programs, the MOU incorporates the option of a harm reduction peer supporter. Integration of harm reduction provides the individuals with choice and support as they work toward their own self-determined individual recovery goals.

B. **Why is this success significant?**
Provision of in person support to not only hospital staff, but to individuals with SUD ED admissions is a new approach. Integration of harm reduction into the community response to the opioid epidemic has emerged as a critical component.

C. **Who benefits and how?**
Hospital emergency department staff and individuals with SUD.

D. **How was the accomplishment achieved?**
Collaboration with multiple community partners including Acadiana Ambulance, multiple local hospitals, Odyssey House Louisiana, and SWLAHEC.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes (access to services, use of best practices, community engagement).

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes (use of MAT, use of harm reduction).

Accomplishment #2: Expansion of services in West Calcasieu Parish

A. **What was achieved?**
ImCal's Sulphur clinic, serving west Calcasieu Parish and Cameron Parish was expanded to increase capacity for behavioral health services, as well as to provide space for an imbedded pharmacy.

B. **Why is this success significant?**
The areas in the western side of Calcasieu Parish and in Cameron Parish are rural and require significant travel time to reach Lake Charles. These areas lack public transportation and access to much needed behavioral health services and resources. To meet this need, ImCal HSA BH Sulphur was opened in 2019. It quickly grew to be our 2nd largest clinic and continues to grow. Construction on the building added five additional offices as well as an additional restroom. The Lake Charles clinic has housed an imbedded pharmacy for many years. The expansion in Sulphur brings that benefit to

the residents of West CalCam by adding a Genoa Pharmacy onsite.

C. **Who benefits and how?**
Clients, residents, and providers in the West CalCam area.

D. **How was the accomplishment achieved?**
Collaboration with Genoa Pharmacy; collaboration with the building owner to complete the major construction project.

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

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

Accomplishment #3: Title of significant accomplishment: Integrated Dietician Services

A. **What was achieved?**
ImCal HSA created an integrated primary care clinic at its Lake Charles clinic in 2015 called ImHealthy. In 2022, an in-house Registered Dietician was added to the ImHealthy staff to provide health and nutrition counseling and education to ImCal clients, ImCal staff, community partners and other providers, and the community at large.

B. **Why is this success significant?**
Nutritional services such as healthy eating education, meal planning for parents to support healthy diets for children, assessment of dietary needs, and individualized dietary planning can be difficult to access.

C. **Who benefits and how?**
Clients, staff members, and community partners benefit from the education provided by ImCal's Registered Dietician.

D. **How was the accomplishment achieved?**
Recruitment of a Registered Dietician and building a program which reaches not only ImHealthy patients, but all ImCal clients as well as staff members.

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

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

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

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

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

Imperial Calcasieu Human Service Authority (ImCal has) 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 polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

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

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

   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 which gets more and more difficult to accomplish with increase in need for services within the community and no new TO positions in which to hire and 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?

Because ImCal has made steady and efficient progress in all objectives and strategies as indicated in our 5-year 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.

  ImCal Executive Management Team utilizes the 5-year Strategic plan to develop ImCal HSA's annual operational goals and objectives within the Annual Business Plan as well as develop its annual budget. Performance measure data outlined within the 5-year Strategic Plan is collected quarterly and shared with the Executive Management Team. Performance measures are adjusted as needed.

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

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

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

Problem/Issue #1: Lack of T.O. to meet increasing programming needs

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

      ImCal HSA struggles to obtain sufficient Civil Service TO positions to manage increasing numbers of services and programs needed in Southwest LA (SWLA) due to the rising number of individuals seeking services and the significant decline of providers in the community. Due to Hurricanes Laura and Delta, in addition to other severe weather events in the last two years, Southwest LA has lost a number of community providers, including but not limited to the closure of a Behavioral Health Hospital, local crisis stabilization and transitional housing units for individuals with severe mental illness, several private psychiatric outpatient practices who accepted Medicaid clients, as well as Home and Community Based Developmental Disability providers. As the behavioral health needs within the community continue to grow,

ImCal has been forced to bring previously contracted services in-house without the additional TO to staff the programs. This has resulted in the closure of programs and longer wait time for services which remain.

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

   Not at this time

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

   The Behavioral Health and Developmental Disability Divisions within ImCal HSA.

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

   Individuals served by ImCal, as well as community providers with whom ImCal partners and collaborates.

5. How long has the problem or issue existed?

   Since ImCal's inception, which was exasperated by COVID and repeated natural disasters.

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

   Increased need of services and reduction in services offered in the community, as evidenced by the increasing behavioral health calls to EMS, increasing number of involuntary psychiatric commitments. Local hospital Emergency Departments are inundated with behavioral health cases.

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

   Increase in suicide and overdose rates; increase in crisis cases that require higher levels of care, which would not have been needed if appropriate supports and services were in place prior to the crisis event.

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: Lack of office space for Administrative and Developmental Disabilities due to catastrophic damage from Hurricane Laura.

A. Problem/Issue Description

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. 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. Repairs on the destroyed building have continued to be delayed, necessitating that ImCal find a new permanent space. This has been challenging because of increased rents and lack of available property due to Hurricanes Laura and Delta, as well as major flooding later that year.

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?

   Admin and DD

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 are having to 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.

5. How long has the problem or issue existed?

   Since 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.

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

   ImCal HSA Board of Directors has approved request by Executive Director to purchase property in order to build a new office.

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?

        Projected timeline to purchase property and build new building is 18-24 months.

      - How much progress has been made and how much additional progress is needed?

        An offer has been made on property.

   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.

      Approximately $9 million to build new building. Have applied for Community Development funding through the City of Lake Charles.

b. How much has been expended so far?

None.

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, escrow funds being utilized for the purchase of the property, will not affect other resources, departments, or appropriated funding.

d. Will additional personnel or funds be required to implement the recommended actions?

e.

No, not at this time.

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 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**
ImCal HSA participates in the Office of Behavioral Health Peer Review process annually. This fiscal year an administrative and clinical peer review was conducted with Northeast Delta Human Services Authority.

☒ **Accreditation review**
ImCal HSA is accredited by CARF, International. Quality of conformance is reviewed annually and a full re-accreditation on-site survey is conducted by CARF every three years. 2022 was a survey year for ImCal and full 3-year accreditation was achieved with outstanding results.

☒ **Customer/stakeholder feedback**
ImCal HSA participates in the Ces't Bon program, which is a program of the Louisiana Office of Behavioral Health through the State Behavioral Health Planning Council. The program employs a specially trained team of behavioral health peers and family members who evaluate services from the persons served point of view. The team interviews some of those served at the clinic regarding the quality of services. The team then analyzes the information obtained. The data is reviewed by the Louisiana Office of Behavioral Health and then presented in a report as feedback to facility managers and their staff. The purpose of the *C'est Bon* survey is continuous quality improvement of both services and facilities. Our greatest goal is to help the behavioral health system work for all by encouraging those involved to work together.

☐ Other (please specify):

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

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

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

1. Title of Report or Program Evaluation:

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

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department: **Louisiana Department of Health (LDH)**
09-376 Central Louisiana Human Services District

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Executive Director: **Rebecca Craig**

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

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

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

Accomplishment #1: Program Treatment Expansion

A. **What was achieved?**
Planning and execution of building expansion project to accommodate expanding service provision for children, adolescents, and adults.

B. **Why is this success significant?**
Early intervention for a young person with mental illness allows for more effective outcomes and prevents more severe and lasting problems as a child grows and matures. The physical constraints of the current buildings used for the delivery of services limit the number of persons served by programs and the type of services delivered. The

facility design and layout are critical when developing treatment programs; limitations are inherent to the spaces within a facility. The expansion of the program service facility allows for additional clinical practice areas for all persons served by the Central Louisiana Human Services District (CLHSD).

C. **Who benefits and how?**
All persons who are in need of assessment and/or interventions to manage symptoms of mental illness and/or addictions.

D. **How was the accomplishment achieved?**
Coordination with the current building owner/obtaining of permissions, obtaining budget allowances necessary for project/project completion, contract development of architectural design to enhance treatment deliver services, execution of permits and construction project according to licensing codes for behavioral health outpatient clinics, licensing and accreditation of building program services location.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, the delivery of services to persons with behavioral health challenges increases the health and safety of all program participants. The expansion of services increases access for all persons seeking support in the CLHSD geographic area. In addition to improving the quality of services through evidenced based programs, the expansion provides additional areas for implementation of evidenced based programs.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
No.

Accomplishment #2: Establishment of New Electronic Documents Storage for Developmental Disabilities Program services (IDD Electronic Document Storage)

A. What was achieved?
Electronic storage of critical Developmental Disabilities records. A consultation and project manager organization was selected. Necessary preparations were made to implement the new IDD Electronic Document Storage for services delivered by CLHSD Developmental Disabilities Service programs.

B. Why is this success significant?
The new IDD Electronic Document Storage will allow for service delivery to be recorded and stored in a more efficient manner, decreasing storage costs. The electronic storage of records permits increased ease of access by professionals during routine service visits, and especially in times of public health emergencies as storage of records can occur in offsite areas permitting the ease in backing up the information and access from remote areas if the primary facility is damaged. In addition, creation of

reports and data analysis is improved with electronic records.

C. Who benefits and how?
Persons served and administrative and clinical staff benefit. Information about persons served will be in a secure, centralized location making it easier to access information, track information, and share appropriate information with others.

D. How was the accomplishment achieved?
Through the use of research organizations that provide services to develop electronic document storage and support improvements to the current method of storage. We also established parameters for the contract agreement with the organization selected for the activity, and developed technical configuration/development for the IDD Electronic Document storage. Current development of the IDD storage system is in process.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, information technology is a fast growing method for the support of program activities. The use of electronic storage of documents such as medical records for persons served within the programs is often critical to facilitate efficient service delivery, report of services delivered, increase access during times of public health emergency, cost saving for storage of information, and ease of access for monitoring services delivered.

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 #3: Increased access to Evidenced-Based practices

A. What was achieved?
Increased access to Evidenced-Based Practices by training/investing in more than five clinicians to attend Eye Movement Desensitization and Reprocessing (EMDR) training. EMDR therapy is Eye Movement Desensitization and Reprocessing and it is an Evidenced-Based Practice that uses eye movements and other forms of stimulation to focus on the brain's ability to learn, modify and adapt to trauma. It has significant positive outcomes for patients diagnosed with post-traumatic stress disorder (PTSD).

B. Why is this success significant?
The benefits of EMDR therapy include a decrease in emotional distress related to memory and trauma. This creates long-lasting behavioral changes. EMDR therapy can separate reactions from stressors, reveal past traumas so healing can begin in a therapeutic setting, mimic sleeping patterns that increase healing of brain function and treat a wide range of symptoms including panic attacks, relationship issues, anxiety, etc.

C. Who benefits and how?
Anyone can experience intense trauma at any point in their lives. Some people develop Post-traumatic Stress Disorder which can have a drastic effect on wellness outcomes for patients. According to the National Center for PTSD, about 6 out of every 100 people will have PTSD at some point in their lives. 12 million adults in the U.S. have PTSD during a given year. Overall, the effects of PTSD are decreased with EMDR therapy.

D. How was the accomplishment achieved?
Budget and funding were approved for training in EMDR.

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.

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

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

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

The overarching mission of CLHSD programs is to support persons who face the challenges of behavioral health and developmental disabilities. There were an unduplicated total of 26,535 persons served within the CLHSD eight parish geographic area, and 31,848 services provided to them. CLHSD provides three areas of support to the mission, Administrative, Behavioral Health, and Developmental disabilities. In order to support the overarching mission, the Administrative supports has implemented technological support which promote the delivery of behavioral health and developmental disabilities services directly to persons served in the respective support areas. The community based supports and services allow all persons served within the programs areas to live more productive and satisfying lives, contributing to their success in homes and communities, decreasing unnecessary hospitalization or incarceration. The program services are monitored continuously for effectiveness and quality. Input from program participants, significant others, and other stakeholders are obtained routinely.

- **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?

  Significant progress has been made in the development of technological supports to program services enhancing the security of electronic information and back-up. These technologies additionally support the delivery of program services and the efficiency of program activities through reduction of labor required for data analysis, billing and reimbursement, enhanced monitoring and oversight of program activities, improved analysis and implementation of program improvements.

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

  The progress is ongoing and expected to continue. Supports provided to the program delivery are thought to provide future gains during times of declared emergency as well as improvements in routine service delivery through continuous program performance activities.

- **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.

  Central Louisiana Human Services District (CLHSD) strategic plan is impacted by limited staffing resources, particularly Licensed Mental Health Professionals (LMHPs). Clinical services are needed most, and are critical to the function of the District. The critical clinical services can only be provided LMHPs as indicated by training and license type. Shortage areas include Psychiatrists, Medical Psychologist, Clinical Social Workers (LCSW's), Professional Counselors (LPC's), and Addictions Counselors (LAC's).

In addition, not all LMPHs (i.e. Licensed Professional Counselors and Licensed Addictions Counselors) are allowed reimbursement by federal 3rd party payors. The reimbursement restrictions affect billing and reimbursement for claims, issues with scheduling, issues with access to care, and other organizational problems.

The constraints on staffing limit progress in implementing new programs, contracting for programs, staffing clinics and crisis teams as well as limits to obtaining financial reimbursement for services.

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?

Reimbursement and staffing issues are a continuing problem. Staffing issues are related to the reimbursement by 3rd party payors/federal payors for LMPHs and the availability of LMPHs who specialize in providing behavioral health services. Efforts have been made to maximize the available resources, however, programs are continuing to be impacted by the staffing shortages.

- **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?

Central Louisiana Human Services District (CLHSD) utilizes all disciplines (LMPHs) allowed by 3rd party payors to provide services to program participants. Efforts have been made to attract providers from outside of the CLHSD defined geographic area. Telehealth is used to expand access to providers.

- **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.

Currently, the plan objective and strategies continue to be appropriate to the overall success and improvement of the quality and quantity of services to the citizens of Louisiana and efforts to increase public safety and education regarding behavioral health services. CLHSD shares the strategic plan with the community as well as internal personnel and stakeholders.

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?
   Shortages for licensed mental health professionals (LMHPs).

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   Yes, problems with vacancies (LMHPs) for Behavioral Health Clinics and programs. In addition, difficulty in establishing staffing for new programs is experienced.

3. What organizational unit in the department is experiencing the problem or issue?
   Clinical Services Programs that provide direct care for persons experiencing mental health and substance use disorders, contract programs that provide direct clinical services, contract programs that provide crisis services, and the billing department are all affected by the shortage.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Customers are directly affected. Internal functions and personnel are also impacted.

5. How long has the problem or issue existed?
   This is a longstanding problem.

6. What are the causes of the problem or issue? How do you know?
   Rural areas have few LMHPs. In addition, federal payors provide reimbursement for certain LMPHs, but not all LMPHs in Louisiana.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   In light of the current Opioid Crisis and Mental Health concerns, staffing of essential programs is difficult.

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.

To address current concerns in behavioral health care would decrease overall costs to the health care system. Untreated or inadequately treated behavioral health issues result in increased costs that are incurred within the criminal justice, judicial, and Hospital systems.

☐ 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 with 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, including:
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

Annual Management and Program Analysis Report
Fiscal Year 2021-2022

Department: **Louisiana Department of Health (LDH)**
09-377 Northwest Louisiana Human Services District

Department Head: **Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Executive Director: **Doug Efferson**

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

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

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

Accomplishment #1: Transitioned back to Workplace Services Despite Covid-19 Challenges

A. **What was achieved?**
Our Covid-19 response resulted in staff safely returning to the workplace and maintaining services despite the pandemic and the Omicron surge.

B. **Why is this success significant?**
In-person clinical services are more effective than telephone or video services, so moving back to the workplace and managing Covid-19 concerns allowed clinicians to more effectively treat those clients who needed more direct care.

C. **Who benefits and how?**
The clients of our nine-parish area received an appropriate level of service despite Covid-19 and the Omicron surge.

D. **How was the accomplishment achieved?**
Weekly fogging of office spaces to reduce viral load followed by enhanced housekeeping, personal protection measures, and enforcement of universal precautions resulted in a safe clinical environment for staff and clients.

E. **Does this accomplishment contribute to the success of your strategic plan?**
Yes. Utilizing best practices for the care of clients is a significant part of our 5-year 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?**
No

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

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

Yes.

- **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?

  Adjusting our business practices to accommodate the Covid-19 pandemic assisted us in maintaining our strategic progress. In addition to following the state-mandated response guidelines, our district contracted for weekly fogging of office spaces to reduce viral load followed by enhanced housekeeping, personal protection measures, and enforcement of universal precautions to assure a safe clinical environment for staff and clients as we moved through the Omicron surge and toward the end of the pandemic. These efforts helped us to maintain services at a significant level throughout the pandemic and kept us on track to 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 polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
    - Other? Please specify.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

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

  None.

  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 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
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, including:
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail: