John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

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

FROM: Cindy Rives
LDH Undersecretary

RE: FY 2019 Annual Management and Program Analysis Report (AMPAR)

DATE: December 4, 2019

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 2019 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 specific management or operational issues that may exist.

If there are any 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 2018-2019

Department:	**Louisiana Department of Health (LDH)** 09-300 Jefferson Parish Human Services Authority
Department Head:	**Rebekah E. Gee, MD, MPH** LDH Secretary
Undersecretary:	**Cindy Rives**
Executive Director:	**Alicia English Rhoden**

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

For each accomplishment, please discuss and explain 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: Expansion of Medication-Assisted Treatment (MAT) Services

A. **What was achieved?**

During FY 18-19, the Health Resources & Services Administration (HRSA) awarded JPHSA with $324,500 in Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH) funding to implement and/or advance evidence-based strategies for integrated substance use disorder (SUD) and/or mental health services. Through its JeffCare program, JPHSA utilized this funding to expand medication-assisted treatment (MAT) and explore non-opioid pain management options.

B. **Why is this success significant?**
Though JPHSA already offered SUD treatment and MAT services, this supplemental funding helped move the JeffCare program closer to establishing a medical home model for people with SUD by bridging gaps in the continuum of care. JPHSA's continuum of care consists of primary care, psychiatric evaluations and medication management, individual and group therapy for mental health and/or SUD, medically-assisted detoxification, ambulatory detoxification, referral relationships with residential programs, MAT, and intensive outpatient treatment, all based on evidence-based practices. JPHSA's Centralized Care Coordination program tracks and engages high-risk individuals throughout the continuum of services. The HRSA funds provided for workforce expansion, clinical workflow and practice transformation, telehealth via the eMocha application, and professional development and training. In addition, for the first time in JPHSA history, resources were available to investigate non-opioid pain management options. This is crucial for individuals who develop opioid use disorders (OUD) as a result of treatment for chronic pain.

C. **Who benefits and how?**
As a result of this grant, JPHSA was able to improve and diversify services available to the Jefferson Parish community. Through workforce expansion of medical staff, JPHSA increased access to both MAT and medication management for individuals in need. Through clinical workflow and practice transformation, JPHSA investigated the feasibility of gating implementing non-opiate pain management alternatives for individuals both with and without a related opioid use disorder (OUD), including acupuncture. Implementation of eMocha gave clinicians a new tool to improve medication adherence and increase patient engagement in MAT via a monitoring and communication application. Through professional development and training, staff members enhanced the skillsets needed to ensure fidelity to evidence-based models and support provider relationships and holistic care. With the availability of funds for the FDA-approved Sublocade™ (once-monthly injectable buprenorphine formulation), JeffCare was able to offer another option in MAT; this long-acting injectable improves medication adherence, a key objective in OUD care where treatment compliance is paramount.

D. **How was the accomplishment achieved?**
This successful HRSA application and subsequent funding was the result of the collaborative research, writing, and implementation efforts of the JPHSA Executive Director, JeffCare Division Director, JPHSA/JeffCare Medical Director, and JPHSA Public Information Officer.

E. **Does this accomplishment contribute to the success of your strategic plan?**
Yes. One strategic plan objective is for JeffCare to provide a continuum of integrated care services appropriate for all ages and abilities that generate sufficient resources to support the implementation and maintenance of evidence-based practices through FY 21-22. MAT services are evidence-based, and these HRSA funds partially support their maintenance. The funds also provide resources for workforce expansion, thus expanding

access. The funds also support the continued training and skills development required for fidelity to evidence-based and best practices.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
This accomplishment focuses on treatment practices, not management practices. However, other agencies providing SUD services, such as the other Local Governing Entities (LGEs), might benefit from the sharing of this information.

Accomplishment #2: Expansion of the Performance and Quality Improvement (PQI) process and PQI Plan Revision

A. **What was achieved?**
In FY18-19, JPHSA completed an extensive revision and enhancement of its Performance & Quality Improvement (PQI) plan and expanded the agency-wide PQI process. Based on best practices outlined in the Council on Accreditation's PQI Tool Kit and Institute for Healthcare Improvement Guidelines, all JPHSA staff members became ad-hoc members of the PQI Committee. This helped to foster engagement and staff buy-in with the process, as well as ensured perspectives from all levels of the organization. The PQI process was updated to include a continuous quality improvement cycle for feedback using the Plan, Do, Check, Act model of change.

B. **Why is this success significant?**
The PQI Plan supports JPHSA's Mission through a focus on the best use of available resources, long-term sustainability, engagement of staff and other stakeholders, and positive outcomes for service recipients. Specifically, the PQI Plan provides a framework to intake and analyze data; identify areas in need of change; develop, implement, and document improvement activities; measure success through well-defined outcome measures; and, communicate change to stakeholders. Thus, updating the Plan to ensure a continuously meaningful PQI process and to further foster staff member engagement is extremely important to JPHSA's success.

C. **Who benefits and how?**
Ongoing quality improvement benefits all stakeholders including individuals and families receiving services and/or supports, staff members, external contractors, community partners, elected officials, community leaders, and residents of Jefferson Parish. Continuous ongoing quality improvement of administrative and service delivery functions ensures JPHSA makes the best use of available resources to support sustainability.

D. **How was the accomplishment achieved?**
The Executive Director, the Division Director of Compliance & Performance Support, and the Quality Improvement Specialist researched best practices and revised the PQI process and plan. The Executive Management team, which is made up of all the Division Directors, provided feedback on the process and plan. JPHSA will work with Comagine Health, to develop and implement training for the PQI Committee. These

valuable consultant services will be provided to JPHSA through its partnership with the Heath Center Controlled Networks (HCCN) **at no cost**.

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

Yes, this accomplishment contributes directly to the first strategic goal, 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." The purpose of the PQI Plan and associated process is to ensure programs and operations are always improving using data-based decision-making, in furtherance of the best use of available resources and long-term sustainability. Moreover, the PQI process contributes to JPHSA's Mission by collecting and addressing needs of all stakeholders to meet the integrated care needs of individuals 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. This is a process that can be easily replicated and sustained by other agencies.

<u>Accomplishment #3: Distribution of Naloxone (Narcan) to Community Partners</u>

A. **What was achieved?**
Through development of Cooperative Endeavor Agreements (CEAs), JPHSA distributed Narcan (otherwise known as Naloxone) to several Jefferson Parish community partners, including Police Departments (PD) and Fire Departments (FD). JPHSA coordinated with these departments so first responders would have access to this much-needed medication free of charge. JPHSA also provided the training to first responders on the safe use of Narcan in the field.

B. **Why is this success significant?**
This success is significant because it recognizes JPHSA's commitment to meeting the needs of the residents of Jefferson Parish and strengthening partnerships with community stakeholders. During FY 18-19, five (5) lives were saved due to first responders having access to the Narcan provided under these agreements.

C. **Who benefits and how?**
The citizens of Jefferson Parish as well as first responders benefited from this accomplishment. Narcan saves lives. Not only are individuals with an Opioid Use Disorder at risk of death from their drug use, so are the First Responders that treat them. First responders are potentially exposed to opioids as a result of their employment and may be at risk of acute opioid intoxication themselves. Narcan can be used to protect first responders as well.

D. **How was the accomplishment achieved?**
Louisiana received two (2) grants from SAMHSA (State Targeted Response and State Opioid Response). These grants, through the Office of Behavioral Health, were filtered

to the Local Governing Entities; at JPHSA the funds were used to provide Narcan. JPHSA entered into Cooperative Endeavour Agreements with police and fire departments to provide Narcan and training to first responders free of charge. The CEA also allowed for replenishing the Narcan, when needed.

E. **Does this accomplishment contribute to the success of your strategic plan?**
This accomplishment supports the first goal of JPHSA's strategic plan. Providing this much needed medication and training to police and fire departments supports the first goal by helping to preserve limited resources in Jefferson Parish.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Naloxone is a medication approved by the Food and Drug Administration (FDA) to prevent overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of the overdose. The provision of Narcan for a suspected opioid overdose is included in the SAMHSA Opioid Overdose Prevention TOOLKIT updated in 2018. If the practice of providing Narcan to police departments and fire departments was to be adopted by the other LGEs, it could help save the lives of individuals across the state.

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 FY18-19, 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 Authority.

- **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 1: 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 achieved significant progress toward reaching this goal in FY 18-19. Specifically, JPHSA maintained its resources in a manner that allowed for the preservation and expansion of services.

Please note in particular:

- JPHSA maintained and worked to expand its Centralized Care Coordination program throughout FY 18-19. This program helps to streamline referrals, improve feedback with community stakeholders, and ultimately, improve upon the services and supports provided to individuals in Jefferson Parish. In FY 19-20, operational changes planned in FY 18-19 will be implemented in furtherance of JPHSA's No Wrong Door philosophy, whereby any individual referred to any Division, program, or service, is assessed for eligibility across JPHSA's full spectrum of services and supports.

- JPHSA increased funding for its Developmental Disabilities Community Services ACT 73 services significantly beyond the 9% of State General Fund funding required by law. These funds were used to provide additional slots in the Flexible Family Fund Program, as well as to assist many individuals and/or families with one-time financial support. Some of the one-time financial support was able to fund services and supports to help aid individuals with developmental disabilities in improving communication, continuing education, and increasing independence at home and in the community.

Goal II: Achieve Universal Design as the model to guide the provision of integrated care to the individuals served by JPHSA and its programs.

JPHSA achieved significant progress toward reaching this goal in FY 18-19.

Please note in particular:

- During FY 18-19, JPHSA expanded its relationship with the Jefferson Parish School System (JPSS) through development of a formalized referral process. This process will allow JPHSA to provide needed in-school services and assessments, including developmental disabilities eligibility screening; parenting classes for both parents of students and students who themselves are parents; and, Functional Family Therapy

(FFT). It also provides a streamlined approach for schools to make referrals to JPHSA for other Health Center or community-based services. Through this arrangement, JPHSA is expanding access to services within the community to the benefit of Jefferson Parish residents.

- During FY 18-19, JPHSA further developed and refined its "No Wrong Door" approach for individuals seeking services through ongoing training of its care coordination staff members. JPHSA screens and assesses all individuals seeking services for mental health, addictive disorder, primary care and/or developmental disabilities. JPHSA utilized grant funding to work with a subject-matter expert on evidence-based practices to develop its Centralized Care Coordination model into a best practice that can be replicated by other agencies nation-wide. This benefits individuals and families by:
    - Reducing redundancy of screenings which may cause confusion and frustration for individuals and their families;
    - Better ensuring individuals and families are linked to the right services and supports at the right time based upon actual needs; and,
    - Promoting a holistic approach to healthcare by assessing and addressing all health and disabilities needs in one place that treats the individual as a person and not a diagnosis.

JPHSA attributes these successes to the following:

- On-going commitment of the Board, Executive Director, Executive Management Team, and staff members to treat the whole person, and not just a disability or diagnosis;
- A strong connection to Mission;
- Effective budgeting and management of resources, which allows JPHSA to more effectively address these needs;
- On-going relationship management with stakeholders to remain informed of community needs; and,
- A commitment to continuous Performance and Quality Improvement.

Progress is not the result of a one-time gain; rather, it is an ongoing process. Universal Design, integration of care, and the person-centered approach are part of the JPHSA culture. Because JPHSA is committed to serving the whole person, and not diagnoses, JPHSA staff members refer to those seeking services as "individuals served" or "service recipients," and not "clients" or "patients." The use of this language is reflected in written policy and staff member training, and is used in daily actions and decision-making.

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

JPHSA achieved significant progress toward reaching this goal in FY 18-19. Specifically, JPHSA was able to attract and hire well-qualified candidates despite significant competition stemming from the recent openings of two major medical centers in New Orleans.

Please note in particular:

- Throughout FY 18-19, JPHSA used brand management as a recruitment tool.

- Throughout FY 18-19, JPHSA expanded its online job postings for certain hard-to-fill positions beyond the State Civil Service website and its own website by posting on external websites including Indeed Jobs, LinkedIn Jobs, and Facebook. Other recruitment efforts included advertising with professional networks, such as the local Behavioral Health Taskforce, and collaborating with local colleges and universities.

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

  FY 18-19 was the second year that JPHSA implemented its revised Strategic Plan, which is planned to be in effect through FY 21-22. The Strategic Plan was reflective of JPHSA's state of strategic management and community needs throughout the fiscal year.

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

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

  JPHSA monitors, reports, and implements corrective action and/or Performance and Quality Improvement (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 Director is required to develop and implement an annual division-specific business plan in support of the JPHSA Strategic Plan. Division Directors provide detailed written reports on progress to the Executive Director on 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 one time each week via the JPHSA email system with special editions provided on an ongoing basis.

  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?

None. 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

◆ 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.

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

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

4. 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**
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 Fiscal Services department 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 through the Office of the Legislative Auditor. The Authority's FY18 audit produced **no** findings or recommendations (e.g. management letter), i.e. the audit was clean. The FY 18-19 audit is scheduled during late August 2019. 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 FY 18-19 on-site audit occurred on April 11, 2019. The OCDD audit produced no findings and required no corrective action. The OBH audit included recommendations for improvement; JPHSA developed and implemented corrective action, which was submitted to OBH in July 2019. The peer review

was done with Florida Parishes Human Services Authority and produced no findings or recommendations.

☒ Policy, research, planning, and/or quality assurance functions in-house
JPHSA's 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. A full-time Policy Planner was hired in FY 18-19 to assist with policy and procedure management. 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
In FY 18-19, JPHSA had **no** contracts for policy, research, planning, and/or quality assurance functions.

☒ Program evaluation by in-house staff
Program performance is monitored on an ongoing basis utilizing the JPHSA Strategic Plan, Operational Plan, Division-Specific Annual Business Plans, Annual 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 Maintenance of Accreditation Committee (a chartered committee representing all facets of JPHSA) helps ensure adherence to accreditation program and service standards through ongoing monitoring on the division level.

The Executive Director, Executive Management Team, Supervisory Staff, and the CPS Division share responsibility for monitoring and technical assistance. The Executive Director is also required to submit ongoing monitoring reports to the JPHSA Board of Directors as defined by Board policy.

☒ Program evaluation by contract
In FY 18-19, JPHSA had **no** contracts for program evaluation

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
JPHSA collects data, performs statistical analysis, and reports outcomes/outputs into LaPAS on a quarterly basis. Notes of explanation are provided for positive and negative variances of 5% or more from quarterly Performance Indicator targets. Each note outlines any needed corrective action or process improvement activities. JPHSA also provides data or makes data available to the Louisiana Department of Health (LDH), Office for Citizens with Developmental Disabilities (OCDD), and the Office of Behavioral Health (OBH) on an ongoing basis and as required by contractual agreement. JPHSA is compliant with the LDH Human Services Accountability 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. JPHSA began its current reaccreditation cycle with the Council on Accreditation in September 2018, which will culminate in February 2020.

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**
During FY 18-19, JPHSA utilized Greenway's Success EHS as its sole electronic health record for behavioral health, developmental disabilities, and primary care services, as well as i2i to enhance 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 FY 18-19, with Florida Parishes Human Services Authority, focused on clinical functions. The Office of Behavioral Health and Office for Citizens with Developmental Disabilities also conduct annual on-site reviews with peers from other Local Governing Entities as participants.

☒ Accreditation review
During FY18-19, JPHSA maintained accreditation and compliance with Council on Accreditation Standards. As JPHSA was awarded four-year full organization accreditation in FY 15-16, the current review cycle began in September 2018 and will culminate in February 2020.

☒ Customer/stakeholder feedback
JPHSA participates in annual satisfaction surveys sponsored by the Office of Behavioral Health and the Office for Citizens with Developmental Disabilities. Additionally, JPHSA fields a proprietary survey within its Health Centers on a semi-annual basis in order to identify opportunities for improvement. Comment boxes are available in all Health Centers; and, JPHSA invites confidential

feedback on its internet site. JPHSA requires contractors delivering community-based behavioral health services to field satisfaction surveys with their service recipients and to share results with JPHSA. Staff members have access to comment boxes in all break rooms, and may also provide the employee-led committee, Esprit de Corps, with suggestions for improvement. The Esprit de Corps Chairperson has direct access to the Executive Director and Executive Management Team. 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, 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:

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 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: Elizabeth Riehl
Title: Division Director, Compliance & Performance Support
Agency & Program: Jefferson Parish Human Services Authority
Telephone: 504-838-5215, ext. 263
E-mail: eriehl@jphsa.org

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

Department:	**Louisiana Department of Health (LDH)** 09-301 Florida Parishes Human Services Authority
Department Head:	**Rebekah E. Gee, MD, MPH** LDH Secretary
Undersecretary:	**Cindy Rives**
Executive Director:	**Richard J. 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: Title of significant accomplishment: Opening of new Denham Springs Behavioral Health Clinic

A. What was achieved? FPHSA was able to open a new full time clinic in Denham Springs to serve Livingston Parish.
B. Why is this success significant? Livingston Parish has a population similar to Tangipahoa and FPHSA had no full time clinic there. The area was already underserved and the need was exacerbated by the floods of 2016 with some providers not reopening in the area and an arguably greater need.
C. Who benefits and how? Stakeholders in Livingston and St. Helena parishes by having

access to critical behavioral health services

D. How was the accomplishment achieved? By strategically repurposing existing resources. No additional budget was required to accomplish this.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, this allows for improved ability to fulfill the agency's mission and a more efficient use of agency resources.
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes in that it involved looking at where positions and funding were previously being spent and redistributing them to where the most impact was needed rather than just continuing what was in place.

Accomplishment #2: Title of significant accomplishment: Began implementation of Zero Suicide model across the agency.

A. What was achieved? FPHSA has begun the process to implement the Zero Suicide model across all agency operations.
B. Why is this success significant? Zero Suicide is an evidence based best practice that has shown to reduce the number of suicides in a treatment population. Because we are a behavioral health organization, those that we serve are at higher risk for suicide.
C. Who benefits and how? Those receiving services from FPHSA and their families.
D. How was the accomplishment achieved? Through the commitment of leadership to make more of a difference in the lives of those we serve. There is minimal additional cost associated with the process; it mostly involves policy changes and a culture that supports the initiative.
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 and goal 2 speaks to improving the effectiveness of behavioral health care services. This effort improves our ability to accomplish both.
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes, Zero Suicide is an internationally accepted best practice for the reduction of suicides in health systems.

Accomplishment #3: Title of significant accomplishment: Job Fairs for individuals with disabilities

A. What was achieved? FPHSA began hosting job fairs specifically targeting individuals with disabilities who are seeking employment.
B. Why is this success significant? One of the major initiatives of FPHSA's and the state's developmental disabilities sections is to increase the number of individuals served who are in the workforce. As with any other person, a job can help create a part of an individual's identity and provide a greater sense of purpose. There are particular challenges for this population to find jobs that we hope these events will help them overcome.
C. Who benefits and how? Individuals with disabilities and their families as well as citizens

of Louisiana in general.

D. How was the accomplishment achieved? By working together with community partners and collateral agencies.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Goal 1 of the strategic plan speaks to improving the quality of life and community participation for those that we serve.
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes, as individuals with greater community participation live happier and healthier lives with less reliance on government programs.

Accomplishment #4: Title of significant accomplishment: Establishment of an opioid mobile response team

A. What was achieved? A mobile team to outreach to those with opioid use disorders in the community was established.
B. Why is this success significant? Some of the parishes in our catchment area are among those with the highest number of opioid deaths per year. This outreach team has been instrumental in engaging them in treatment and linking individuals to the proper care.
C. Who benefits and how? Those impacted by the opioid epidemic in the Florida Parishes as well as the community as a whole.
D. How was the accomplishment achieved? FPHSA was able to use federal grant dollars through the Office of Behavioral Health to contract with an outside agency to staff the mobile 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, proactive treatment in the community yields improved outcomes.

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 agency's strategic goals, as outlined in the strategic plan developed in 2016, remain appropriate. Because of the ever changing landscape of provision of healthcare services how to best meet those goals is constantly changing but the goals themselves are the

same. Numbers of clients served, outcome measures, quality measures, monitoring reports, accreditation, and developing partnerships in the community all indicate that significant progress continues to be made in this effort.

- **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.

  Improved availability of resources through increased self-generated revenue and grant funding, reallocation of existing resources to direct them towards appropriate priorities, increase community involvement, support of the governing board, and most importantly an engaged and innovative management team are responsible for this progress.

     -
  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 likely to continue at a sustained pace as none of the factors, with the exception of the grants, are factors that are unexpected to exist in the future.

- **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?

The current 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.

☐ 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.

Senior managers gave input into the development of the strategic plan and received a copy of the final version. 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?
   Recruiting and retaining staff continues to be a challenge.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   The recruiting and retention has not, yet, prohibited progress towards the agency's goals but it does impact the degree to which progress can be made beyond the current level.
3. What organizational unit in the department is experiencing the problem or issue?
   Direct care positions in the behavioral health clinics and residential program are currently the most severely impacted.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Persons served must wait longer between appointments due to a limited number of providers. Longer waits between appointments may result in poorer outcomes and more potential for behavioral health crises is individuals whose symptoms are not managed appropriately.
5. How long has the problem or issue existed?
   The problem has existed for many years.
6. What are the causes of the problem or issue? How do you know?
   Disparities between compensation available by competing agencies is a key factor. Many candidates have been selected for and offered positions but turned them down due to rate of pay. Additionally, former staff have left employment to accept better paying jobs elsewhere.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   Failure to resolve the problem will hinder the agency's ability to ultimate fulfill its mission and complete the strategic plan goals. Management is encouraged, though, by the recent compensation changes approved by the Department of Civil Service and hope to see a positive impact in the coming months. Additionally, the agreement by the legislature to stabilize the budget for the near future should positively impact recruiting and retention.

B. Corrective Actions

- 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.

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

2. Has this recommendation been made in previous management and program

analysis reports? If so, for how long (how many annual reports)?

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

4. 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**
FPHSA's Behavioral Health and Development Disabilities Services areas conduct quarterly quality enhancement reviews and audits.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
Civil Service, Office of Risk Management, LDH, and the Healthy Louisiana

plans conduct audits and reviews of FPHSA's processes, procedures and services.

☐ 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**
Peer reviews are conducted by neighboring LGEs once per year as required by

the Substance Abuse Block Grant

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

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

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

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

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

1. Title of Report or Program Evaluation: Civil Service Audit/Human Resources
2. Date completed: March 28-29, 2019
3. Subject or purpose and reason for initiation of the analysis or evaluation:
To evaluate the FPHSA Human Resource Office compliance with Civil Service Rules and documentation requirements.
4. Methodology used for analysis or evaluation: Civil Services Rules used to review actions that occurred from April 1, 2018 through February 1, 2019.
5. Cost (allocation of in-house resources or purchase price): Not calculated
6. Major Findings and Conclusions: Written justification for three job appointments was insufficient, one appointment and one promotion the hire authorization was not entered into LA Careers within 30 days.
7. Major Recommendations: Agency recommended for achieving 100% compliance

in 17 of the 19 categories reviewed such as authority for pay, appointing authority approval and position descriptions updated. 100% compliance in all PES categories.
8. Action taken in response to the report or evaluation: Written justification form (HR-3) has been revised to require a detailed explanation regarding the need and for the type of appointment, HR staff in-serviced on the revisions Modified the checklist for appointments to include 30-day hire authorization and updated the HR Turnaround Frames to include the 30-day hire authorization.
9. Availability (hard copy, electronic file, website) electronic file: electronic file
10. Contact person for more information, including

Name: Richard Kramer
Title: Executive Director
Agency & Program: FPHSA
Telephone: (985) 543-4333
E-mail: richard.kramer@fphsa.org

1. Title of Report or Program Evaluation: Office of Risk Management Audit
2. Date completed: March 1, 2019
3. Subject or purpose and reason for initiation of the analysis or evaluation: To rate compliance with State requirements
4. Methodology used for analysis or evaluation: Reviewed agency documents to compare with standards specified in the Office of Risk Management Manual
5. Cost (allocation of in-house resources or purchase price): Not calculated
6. Major Findings and Conclusions: No documented training on the Return to Work policy
7. Major Recommendations: Conduct and document employee training on the Return To Work policy
8. Action taken in response to the report or evaluation: Request submitted to Human Resources to conduct and document employee training on the Return to Work policy
9. Availability (hard copy, electronic file, website) electronic file: electronic file
10. Contact person for more information, including

Name: Richard Kramer
Title: Executive Director
Agency & Program: FPHSA
Telephone: (985) 543-4333
E-mail: Richard.kramer@fphsa.org

1. Title of Report or Program Evaluation: Monitoring of Comprehensive Opioid Abuse Program
2. Date completed: April, May, and June 2019
3. Subject or purpose and reason for initiation of the analysis or evaluation: To determine if program is in compliance with MOU and funding requirements
4. Methodology used for analysis or evaluation: Administrative Facility Review and Administrative Individual Participant Records

5. Cost (allocation of in-house resources or purchase price): Not calculated
6. Major Findings and Conclusions: The overall compliance score was 100%; therefore, there were no major findings or conclusions
7. Major Recommendations: To implement a peer support group for those with substance use issues within the jail
8. Action taken in response to the report or evaluation:
9. Availability (hard copy, electronic file, website) electronic file: electronic file
10. Contact person for more information, including

Name: Richard Kramer
Title: Executive Director
Agency & Program: FPHSA
Telephone: (985) 543-4333
E-mail: rachelle.sibley@fphsa.org

1.Title of Report or Program Evaluation: Healthy Louisiana Plan Treatment Record Reviews/Desktop Audits (Aetna)
2.Date completed: March 2019
3. Subject or purpose and reason for initiation of the analysis or evaluation
Requirement of the LBHP Partnership and a component of Aetna's Quality Improvement Program
4. Methodology used for analysis or evaluation: Review completed by Aetna based on Medicaid Services Manual and their provider manuals and requirements
5. Cost (allocation of in-house resources or purchase price): Not calculated
6. Major Findings and Conclusions:
FPHSA Mandeville Clinic received an overall cumulative final score of 92% which exceeded the benchmark score of 80%. There were no major findings.
FPHSA Bogalusa Clinic for client D received an overall cumulative score of 88% which is higher than the benchmark score of 80%. There were no major findings.
FPHSA Franklinton Outreach Clinic for client A received an overall cumulative score of 76% which did not meet the benchmark score of 80%; however, there were no major findings.
FPHSA Bogalusa Behavioral Health Clinic for client B received an overall cumulative score of 70%; however, there were no major findings.
FPHSA Bogalusa Behavioral Health Clinic for client C received an overall cumulative score of 70% which did not meet the benchmark score of 80%; however, there were no major findings.
7. Major Recommendations: None
8. Action taken in response to the report or evaluation
Audit results are discussed leadership team meetings and necessary changes are made to processes and procedures for improvement.
9. Availability (hard copy, electronic file, website) Hard copy
Contact person for more information, including

Name: Richard Kramer
Title: Executive Director
Agency & Program: Florida Parishes Human Services Authority

Telephone: (985) 543-4333
E-mail: Richard.Kramer@fphsa.org

1. Title of Report or Program Evaluation: FPHSA Monitoring Summary Report
2. Date completed: 1/8/19
3. Subject or purpose and reason for initiation of the analysis or evaluation: To determine whether the terms of the LDH PSH program contract are being consistently met.
4. Methodology used for analysis or evaluation: Client and staff interviews; staffing credentialing review.
5. Cost (allocation of in-house resources or purchase price): N/A
6. Major Findings and Conclusions: Terms have been met within the LDH PSH program contract. Clients are pleased with their services.
7. Major recommendations: None
8. Action taken in response to the report or evaluation: None required
9. Availability (hard copy, electronic file, website) electronic file: Electronic file
10. Contact person for more information, including
    Name: Richard Kramer
    Title: Executive Director
    Agency & Program: Florida Parishes Human Services Authority
    Telephone: (985) 543-4333
    E-mail: Richard.Kramer@fphsa.org

1. Title of Report or Program Evaluation: FPHSA Monitoring Summary Report
2. Date completed: 7/16/19
3. Subject or purpose and reason for initiation of the analysis or evaluation: To determine whether the terms of the LDH PSH program contract are being consistently met.
4. Methodology used for analysis or evaluation: File reviews of assessments, plans, and progress notes.
5. Cost (allocation of in-house resources or purchase price): N/A
6. Major Findings and Conclusions: Terms have been met within the LDH PSH program contract.
7. Major recommendations: None
8. Action taken in response to the report or evaluation: None required
9. Availability (hard copy, electronic file, website) electronic file: Electronic file
10. Contact person for more information, including
    Name: Richard Kramer
    Title: Executive Director
    Agency & Program: Florida Parishes Human Services Authority
    Telephone: (985) 543-4333
    E-mail: Richard.Kramer@fphsa.org

1. Title of Report: The Human Services Accountability Plan (AP), Onsite Monitoring Preliminary Report
2. Date Completed: 03/14/19
3. Subject/Purpose: 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 (HSIC) and the Louisiana Department of Health (LDH) to guide the delivery of substance use disorders (SUD), developmental disabilities (DD), and mental health (MH) services funded by appropriations from state, gambling and block grant dollars. As part of the AP, the local governing entity (LGE) and service site(s) within are subject to monitoring.
4. Methodology Used: LGE Monitoring Tool
5. Cost: Not calculated
6. Major Findings and Conclusions: There were no major findings. A) For the OBH AP portion of the review, FPHSA scored an overall 97% in the Administrative Review, 99% in the facility review of the Bogalusa Behavioral Health Clinic, and 100% in the facility review of the Mandeville Behavioral Health Clinic. B.) For the OCDD AP portion of the review, it was found that FPHSA met the performance standard for 93% of the performance indicators.
7. Major Recommendations: None
8. Action Taken in response: Results were reviewed and discussed at leadership team meetings and corrective action plans for put in place where improvement was needed.
9. Availability: Electronic file
10. Contact Person-Name:
    Richard Kramer
    Title: Executive Director
    Agency/Program: FPHSA
    Telephone: (985) 543-4333
    Email: Richard.kramer@fphsa.org

1. Title of Report or Program Evaluation: Contract Monitoring
2. Date completed:
   Quarterly
3. Subject or purpose and reason for initiation of the analysis or evaluation
   FPHSA Contract Regulations Policies and Procedures
4. Methodology used for analysis or evaluation
   FPHSA Contract Regulations Policies and Procedures
5. Cost (allocation of in-house resources or purchase price)
   Not calculated
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)
   Hard copy
10. Contact person for more information, including
    Name: Richard Kramer
    Title: Executive Director
    Agency & Program: Florida Parishes Human Services Authority
    Telephone: (985) 543-4333
    E-mail: Richard.Kramer@fphsa.org

1. Title of Report or Program Evaluation: LDH/OBH Prevention Site-Monitoring Visits
2. Date completed: December 13, 2018 and January 3, 2019
3. Subject or purpose and reason for initiation of the analysis or evaluation: Site visits are structured to address data and activities relative to the Strategic Prevention Framework .(SPF). All prevention work funded via SAPT block grant required that the SPF be used to inform, guide, and operate prevention services. Additional federal funds are also allocated to FPHSA (LaPFS) for implementation of required activities. These efforts follow SPF guidelines as well.
4. Methodology used for analysis or evaluation: These reviews address a.) the LGE's organizational capacity to meet grant goals and objectives, b.) The LGE's contract monitoring efforts. c.) step one of the Strategic Prevention Framework (SPF) process addressing assessment, d.) Step two of the SPF addressing capacity, e.) step three of the SPF addressing Planning, f.) step four of the SPF addressing implementation, and g.) step five of the SPF addressing evaluation. Site visits also review/consider the LGE's work relative to the State Targeted Response (STR) program relative specifically to prevention work.
5. Cost (allocation of in-house resources or purchase price) Not calculated
6. Major Findings and Conclusions:
   - Assessment: OBH and FPHSA will focus on discovering new and improved methods of collecting community-based data to better assess community primary prevention needs
   - Hiring & Staff Qualifications: FPHSA has successfully hired a new prevention coordinator and existing staff have met requirements for test for the Certified Prevention Professional credential.
   - Capacity: FPHSA "does an outstanding job coordinating" with OBH regionally sponsored and required prevention training
   - Implementation: FPHSA has, as requested, successfully submitted the list of prevention contract providers.
   - STR: FPHSA's award for STR included the requirement to mount the Generation Rx program and meets the requirement without difficulty
7. Major Recommendations: None
8. Action taken in response to the report or evaluation: None
9. Availability (hard copy, electronic file, website) electronic file: electronic file
10. Contact person for more information, including
    Name: Richard Kramer

Title: Executive Director
Agency & Program: FPHSA
Telephone: (985) 543-4333
E-mail: richard.kramer@fphsa.org

:

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

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

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

Undersecretary: **Cindy Rives**

Executive Director: **Dr. Jan Kasofsky**

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: CAHS Earns Three-Year CARF Reaccreditation:

A. What was achieved? The Commission on Accreditation of Rehabilitation Facilities (CARF International) has reaccredited Capital Area Human Services for three years, through November 30, 2021.
B. Why is this success significant? This latest accreditation is the third consecutive three-year accreditation that CARF International has issued to CAHS. “This achievement is an indication of your organization’s dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of conformance to standards,” wrote CARF President and CEO

Brian Boon, PHD, in a Nov. 30 reaccreditation letter to CAHS Program Manager Karen Pino, LCSW-BACS, LAC, who coordinated CAHS' reaccreditation efforts.

C. Who benefits and how? CAHS was reaccredited for the following programs and services: Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults); Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents); Outpatient Treatment: Mental Health (Adults); Outpatient Treatment (Children and Adolescents); and Residential Treatment: Alcohol and Other Drugs/Addictions (Adults).
D. How was the accomplishment achieved? CAHS was reaccredited for the following programs and services: Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults); Outpatient Treatment: Alcohol and Other Drugs/Addictions (Children and Adolescents); Outpatient Treatment: Mental Health (Adults); Outpatient Treatment (Children and Adolescents); and Residential Treatment: Alcohol and Other Drugs/Addictions (Adults).
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Founded in 1966 as the Commission on Accreditation of Rehabilitation Facilities, and now known as CARF International, the accrediting body establishes consumer-focused standards to help organizations measure and improve the quality of their programs and services. It is required for payment by MCO's and private payers.
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? CARF is an independent, nonprofit accrediting body whose mission is to promote the quality, value and optimal outcomes of services through a consultative accreditation process and continues improvement services that center on enhancing the lives of persons served

<u>Accomplishment #2: CAHS Offering Vivitrol for Opioid Treatment (9/18):</u>

A. What was achieved? Capital Area Human Services is now offering Vivitrol injections (when indicated) as part of a comprehensive treatment program that includes screening, assessment, and counseling for individuals with a history of opioid dependence or misuse.
B. Why is this success significant? "Vivitrol is an FDA-approved medication that reduces cravings and prevents relapse among individuals in addiction recovery treatment," said CAHS Medical Director Aniedi Udofa, MD,DABPN
C. Who benefits and how? CAHS Director of Addiction Recovery Services Jan Laughinghouse, PhD, LCSW, said Vivitrol is administered monthly by injection and is part of a comprehensive treatment plan that includes group and individual therapy.
D. How was the accomplishment achieved? "Vivitrol is an opioid blocker, preventing opioids from affecting the brain, so individuals don't experience the euphoria or "high" they normally world from opioids," Dr. Laughinghouse explained. She added that clients must undergo complete detoxification from any opioids or opioid-containing medications for seven to 14 days before starting Vivitrol.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, it is a reacted treatment for opioid addiction and helps to save lives.
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: CAHS Peers Have Distributed Nearly 1,500 Naloxone Kits (10/18):

A. What was achieved? In recent months, CAHS Peers have distributed 1,486 naloxone kits that include instructions and easy-to-use nasal spray that can be administered to someone who is overdosing on opioids.
B. Why is this success significant? Capital Area Human Services is using the latest medications in the fight against opioid dependence: naloxone to help save lives.
C. Who benefits and how? "We work with people wherever they are, including area jails and prisons, and we encourage them to follow up with CAHS for successful treatment options that include counseling and Vivitrol." Avoids overdose deaths amoung people who abuse opioids.
D. How was the accomplishment achieved? "We are distributing naloxone to individuals, their friends, family, and other agencies on the front lines of the fight against opioids," says Myles.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes, it is a harm reduction strategy.
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes

Accomplishment #4: School Based Therapy Program Delivers Trauma Kits to Teachers:

A. What was achieved? Thanks to community assistance grant from the East Baton Rouge Mayor's Office, CAHS' School Based Therapy Program assembled and distributed 250 " Trauma Teacher Toolkits" during the month of September for every teacher in five area schools.
B. Why is this success significant? All school systems are looking for approaches to assist children to self soothe through to better manage stress and violence.
C. Who benefits and how? Each classroom is being furnished with a beanbag or ball chair to use in a "calm down" corner. A disc of relaxing music, yoga video, flexible pencils, stress reliever toys, fidget cubes, inflatable square cushion seats, and art supplies were provided for teachers to use with students when the needs arise.
D. How was the accomplishment achieved? School Based staff and therapists distributed the kits to teachers at Capital Middle, Capitol Elementary, Claiborne Elementary, Howell Park Elementary, and Melrose Elementary.
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 #5: CAHS and Court Officials Review AOT Programs in Ohio:

A. What was achieved? CAHS Medical Director Aniedi Udofa, MD, and Program Manager John Nosacka, LCSW,MSHCM, joined a group of community partners to review Assisted Outpatient Treatment (AOT) programs in Ohio, as CAHS works to help implement AOT in Baton Rouge courts.

B. Why is this success significant? The program reduces hospitalization rates, homelessness, arrests, and incarceration.
C. Who benefits and how? AOT is court-ordered outpatient treatment for persons with severe mental illness.
D. How was the accomplishment achieved? The Ohio trip, sponsored in part by the Treatment Advocacy Center, allowed Dr. Udofa, Nosacka, and others to visit model AOT courts and programs in Butler and Summit counties. The team talked with judges Patricia Hider and Elinore Marsh Stormer about their AOT programs and observed hearings for persons on existing AOT commitment orders. The team also visited a behavioral health provider that provides wrap-around services for AOT participants.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) This summer, Governor John Bel Edwards signed Senate Bill 306 into law, updating Louisiana's law that provides for court-ordered AOT. The law calls on CAHS and all Human Services Districts to provide clinical oversight for all AOT cases in the courts within their boundaries. Judges, also, have more defined roles in helping participants adhere to their treatment plans.
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? CAHS Executive Director Jan Kasofsky, PhD, and Noscaka appeared in March before a Louisiana Senate committee to provide information about AOT. In February, CAHS co-sponsored a statewide seminar about AOT with Healing Minds NOLA. Nosacka also met with community partners to revise the old law, clarify language, and establish roles.

<u>Accomplishment #6: Partnering with DEA for "Prescription Drug Take Back Day" (11/19)</u>

A. What was achieved? Capital Area Human Services (CAHS) joined with the U.S. Drug Enforcement Administration (DEA) and regional law enforcement agencies for National Prescription Drug Take Back Day on October 27th at four locations in the region.
B. Why is this success significant? Experts say the improper use of medications can lead to addiction and overdose. More than 54 percent of people who misuse opioids get them from family and friends.
C. Who benefits and how? CAHS Prevention staff members joined DEA agents, local law enforcement, and area business to distribute information about medication safety and community resources at four locations: the Baton Rouge Police Department, the Baton Rouge Sheriff's Office at Woman's Hospital, the West Feliciana Drug and Alcohol Awareness Team in Saint Francisville, and the Iberville Sheriff's Office and Plaquemine Police Department, both in Plaquemine.
D. How was the accomplishment achieved? CAHS- produced medication safety campaign video that was launched via social media, YouTube, and websites during Prescription Drug Take Back Day event. The medication safety campaign will continue through December 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

<u>Accomplishment #7: CAHS Officials Play Key Roles at Mental Health Summit:</u>

A. What was achieved? CAHS Licensed Clinical Social Worker Sheidra Boutte' was a panelist at an October 30th summit, presented by United States Senator Bill Cassidy, MD of Louisiana and designed to promote proven methods that improve mental health care in Louisiana and the nation.
B. Why is this success significant? Between 50% and 80% of people in jail who identified with behavioral health need also have co-occurring substance use/misuse disorders, according to national statistics.
C. Who benefits and how? Boutte' gave details about the CAHS Justice-Involved Intensive Outpatient Program (JI-IOP), which began in 2016 and helps participants avoid returning to jail. The program provides the necessary tools to maintain emotional stability and sobriety during the recovery process. She also spoke about the Behavioral Health Reentry Program (BHRP) at the East Baton Rouge Parish Prison. CAHS has had staff members assigned to the Parish Prison over the past several years, conducting assessments, conducting groups, and coordinating aftercare services for individuals who are in the process of being released.
D. How was the accomplishment achieved? The regional plan addresses topics related to opioid addiction prevention, treatment, and recovery that includes an overview, facts, recommendations, and action steps in each of these nine areas:
   1) Understanding Addiction and Reducing Stigma
   2) Prevention Services
   3) Law Enforcement, Criminal Justice Reform, and Corrections
   4) Prescribing Practices
   5) Harm Reduction: Overdose Reversal and Syringe Access
   6) Pain Management
   7) Detoxification Medication-Assisted Treatment (MAT) and Supportive Counseling
   8) Treatment of Pregnant Women and Neonatal Abstinence Syndrome
   9) Recovery Services and Community Supports
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes

<u>Accomplishment #8: CAHS' Behavioral Health Collaborative Hosts Summit, Releases Response Plan to the Opioid Crisis:</u>

A. What was achieved? The "Community-Wide Response Plan to the Opioid Epidemic" was released December 5th at a regional summit in Baton Rouge with more than 150 community participants.
B. Why is this success significant? The plan will be used broadly by local entities who will match their missions to the plan's recommendations to provide prevention, evidence based safe approaches to treatment and rehabilitation services.
C. Who benefits and how? The plan, which contains recommendations and action steps, was written and published by CAHS after 18 months of meetings by the Capital Region Behavioral Health Collaborative. The Collaborative meetings were facilitated by CAHS staff and included presentations by local experts in the field, research of best practices,

and input by stakeholders, including individuals impacted by opioid addiction.

D. How was the accomplishment achieved? The regional plan addresses nine topics related to opioid addiction prevention, treatment, and recovery that includes an overview, facts, recommendations, and action steps in each of these topics:
   1) Understanding Addiction and Reducing Stigma
   2) Prevention Services
   3) Law Enforcement, Criminal Justice Reform, and Corrections
   4) Prescribing Practices
   5) Harm Reduction: Overdose Reversal and Syringe Access
   6) Pain Management
   7) Detoxification, Medication-Assisted Treatment (MAT) and Supportive Counseling
   8) Treatment of Pregnant Women and Neonatal Abstinence Syndrome
   9) Recovery Services and Community Support

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 #9: CAHS Student Film Fest a Hit:</u>

A. What was achieved? Twenty –five students from Belaire Magnet High and thirty students from McKinley Senior High showcased their creative talents in producing videos that debuted at a film festival co-hosted with CAHS on April 1 at the Manship Theatre in downtown Baton Rouge.
B. Why is this success significant? The students produced and starred in the videos that are now being shared on social media. CAHS awarded grants to the schools to produce the videos with messages about safe medication practices and dangers of opioids. These students are now also advocates in substance abuse prevention approaches.
C. Who benefits and how? The film and videos were part of "Generation Rx," a new program implemented by CAHS' Prevention Division that uses peer-to-peer activities to educate teens about medication safety, including the prevention of opioid misuse.
D. How was the accomplishment achieved? CAHS Certified Peer Support Specialist Ivan Toldson was featured telling his life story in the video, "Real-Talk Addiction," produced by Belaire. In his introductory remarks before the video debuted, Toldson said youth are "going through much more than we realize" these days, and the arts, like video production and acting, can serve as positive alternatives to activities that have negative consequences, such as drinking alcohol or using drugs.
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 #10: CAHS Hosts Symposium on Advances in Non-Opioid Pain Care:</u>

A. What was achieved? Chronic pain is real for nearly 50 million adults in the United States,

and the public health problem is compounded when that pain is treated with opioids, which can cause other problems, such as dependence, addiction, and even death. To raise awareness about the profound physical, emotional and societal impacts of opioids and to examine advances in non-opioid care, CAHS' Prevention Division hosted a region wide Pain Management Symposium on May 30th.

B. Why is this success significant? "This is the beginning of a new frontier, taking a different approach and managing pain without opioids whenever possible," said CAHS Executive Director Jan Kasofsky, PhD. "We are promoting person-centered care that reduces opioid related harms while addressing the challenges of chronic pain."
C. Who benefits and how? The symposium included a facilitated discussion among 120 attendees about the topics of clinical services, healthcare costs and reimbursement strategies, and public attitudes and perceptions about pain and opioid use.
D. How was the accomplishment achieved? Keynote speaker Davis Gavel PhD, of Southern Behavioral Medicine Associates in Hattiesburg, MS, detailed alternatives to opioids and described his clinic's work to help clients achieve "functional restoration." Dr. Gavel explained that a biophysical model is used to individualize an outpatient treatment program for participants. The comprehensive, multi-disciplinary program includes both physical movement therapies (physical therapy, yoga and body mechanics) and psychosocial therapies to improve coping with pain. Dr. Gavel said meditation, mindfulness-based stress reduction, biofeedback, cognitive behavioral therapy, and nutritional counseling are very effective. He emphasized the importance of educating participants about the biology of the pain pathways and the mind-body connections. He said the program has demonstrated very good outcomes for the majority of participants by reducing medical costs and improving quality of life.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Yes
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes

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

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

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

  The District operates under two separate plans, a strategic plan with the state, and a internal operational plan as well. 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 by specific programmatic disabilities

with pre-set performance standards used to establish funding needs and efficient use of allocated resources. The District is on target with the expected accomplishments set forth in this plan.

The District's Internal 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 significant progress on accomplishing many of the objectives covered under these goals. Progress on meeting our annual goals is reported semi-annually to the CAHSD Board.

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

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

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

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

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall

significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

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?

Our revised Strategic Plan is planned to be in effect through FY 21-25.

☐ 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?**

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.

None.

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

- 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.

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

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

corrective actions and generate improvements?

4. 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
☐ 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
   Louisiana Performance Accountability System (LaPAS)
2. Date completed
   Quarterly July 01, 2018 through June 30, 2019
3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Legislative requirement
4. Methodology used for analysis or evaluation
   LaPAS: Standard methodology required by the DOA; actual performance indicators developed in conjunction with program offices and approved by the DOA
5. Cost (allocation of in-house resources or purchase price)
   LaPAS: Cost uncalculated
6. Major Findings and Conclusions
   LaPAS: None
7. Major Recommendations
   LaPAS: None
8. Action taken in response to the report or evaluation
   LaPAS: None
9. Availability (hard copy, electronic file, website)
   LaPAS: www.louisiana.gov/opb/lapas/lapas.htm

10. Contact person for more information, including

Name: Jan Kasofsky, PhD
Title: Executive Director
Agency & Program: Capital Area Human Services District
Telephone: 225-922-2700
E-mail: Jan.Kasofsky@la.gov

Name: Ramona Harris
Title: Accountant Administrator
Agency & Program: Capital Area Human Services District
Telephone: 225-922-0004
E-mail: ramona.harris@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

Department:	**Louisiana Department of Health (LDH)** 09-303 Developmental Disabilities Council
Department Head:	**Rebekah E. Gee, MD, MPH** LDH Secretary
Undersecretary:	**Cindy Rives**
Executive Director:	**Sandee Winchell**

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?

<u>Accomplishment #1: Leadership in Advocacy, Capacity Building and Systemic Change Activities:</u>

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: funding appropriated to restore home and community-based provider rates to 2008 levels; directing LDH to implement a Medicaid program to serve the TEFRA population for 2020 (pending CMS approval); and two of the human services districts/authorities, with the lowest state funding per capita, received additional funds to serve people in their respective regions.

B. Why is this success significant?
Louisiana is experiencing a severe shortage of Direct Support Professionals due to the low provider rates and accompanying low wages. The restoration of rates will ease the burdens of individuals' inability to find and keep staff and providers' inability to continue to provide quality services. TEFRA will ensure families of children with developmental disabilities and complex medical needs will have a safety net of Medicaid to cover necessary medical procedures. Families across the state will have more equity in access to state funded services outside of the waiver system.

C. Who benefits and how?
People with developmental disabilities, their family members, providers of home and community-based services, and ultimately, the entire state of Louisiana in realizing better health outcomes, quality of life, and increased employment, all at a lower cost than institutional care.

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. Collaboration of advocates and providers, including the Community Provider Association, Supported Living Network, and the Arc of Louisiana were critical in getting the provider rates restored.

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.

<u>Accomplishment #2: Capacity Building through Training and Technical Assistance:</u>

A. What was achieved?
The Council provided support to a number of capacity building initiatives. A series of

activities, including single day training sessions and multi-day, intensive training coupled with on-going technical assistance in the area of customized employment has improved the awareness and skill sets of providers, family members and individuals with developmental disabilities in effective approaches, strategies and techniques to develop customized employment opportunities for individuals with the most significant support needs.
In collaboration with Early Steps and LSU-HDC, intensive training and follow-along coaching was provided to childcare center directors and staff in two regions of the state on effective strategies to include young children with developmental disabilities.

Ten workshops on sexuality and relationships provided people with developmental disabilities and their family members with information on recognizing and handling sexual abuse and exploitation.

A six-month 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.

B. Why is this success significant?
The success of building the capacity of providers and community members improves the quality of services delivered and results in better outcomes. For example, skills learned through the training series on customized employment will result in more individuals with significant disabilities discovering employment opportunities that match their interest and strengths.

C. Who benefits and how?
First and foremost, people with developmental disabilities will benefit from the improved quality of services delivered, reduced staff turnover, better health outcomes, and improved employment outcomes.

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

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. The accomplishments directly contribute to the success of the Council's five-year goals and annual objectives/activities.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Some of the methods to accomplish these results represent best practices. Other 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 are being realized?

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

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

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

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

actions taken by the Council. The Council has expanded its repertoire of strategies and tools to connect with the public and policy makers and has plans to continue to build its capacity to utilize social media networks and tools to conduct 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 and growing.

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

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

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 Council just finalized the fourth year of action planning for its five-year plan. Each activity is reviewed for performance outcomes and adjustments are made in response to feedback and outcome data.

- **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.

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

All Council activities are dependent on federal and state appropriations. The Council

consistently takes all actions possible to ensure continuation of allocations. One significant issue is the economy in general and Louisiana's capacity to maintain the contributions to supporting necessary programs in the future.

B. Corrective Actions

- 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.

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

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

4. 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

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

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

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

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

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

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

☒ Policy, research, planning, and/or quality assurance functions in-house
☐ Policy, research, planning, and/or quality assurance functions by contract
☒ Program evaluation by in-house staff
☐ Program evaluation by contract
☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative

variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

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

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

☒ **Performance-based contracting (including contract monitoring)**
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

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

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

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

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

1. Title of Report or Program Evaluation

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

As required by federal law, the Council submitted a Program Performance Report (PPR) to the federal Department of Health and Human Services, Administration on Intellectual and Developmental Disabilities in March 2019 on its performance in compliance with the federal Developmental Disabilities Assistance and Bill of Rights Act.

This report is based on the federal fiscal year – October 1 to September 30, and therefore covered the first quarter of state fiscal year 2017-2018. A report covering the remainder of the state fiscal year will be submitted to the federal government in December 2019.

This report is required by the federal DD Act, and it is used by the Administration 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 Administration on Intellectual and Developmental Disabilities (AIDD).

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

For more information contact:
Shawn Fleming
Deputy Director
Developmental Disabilities Council
(225) 342-6804 (phone)
(225) 342-1970 (fax)
shawn.fleming@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

Department:	**Louisiana Department of Health (LDH)** 09-304 Metropolitan Human Services District
Department Head:	**Rebekah E. Gee, MD, MPH** LDH Secretary
Undersecretary:	**Cindy Rives**
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: (Care Management/Administration) MHSD Dashboards:

A. What was achieved?

The continued development of the MHSD monthly data dashboard and the expansion of dashboards for five different Divisions within MHSD. MHSD strives to create and maintain a data driven environment. The dashboards are comprised of data tables and charts related to person served demographics, service utilization, access to services and service outcomes. The expansion of dashboards specific to addictive disorders, adult mental health, child and youth, clinic management and intellectual/developmental

disabilities gives an even more differentiated, "drill down" picture of performance within the organization.

B. Why is this success significant?
The dashboards serve as tools to provide manageable and timely information to MHSD's Leadership, Board, staff, persons served and the public relative to MHSD's performance in key areas. 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 data 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. Within these divisions, dashboards are created which give even greater specificity to activities and outcomes occurring in their division.

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: (Care Management/Administration) MHSD Grant Expansion</u>

A. What was achieved?
MHSD has significantly increased its grant activity (i.e., identification, application and awards) in the last year. Grant descriptions are provided below:

- MHSD Community R.E.A.C.H Project. Funded by a Baptist Community Ministries (BCM) Transom Grant, this project is focused on educational

outreach activities by teams of Peer Support Specialists (PSS). It is designed to educate the larger community about the supports needed for persons in recovery from mental illness and substance use disorders.

- MHSD Faith Partners Initiative. Funded by a Baptist Community Ministries (BCM) Strategic Grant, this project is designed to provide leadership, training, educational materials, and consultation to clergy and congregational team ministries in the tri-parish area. Through a facilitated process, the faith community can be equipped to recognize mental illness and substance use disorders and link congregation members to professional services for long-term recovery outcomes.

- COAP (Comprehensive Opioid Abuse Site-based Program) Grant. MHSD serves as the sub-recipient of the US Department of Justice (DOJ) and Louisiana Office of Behavioral Health (OBH) grant to identify and engage individuals who use illicit or prescription opioids and have been incarcerated. The grant utilizes peers to go into the correctional setting to conduct peer support groups with these individuals. The ultimate goal of this funded activity is to provide transitional linkage to community based service upon release, to enhance their recovery efforts and to reduce recidivism.

- COAP Expansion Grant. A grant application has been submitted to US Department of Justice and Louisiana Office of Behavioral Health (DOJ/OBH) to expand peer support activity in the Orleans Parish Jail for opioid users.

- LaSOR (Louisiana State Opioid Response) Grant. This grant provides outreach and prevention activity to increase public awareness and education for prevention and treatment for Opioid Use Disorder (OUD). The grant also supplements the costs for MAT Prescribers.

- MAT PDOA Grant. MHSD serves as the sub-recipient of the Substance Abuse & Mental Health Services Agency (SAMHSA) Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) Grant, awarded to the Louisiana Department of Health's Office of Behavioral Health. This is the third and final year of this successfully implemented grant that addresses access to treatment, MAT services and coordination of care between providers for persons with Opioid Use Disorders.

- State Targeted Response (STR) Grant. This grant is SAMSHA funded and intended to address the epidemic use of Opioids, which has resulted in record numbers of deaths in Louisiana. The emphasis of the grant is prevention education for two major targeted groups, school-based sports programs and dental offices, areas at highest risk for first time exposure to opioids. Additionally, the grant supports Naloxone kit distribution and associated trainings.

- Additionally, MHSD has applied for a US DOJ/Bureau of Justice Assistance/ Louisiana OBH Implementation Planning grant. The nine-month planning grant is a partnership with MHSD, OPSO, Tulane University Forensic Dept. and the City of NO, for the purpose of developing an implementation strategy for increasing MAT in jails.

B. Why is this success significant?
Helps MHSD expand its core service capabilities and partnering collaborations for persons served.

C. Who benefits and how?
Persons served and their families by providing increased outreach, prevention and specialized treatment services and supports.

D. How was the accomplishment achieved?
MHSD Executive Leadership tasked a team of staff to monitor, identify and apply for grants.

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: (Care Management/Administration) Outreach and Peer Support Expansion</u>

A. What was achieved?
MHSD substantially expanded outreach and peer support activities in FY2019 across Orleans, St. Bernard, and Plaquemines Parishes. This was accomplished through a new partnership with the CrescentCare Mobile Unit and grant funding. In partnership with CrescentCare Mobile Unit, a scientifically sound community outreach model is being used to encourage individuals to seek treatment services. Outreach services are provided by personnel that have been trained and certified by the Louisiana Office of Public Health. Outreach workers receive job-specific instruction, including the specific objectives for intravenous substance use treatment, HIV and Hepatitis C prevention, Behavioral Health education, and risk-reduction.

Additionally, MHSD grants have also expanded outreach activity substantially via targeted partnerships and the funding of Peer Support Specialists. Grant funding has allowed for the expansion of peer support activities. Across the active grants in MHSD,

at least ten (10) new peers have been hired to support outreach activities.

B. Why is this success significant?
Peer Support Specialists (PSS) provide recovery support services which are non-clinical services that assist individuals and families working towards recovery. Recovery support services include social supports, linkage to and coordination among allied service providers, and other resources to improve quality of life for people seeking recovery and their families. This is considered best practice by SAMHSA. Because they are in recovery, a PSS serves as someone who has experienced the same challenges as those they serve. Because of this unique identification, PSS can build relationships with those they serve that are based in empathy and trust, and provide hope that recovery is possible. As part of comprehensive treatment services, peer recovery support services and activities have contributed to more positive outcomes for individuals with behavioral health diagnoses and have become integral to the recovery of those individuals.

Additionally, increased outreach efforts is significant because it 1) fosters more widespread understanding about behavioral health disorders, thereby helping to reduce misperceptions and negative attitude towards mental illness and Substance Use Disorders (SUD); 2) increases awareness of the role of prevention and treatment of mental illnesses and SUD; and 3) increases awareness about the opportunities to benefit from participation in mental health and SUD treatment/ support services.

C. Who benefits and how?
Persons served and their families, the community, treatment team members, and MHSD.

D. How was the accomplishment achieved?
This was accomplished through partnership with the CrescentCare Mobile Unit and grant funding.

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: (Care Management/Administration) ROSC</u>

A. What was achieved?
In FY19, MHSD continues to advance efforts towards the establishment of a ROSC (Recovery-Oriented Systems of Care) in Orleans, Plaquemines and St. Bernard Parishes. Simply stated, a ROSC is a network of clinical and nonclinical services and

supports that sustain long-term, community-based recovery. Implementation of a successful, sustainable ROSC, however, is complex.

As part of its initial implementation, in 2016 MHSD secured technical assistance from SAMHSA to conduct two environmental scans to assess MHSD's readiness for change and to outline the systems assets, capacities, gaps, and challenges pertaining to ROSC development. With completion of the two scans in the last year MHSD has moved into the next phase of implementing a ROSC by applying for and obtaining grants to fund critical next steps in ROSC development. One of those steps was to hold a ROSC Recovery Walk to educate the larger public about those in recovery and the need of a support system to aid their recovery. In preparation for ROSC implementation, a ROSC Symposium is being planned for FY2020.

B. Why is this success significant?
The ROSC work is significant because these efforts are supporting the establishment of a network of clinical and nonclinical services and supports with the MHSD communities. Developing a successful network entails aligning many aspects of a service system and community with a recovery-oriented approach, including treatment, peer and other recovery support services, system monitoring, performance improvement and evaluation strategies, prevention and early intervention, cross-system collaborations, and the fiscal, policy, and regulatory environments. All of these elements must become aligned with a recovery-oriented approach in order to create a strong, sustainable ROSC.

C. Who benefits and how?
A ROSC benefits people 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?
MHSD Executive Management provided administrative and staffing resources to support the implementation of the ROSC. This includes, but is not limited to, SAMHSA Technical Support, resources and activities that led to grant funding, a dedicated team of Peer Support Specialist, and leadership from the MHSD Advocacy Division.

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: (Adult Behavioral health Services) Access to Care: Open Access Model,</u>

Centralized Scheduling and Telemedicine

A. What was achieved?
MHSD has implemented an initiative to increase access to care for individuals seeking mental health or addictive disorders services. The agency has adopted an Open Access/ On Demand Model for adult assessments and evaluations, Centralized Scheduling Model for all services and Telemedicine as a modality of service delivery. The amount time between an individual identifying their need for services and seeing a provider is clearly a measure of access to care.

Open access—also known as on demand or same-day scheduling—is a method of scheduling in which all persons can receive a service on the day they arrive to the clinic. MHSD will identify open access days (for select clinics) to provide adult assessments and evaluations.

Centralized scheduling is a model in which a team is in charge of the scheduling for all providers in the agency. The task of scheduling no longer falls on the shoulders of many individuals, who may be following various scheduling rules, but on one team whose main responsibility is scheduling under uniformed guidance.

Telemedicine is the remote diagnosis and treatment of persons by means of telecommunications technology.

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. Combined with telemedicine, centralized scheduling can literally increase service capacity by matching a person in need of services to an available MHSD clinician housed at any MHSD clinic. That is, if a clinician is available to provide care in one clinic location, through telemedicine technology, that clinician is able to render services even if the person served presents at a different clinic location.

C. Who benefits and how?
Individuals seeking mental health, substance use and intellectual/developmental disability services who are able to access services in a timely manner.

D. How was the accomplishment achieved?
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.

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: (Child and Adolescent Behavioral Health Services) Child and Youth Services Expansion

A. What was achieved?
The Child & Youth Services mission is to serve and support youth with emotional and behavioral impairments and caregivers to keep families healthy and intact. Areas of division responsibility include but is not limited to, the provision of services in MHSD child & youth outpatient clinics, referral to community supports and prevention services. MHSD child and youth services expanded access to care by adding two new clinic service locations; New Orleans East and St. Bernard. Expansion of services also occurred with the implementation of telehealth at South Plaquemines Elementary and South Plaquemines High School. That is, MHSD is providing mental health services (e.g., psychiatric evaluations, medication management, and/or family psychotherapy) via telehealth technology to children and youth in Plaquemines Parish.

B. Why is this success significant?
Expanding child and youth service provision geographically in the tri-parish area increases ease of access to services for a number of residents and their family.

C. Who benefits and how?
Children and youth with behavioral health needs, families and the community at large. All benefit from improved access to care.

D. How was the accomplishment achieved?
MHSD Executive Management provided administrative support, staffing and funding.

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 (2015-2019) strategic plan, and plan to continue to make progress as we work under the 2020-2025 five-year strategic plan. Strategies, as measured by performance indicators, have generally been shown to be effective. Performance measurement, data analysis and other information indicate a positive ROI (Return on Investment) when monitoring the linkage between performance and district budgeting.

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

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

  Significant progress has been made with the goal of establishing a data driven environment that includes system infrastructure, data management, and the service delivery monitoring that supports continuous quality improvement across MHSD. Our organization's stated objectives of disseminating information to staff, providers, community partners, and state/federal agencies, and continuing to develop a data systems infrastructure, meets or exceeds the expected timeline. The MHSD dashboards are an example of MHSD Leadership's commitment to transparency in reporting the agency's performance and data driven decision making with regard to agency goals and objectives. The utilization of electronic data sources, as well as, information sharing with MHSD Mental Health, Addiction and Intellectual/Developmental Disabilities Divisions in producing the dashboards, speaks to the development of a data system infrastructure that meets or exceeds the expected timeline. Achievement with this goal and objective is seen to continue within an expected range.

- **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. MHSD is not currently experiencing a lack of progress.

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

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

  After careful review and consideration of our successes, the current strategic plan adequately represents the agency. MHSD goals and objectives remain unchanged, but MHSD has modified performance indicators (e.g., deletions or additions) to build on successes and address shortfalls.

  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 identified. MHSD continues to work toward its goal of providing quality behavioral health care.

B. Corrective Actions

- 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.

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

2. Has this recommendation been made in previous management and program

analysis reports? If so, for how long (how many annual reports)?

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

4. 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
MHSD executive leadership created the Quality and Data Management (QDM) division, whose mission is to establish a data driven environment that encompasses data management, performance measurement, monitoring the linkage between performance and budgeting, and supporting continuous quality improvement across MHSD. The QDM division is responsible for data management, performance management and quality. The QDM division works to educate personnel and other relevant stakeholders about the District's performance, works closely with executive leadership to identify the practical implications of findings, and assists in corrective action planning and evidence-based decision making. The QDM division shares MHSD performance information with district staff, persons served, stakeholders, and the public. The QDM division is responsible for providing support to all district staff to ensure performance data is being collected and to oversee the integrity of the data collection practices.

☐ 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, 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: **AP/Accountability Plan**
2. Date Complete: 12/06/2018
3. Subject/Purpose: To guide the delivery of addictive disorders (AD), Developmental Disabilities (DD), and Mental Health (MH) services funded by appropriations from the state.
4. Methodology: Site monitoring consisted of a joint OBH and OCDD Review team to include data reviews, chart audits, and interviews with staff.
5. Cost: Allocation of committed staff time to the process for the day.
6. Major Findings: none
7. Major Recommendations: none

8. Action taken: MHSD responded as needed in writing with a Plan of Correction (POC) to any major findings.
9. Availability: AP is available in hardcopy and electronic file; report file will be available in same format.
10. Contact person for more information, including

    Name: Rochelle Head-Dunham, M.D.
    Title: Executive Director/Medical Director
    Agency & Program: 09-304 Metropolitan Human Services District (MHSD)
    Telephone: 504-535-2909
    E-mail: Rochelle.Dunham@mhsdla.org

1. Title of Report: **Independent Financial Audit**
2. Date Completed: August 30, 2018 (for FY18)
3. Subject/Purpose: Full independent audit of MHSD as an independent fiscal entity
4. Methodology: External audit firm selected by LLA and used standard audit approach including A-133 single audit
5. Cost: None
6. Major Findings: No findings – unqualified audit
7. Major Recommendations: No recommendations for MHSD
8. Action: MHSD has shared report with its Board and Leadership staff.
9. Availability: hardcopy and electronic format
10. Contact person for more information, including

    Name: Rochelle Head-Dunham, M.D.
    Title: Executive Director/Medical Director
    Agency & Program: 09-304 Metropolitan Human Services District (MHSD)
    Telephone: 504-535-2909
    E-mail: Rochelle.Dunham@mhsdla.org

1. Title of Report or Program Evaluation: **MHSD Operations Risk Management Audit**
2. Date completed: March 21, 2019
3. Subject or purpose and reason for initiation of the analysis or evaluation Annual Audit/compliance review
4. Methodology used for analysis or evaluation Full site visits with auditor, sit down meeting with auditor to review required records.
5. Cost (allocation of in-house resources or purchase price) N/A
6. Major Findings and Conclusions scored: Pass 80.98%, status: compliant
7. Major Recommendations:
    - **Inspections:** Include bodily injury and/or property concerns in Investigative Procedures.
    - **Return to Work**: Conduct and document employee awareness/training within 90 days of hire with all new employees.

Conduct and document employee awareness/training once every 5 years after initial employee awareness/training. Complete the DA WC4000 form each month and maintain a copy for the audit.

- **Blood Borne Pathogens**: Conduct documented employee awareness training on bloodborne pathogens for all low risk employees at least once every 5 years after initial orientation training.
- **Hazardous Materials**: Conduct and document an inspection/assessment of all buildings, grounds, vehicles and any other area of your site to determine if there are any hazardous materials present.
- **Records and Forms**: Ensure DA 2054 forms that have been signed and dated annually are available on all authorized drivers. DA 2054 must be signed by ED within 45 days. Ensure ODR's reviewed annually are available on all authorized drivers. Complete a DA 2041 for each vehicle accident and maintain a copy for the audit.
- **Equipment Management Program**: Develop a current, specific inventory of all applicable program equipment (mechanical and electrical) that includes the name of the equipment, location, model number and serial number. Maintain and have available preventive maintenance documentation for mechanical equipment. Develop a written Lockout/Tagout Program.
- **Elevators and Fire Service Key/Equipment Room**: Write procedures outlining availability of the fire service key including a listing of personnel assigned the responsibility of the fire service key and the procedures to ensure the fire service key is provided to the local fire department or that the key is readily accessible upon their arrival. Provide documentation that the fire service key is provided to the designated employee.
- **Bonds, Crime and Property**: Develop written procedures to address reporting losses/damages to the correct Claims unit within a timely manner.

8. Action taken in response to the report or evaluation:
    - **Inspections**: Change verbiage in Risk/Safety Plan to include procedures for bodily injury and/or property concerns.
    - **Return to Work**: During orientation, new hires are informed of the TRW Policy. System set up for reminder of 5 year training for all employees. Completion of DA WC4000 form put into action monthly.
    - **Blood borne Pathogens**: low Risk employees to receive copy of policy that they will sign off on receiving every 5 years.
    - **Hazardous Materials**: MHSD has no Hazardous Materials, so we are allowed to put on MHSD letterhead a statement saying "A site

assessment found no hazardous materials at the facility" Must be placed in binder for ORM to see when they visit.

- **Records and Forms**: Have authorized signatures, and appropriate date annually on DA 2054 forms. Run ODR's same time every year.
- **Equipment Management Program**: Facilities Department to update ALL equipment and inventory. Have information on each piece of equipment and where it's housed. Since MHSD does not do LO/TO (our contractors do) Facilities Department is to obtain LO/TO procedures for each contractor that services MHSD. Must have statement in binder on letterhead saying that we don't do LO/TO with contractor LO/TO procedures attached.
- **Elevators and Fire Service Key/Equipment Room**: Facilities knows where the fire key is for CP, we've never had a fire key for CC. Statement in binder on letterhead should say such, and document who knows where the key is at CP.
- **Bonds, Crime and Property**: Include a statement in policy that speaks to specific property and negotiable items.

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

10. Contact person for more information, including

Name: Rochelle Head-Dunham, M.D.
Title: Executive Director/Medical Director
Agency & Program: 09-304 Metropolitan Human Services District (MHSD)
Telephone: 504-535-2909
E-mail: Rochelle.Dunham@mhsdla.org

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

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

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

Undersecretary: **Cindy Rives**

Assistant Secretary: **Jen Steele**
Medicaid Director

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

For each accomplishment, please discuss and explain 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: Medicaid Eligibility and Enrollment System (LaMEDS):

A. What was achieved?
Effective November 13, 2018, the Louisiana Department of Heath launched a new Medicaid eligibility and enrollment system. The new web-based system will improve the application process, boost efficiency, and create a more accurate and immediate approval process.

B. Why is this success significant?
The new system replaces one that was more than 20 years old. Advanced features offer self-

service options for recipients, including real-time eligibility decisions for applicants. It also helps Louisiana to meet the changing needs of applicants and enrollees while complying with all federal and state requirements.

The system will connect with state and federal databases to provide more data in real-time verification of citizenship, income, disability, and lawful presence in the United States.

This system enables consistent enforcement of policy, with timely, automated terminations for non-compliance – this includes real-time information verification.

Medicaid caseworkers will be free to focus more on individual clients and their cases. The automated process will increase productivity, efficiency, and accuracy.

C. Who benefits and how?
The new system allows Louisiana residents to submit an online application and receive notice of their eligibility within minutes (real-time eligibility).

Customers will have a more convenient, self-service system, improving the customer experience. Specifically, the self-service portal will allow users to edit or change their address, employment and/or other household characteristics.

The new automated system will also replace inefficient manual processes for caseworkers with modern new tools, technologies, and electronic data sources.

D. How was the accomplishment achieved?
LDH partnered with OTS contracted with Deloitte Consulting to design, develop, and implement a modernized Eligibility and Enrollment system over a period of 3.5 years.

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, LDH worked diligently with other entities to achieve this accomplishment that will ultimately benefit Medicaid enrollees. It took significant coordination and cooperation, as the new web-based system will improve the application process, boost efficiency, and create a more accurate and immediate approval process.
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<u>Accomplishment #2: Code for America Text Messaging Platform</u>:

A. What was achieved?
The Code for America pilot, LA'MESSAGE, assisted Medicaid members at critical moments of eligibility determination through text message reminders.

B. Why is this success significant?
To date more than 6,600 Louisiana citizens opted in to and received Medicaid text message reminders. The opt-in rate ranges between 20-35%. LA'MESSAGE improved response rates to important Medicaid eligibility requests for information by 5%.

C. Who benefits and how?
Medicaid members benefited by receiving text message reminders to renew benefits and prevent closure. The State benefited by reducing churn, the common process of individuals shifting in/out of Medicaid as income fluctuates, and associated staff workload.

D. How was the accomplishment achieved?
LDH collaborated with Code for America to conduct a 6-month pilot with three phases. Each phase increased the sample size. Medicaid members received an initial text message to opt in. Individuals who opted in received text message reminders to return renewal information to the agency.

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

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, we collaborated with other entities to achieve this accomplishment that will ultimately benefit Medicaid enrollees.

<u>Accomplishment #3: Medicaid Quality Dashboard</u>:

A. What was achieved?
Effective June 27, 2019, Medicaid launched the Medicaid Managed Care Quality dashboard. The Medicaid Quality Strategy outlines the responsibility of the Louisiana Medicaid managed care program to provide high quality, innovative and cost-effective health care to Medicaid enrollees. In the spirit of these responsibilities, LDH designed the Quality Dashboard to promote transparency and accountability and made it visible to the public. The Medicaid Managed Care Quality dashboard is available at http://qualitydashboard.ldh.la.gov/.

B. Why is this success significant?
Medicaid regularly monitors the performance of Medicaid managed care organizations (MCOs) on a number of Healthcare Effectiveness Data and Information Set (HEDIS) and non-HEDIS quality performance metrics to evaluate MCO performance, improvements, and outcomes. The measures reported include a performance rate or percentage by each MCO, baseline data, and benchmarks. The Medicaid Managed Care Quality Dashboard provides useful information on children and adults who are and who are not taking advantage of beneficial and potentially cost-saving preventative medical services. The use of preventative

services could improve the enrollee's health and longevity of life, as well as reduce costs in the health care system.

C. Who benefits and how?
Louisiana citizens, Medicaid enrollees, Medicaid providers, Managed Care Organizations and Louisiana Medicaid. Improvements in health outcomes could have a positive effect on the enrollee's health and overall costs in the health care system.

D. How was the accomplishment achieved?
Over a two-year period, Medicaid worked diligently to design, research, incorporate data, and implement the dashboard.

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, the utilization of a standardized performance measures tool and standardized benchmarks, ensures best practice in effective, efficient performance monitoring. In addition, displaying this data for public consumption allows citizens to compare MCOs by quality metrics and benchmarks while holding MCOs accountable for quality improvement.

Accomplishment #4: Single Preferred Drug List (PDL):

A. What was achieved?
The Single PDL is a list of preferred and non-preferred drugs used by the fee-for-service program and all managed care organizations, designed to reduce administrative complexity for prescribers and pharmacists, increase timely access to care, and improve health outcomes for Medicaid members. Prior to implementation of the Single PDL, each managed care organization and fee-for-service addressed each process separately.

B. Why is this success significant?
The shift from six separate PDLs to one list for both MCOs and fee-for-service Medicaid is an important administrative simplification for the prescribers and pharmacists who care for Medicaid members.

C. Who benefits and how?
The Single PDL will streamline the provision of care, with the ultimate goal of improved health outcomes for members and a better experience for providers who work with the Medicaid program.

D. How was the accomplishment achieved?

The Medicaid Pharmacy Program incorporated the five managed care organizations (MCOs) into our Pharmaceutical and Therapeutics Committee (P&T) drug review process to determine the prior authorization status of drugs. The P&T Committee groups drugs with

similar therapeutic actions into categories. We reviewed drugs that treat identified conditions for clinical efficacy and cost containment initiatives. The Committee considers supplemental rebates offered by manufacturers to defray costs combined with the clinical effectiveness of these drugs to recommend prior authorization status of drugs within a category.

Additionally, Medicaid met with stakeholders, including prescribers, pharmacists, legislators, lobbyists, MCO staff, and actuaries to project the fiscal impact of this project on enrollees, providers, MCOs and LDH.

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, LDH worked diligently with stakeholders to streamline a process for clinical review and provide a platform for administrative simplification for prescribers and dispensers – ultimately benefiting Medicaid enrollees. It took significant coordination and cooperation but the simplification of billing requirements and outcomes justified the program. Administrative simplification across managed care plans is a noteworthy project.

<u>Accomplishment #5: Managed Care Organization (MCO) Delivery System Reform and MCO Value-Based Payment (VBP) Program Implementation</u>:

Managed Care Organization (MCO) Delivery System Reform:

A. What was achieved?
Medicaid designed and developed key policies to inform the future Medicaid managed care program/model contract that aligns MCO policies and requirements with LDH's vision for population health, social determinants of health, innovation in care management, and value-based care.

B. Why is this success significant?
The new content of the MCO Model Contract promotes both improved health outcomes and promotes better stewardship of federal and state funds.

C. Who benefits and how?
Managed care enrollees and the state at large benefit from better health outcomes.

D. How was the accomplishment achieved?
LDH achieved this accomplishment through a multi-year process that included significant stakeholder engagement, the design and development of the MCO Model Contract, and the publishing of a request for proposals (RFP) that contained Medicaid's vision.

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, the development of a Model Contract that contains requirements in lieu of using the RFP as the source of requirements is a national best practice.

MCO Value-Based Payment (VBP) Program Implementation:

A. What was achieved?
Effective February 2018, LDH-Medicaid introduced a two percent (2%) withhold requirement into its MCO contracts to incentivize quality, health outcomes, and VBP. One percent (1%) of the withholding is to increase the use of VBP. The implementation of the MCO VBP program added meaningful financial incentives to advance payment and delivery system reform, focused the MCOs and providers on shared targets for population health improvements, aligned financial incentives for MCOs and providers and established a withhold for MCOs to report on use of VBP and develop a strategic plan to increase VBP to providers. MCOs are required to increase provider payments by ten percent (10%) over initial baselines. All MCO VBP arrangements with providers must include at least one of the incentive-based quality measures.

B. Why is this success significant?
VBP increases MCO accountability and drives better performance. In addition, the VBP program involves moving away from traditional fee-for-service (FFS) payment at the provider level and implementing a broad set of payment strategies intended to improve quality, outcomes, and efficiency by linking financial incentives to performance at the provider organization level.

C. Who benefits and how?
Louisiana citizens, Medicaid enrollees, Medicaid providers, Managed Care Organizations and Louisiana Medicaid by advancing value-based payment and delivery system reforms.

D. How was the accomplishment achieved?
Medicaid achieved this accomplishment by consulting with national experts in payment and delivery system reforms regarding best practices and options for incorporating VBP into MCO contracts.

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. The alignment of a program with a national framework, in this case the Health Care Payment Learning and Action Network Alternative Payment Model (APM) Framework, should be considered a best management practice.

Accomplishment #6: Community Health Worker (CHW) Blueprint:

A. What was achieved?
In November of 2018, LDH collaborated with the Penn Center for Community Health Workers (PCCHW) and the Center for Healthcare Value & Equity (CHVE) at the LSU Health Sciences Center to develop a preliminary Blueprint for a Louisiana Demonstration Community Health Worker Program. The purpose of the Blueprint is to inform a Medicaid managed care community health worker (CHW) pilot, in support of LDH's commitment to advancing evidence-based, community-engaged solutions.

B. Why is this success significant?
While CHWs are increasingly common in healthcare organizations across the United States, many programs fail because of implementation factors: high turnover, inadequate infrastructure, lack of integration with provider teams, disease-specific fragmented models and lack of high-quality evidence. Currently in Louisiana, fragmented payer-specific initiatives offer numerous small-scale and marginally effective population health programs. All Louisiana MCOs currently utilize CHWs, but these programs do not always align with evidence-based practice.

This Blueprint is to guide the design and implementation of an effective, scalable CHW program run by a Louisiana MCO. The Blueprint reviews strengths and challenges for existing population health initiatives, and makes recommendations about a model CHW program, 'IMPACT Louisiana', which achieves a common vision.

C. Who benefits and how?
Medicaid's vision of supporting an evidence-based, scalable, and financially sustainable CHW program will improve lives and health for high-risk Medicaid members. Some additional benefits from the ensuing CHW pilot could include financial savings to MCOs and the Department from reduced hospital admissions and emergency room visits and enhanced payments to providers for post-hospital primary care visits and for meeting incentivized outcomes measure targets.

D. How was the accomplishment achieved?
The current version of the Blueprint draws from work group meetings over the course of 2018 with key LDH stakeholders. LDH's geocoded population health data also informed this Blueprint along with independent research and analysis by PCCHW.

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, LDH worked diligently with other entities to achieve this accomplishment that will ultimately benefit Medicaid enrollees.

Accomplishment #7: Electronic Visit Verification (EVV):

A. What was achieved?
LDH successfully implemented an EVV system across all regions of the state for in-home and center-based waiver services and Long-Term Personal Care Services.

B. Why is this success significant?
The department faced substantial challenges in efficiently monitoring and verifying that home and community-based service (HCBS) providers delivered services as prescribed in the approved plan of care for the recipient. EVV is a web-based system that electronically verifies service visit occurrences and documents the precise time services begin and end via smart devices.

C. Who benefits and how?
The EVV system allows the Department to verify that individuals are receiving the services authorized in their plans of care, reduces inappropriate billing/payments, safeguards against fraud, and improves program oversight. The department has realized cost and operational benefits through mechanisms described above. Following implementation of EVV for in-home personal care services, the department has seen a decrease in both the number of services reported and paid out. During calendar year 2018, payments were approximately $19.2 million less compared to 2017.

The EVV system allows LDH employees to access and view all services collected in real-time including check-in/out times for each service record. Through the department's work with its EVV contractor, LDH incorporated several operational benefits into the EVV system with the intent to increase system usability for both staff and providers. The primary benefit is an EVV solution that fully integrates with the existing service reporting and prior authorization system, which allows providers to use a single system. Additional benefits include greater oversight and validation of services resulting in less audit findings and recoupments, access to free personnel management reports for providers, reduction in the need for manual data entry, and reduced lag time for billing reports.

D. How was the accomplishment achieved?
As part of a cross-departmental collaboration between Medicaid, the Office of Aging and Adult Services (OAAS), and the Office for Citizens with Developmental Disabilities (OCDD) staff worked diligently during the past few years to identify and secure a successful EVV solution capable of meeting all state and federal requirements. After working with the initial EVV contractor, researching best practices, and documenting system issues, the Division of Administration (DOA) approved a sole source request to include EVV for in-home services in the current prior authorization data contract with Statistical Resources, Inc. (SRI) during the fall of 2016. EVV implementation was successful for services delivered outside of the home including center-based, vocational and transportation services on March 1, 2016 and in-home personal care service providers on May 1, 2018. Implementation of EVV for Early and Periodic Screening, Diagnostic and Treatment (EPDST) Personal Care Services (PCS) will tentatively occur on October 1, 2019.

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. LDH utilized a collaborative approach among several agencies to carefully plan and implement an EVV solution to comply with federal legislation (21st Century Cures Act, signed into law on December 13, 2016). This legislation requires that states implement an EVV system for Medicaid funded personal care services by January 1, 2020 or the Federal Medical Assistance Percentage (FMAP) for these services will decrease.

Accomplishment #8: Transformed Medicaid Statistical Information System (T-MSIS) Data Quality Initiatives:

A. What was achieved?
Recognized by CMS as a top-improving state and a model for other states to follow, Louisiana went from "red" and bottom 10% of all states in August 2018 to "green" by May 2019 for T-MSIS Top 12 Priority Items. Louisiana established a T-MSIS SQL database to facilitate the identification and correction of data issues and errors.

B. Why is this success significant?
CMS issued a guidance in the State Health Official Letter (SHO #18-008) informing all "states should be aware ongoing access to enhanced funding for additional systems enhancements and operational costs is contingent upon the state's continued ability to meet T-MSIS requirements of complete, accurate, and timely data reporting."

Given the above guidance, CMS would have penalized Louisiana if we had remained in "red" which indicated lack of effort on the part of the State in accomplishing CMS goals. This would have resulted in the loss of federal funding for system enhancements and operational cost.

C. Who benefits and how?
The Department benefits from meeting T-MSIS CMS guidelines. Specifically, achieving CMS stipulations for T-MSIS enables and helps Louisiana to access federal enhanced funding for current and future Medicaid systems modularity projects.

D. How was the accomplishment achieved?
The Medicaid T-MSIS team collaborated with Medicaid business owners, CMS, and DXC (Medicaid's fiscal intermediary) to research, understand, and correct CMS Top 12 Data Priority Issues.

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?
The Medicaid T-MSIS team collaborated with other entities to achieve this accomplishment that will ultimately benefit Medicaid enrollees.

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?

  Accomplishment #1: Medicaid Eligibility and Enrollment System (LaMEDS):

  LDH implemented LaMEDS on November 13, 2018. This accomplishment contributes to the success of the following sections of the department's Medical Vendor Administration strategic plan: Activity 1 – Medicaid and CHIP Eligibility Determination.

  Accomplishment #2: Code for America Text Messaging Platform:
  Text messaging through the Code for America platform launched in 2019 and remains ongoing. This accomplishment contributes to the success of the following sections of the department's Medical Vendor Administration strategic plan: Activity 1 – Medicaid and CHIP Eligibility Determination.

  Accomplishment #3: Medicaid Quality Dashboard:
  The Medicaid Quality Dashboard went "live" on June 27, 2019, and will continue to support objectives in the department's Medical Vendor Payments strategic plan, Activity 3 – Healthy Louisiana, to include increasing preventive and primary healthcare use, thereby improving quality, health outcomes, and patient experiences for Louisiana Medicaid members.

  Accomplishment #4: Single Preferred Drug List (PDL):
  The move to a Single PDL began to provide administrative simplification for both prescribing and dispensing providers. In 2017, the concept went through the legislative process, but stakeholders had concerns about the fiscal impacts to their organizations–the MCOs were concerned about the loss of internal drug rebates and the independent pharmacists were concerned about additional expenditures on brand name drugs. In 2018, LDH attempted a modified Single PDL focusing on just 10 therapeutic classes of drugs, but the same groups of stakeholders objected. In SFY 2019, LDH took a different approach, considered the move to a Single PDL from the stakeholders' perspectives, and considered potential fiscal impacts on stakeholders including LDH as well as the benefits of administrative simplification to providers and enrollees. The transition has simplified the prior authorization process across the MCOs. Providers received it well but the transition

will require ongoing maintenance as the drug market changes. We learned over time that stakeholder involvement was necessary for the Single PDL project to succeed. Our strategies required a change in focus and willingness to create a "win" for all impacted parties. Over time, the LDH will reap the benefits of additional supplemental rebates.

This accomplishment contributes to the success of the following sections of the department's Medical Vendor Administration strategic plan: Activity 5 – Pharmacy Benefits Management.

Accomplishment #5: Managed Care Organization (MCO) Delivery System Reform and MCO Value-Based Payment (VBP) Program Implementation:

Developing a MCO Model Contract and RFP contributes to the success of the following sections of the department's Medical Vendor Payments strategic plan, Activity 3 – Healthy Louisiana:

a. **Activity 3 - Objective I**: Through the Medicaid Managed Care Program activity, to increase budget predictability while providing for a service delivery model of high quality, medically necessary health and avoiding unnecessary duplication of services
b. **Activity 3 - Objective II**: Increase preventive healthcare through the Medicaid Managed Care Program activity, and improve quality, performance measurement, and patient experience for managed care members

Accomplishment #6: Community Health Worker (CHW) Blueprint:
The Blueprint is a high-level working document that will evolve over time and will include detailed manuals, training, tools, and additional scopes of work for aspects of program implementation and evaluation. At the time of the Blueprint's initial publication, LDH was still developing the MCO Request for Proposals (RFPs) and sharing its intent to work with a to-be-determined MCO to spearhead a model CHW program during the next MCO contract period. This evidence-based demonstration program will continue to move forward with implementation in partnership with PCCHW and CHVE to apply best practices and serve as a model for statewide replication.

This accomplishment contributes to the success of the department's Medical Vendor Payments strategic plan, Activity 3 – Healthy Louisiana and related objectives to increase preventive healthcare, and improve quality, performance measurement, and patient experience for managed care members.

Accomplishment #7: Electronic Visit Verification (EVV):
EVV implementation was successful for services delivered outside of the home including center-based, vocational and transportation services on March 1, 2016 and in-home personal care service providers on May 1, 2018. Implementation of EVV for EPDST PCS will tentatively occur on October 1, 2019. Implementation of EVV has aided the department in its mission to combat fraud, waste, and abuse within its home and community-based services. Furthermore, EVV allows for increased monitoring and oversight of services for both the department as well as providers that help to ensure health and safety of participants and overall quality of services.

Accomplishment #8: Transformed Medicaid Statistical Information System (T-MSIS) Data Quality Initiatives:
This accomplishment meets federal reporting requirements and does not hinder the procurement of federal funding for the modularization of Louisiana Medicaid Management Information Systems (MMIS). This directly contributes to the success of the following sections of the department's Medical Vendor Administration strategic plan, Activity 4 - Medicaid Management Information Systems (MMIS) Operations:

a. **Activity 4 - Objective 1.2**: Oversee federal, internal, and external reporting. Act as liaison between the Medicaid Fiscal Intermediary (FI) and all external agencies and organizations in addition to BHSF staff
b. **Activity 4 - Objective 1.6**: Reform the service delivery model and processes as currently deployed by the FI to one that achieves a common project planning and delivery methodology that will produce more timely, cost efficient and results-directed solutions resulting in attaining tangible benefit to the state or recipients
c. **Activity 4 - Objective 1.8**: Initiate planning activities for addressing deficiencies in the existing MMIS, through the application of a more efficient architectural model that will achieve a significant reduction on the "Total Cost of Ownership" (TCO).

Strategies for T-MSIS, though in its infant stage, have been effective. Louisiana is building more capacity in hiring additional personnel to enable the state meet Federal mandate of ensuring that T-MSIS is a permanent and ongoing process of state's MMIS operations.

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

1. To what do you attribute this success? For example:
   - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
   - 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: Medicaid Eligibility and Enrollment System (LaMEDS):
The new system replaces a tool that was more than 20 years old. Advanced features offer self-service options for recipients, including real-time eligibility decisions for applicants. It

also helps Louisiana to meet the changing needs of applicants and enrollees while complying with all federal and state requirements. The system will connect with state and federal databases to provide more data in real-time verification of citizenship, income, disability, and lawful presence in the United States. This system enables consistent enforcement of policy with timely automated terminations for non-compliance–this includes real-time information verification. Medicaid caseworkers will be free to focus more on individual clients and their cases. The automated process will increase productivity, efficiency, and accuracy.

Accomplishment #2: Code for America Text Messaging Platform:
The Code for America text messaging platform is an example of a new technology used to improve service delivery/customer service. As more Louisiana citizens opt in to receive text message reminders, we expect the use of the platform to grow at a steady pace for sending reminders to Medicaid members to respond to important Medicaid eligibility requests for information.

Accomplishment #3: Medicaid Quality Dashboard:
Of the 22 Healthcare Effectiveness Data and Information Set (HEDIS) measures Louisiana Medicaid has tracked since implementation of the program, we have met or exceeded the Southern regional average on 10 metrics; substantially improved from the 2012 fee for service baseline on 9; made slight improvement on one; and regressed on 2 (Emergency Department visits and Cervical Cancer Screening). These successes are due to a collaboration between LDH Medicaid Quality, the Managed Care Organizations, education initiatives, outreach, and provider engagements. This progress will continue, the MCOs will monitor the progress, and provide annual reports for review and validation by Medicaid's External Quality Review Organization (EQRO) and LDH.

Accomplishment #4: Single Preferred Drug List (PDL):
The Single PDL implementation was due primarily to persistence by the Medicaid team and a willingness to modify the strategic approach by including stakeholders in the discussions and responding to their specific concerns. The change in approach considered the costs and expenditures of individual drug choice selections for specific stakeholders and the selection of preferred products based on stakeholder costs versus state rebates. This process reduced the amount of rebates received, but increased rebates from the pre-Single PDL status. LDH accomplished the ultimate goal of administrative simplification. A major one-time switch from six (6) Preferred Drug Lists to one (1) Single Preferred Drug List created the simplification process. However, criteria development and alignment of preferred drug status is an on-going process.

Accomplishment #5: Managed Care Organization (MCO) Delivery System Reform and MCO Value-Based Payment (VBP) Program Implementation:

Managed Care Organization (MCO) Delivery System Reform:
BHSF engaged legislators, providers, MCOs, and other key stakeholders in the development of the Model Contract and RFP. BHSF has invested in staff with experience in administration of the program to further the progress. BHSF has also contracted with

nationally recognized experts to assist with driving the delivery of services in a way that improves outcomes. LDH expects to continue our progress at a steady pace.

MCO Value-Based Payment (VBP) Program Implementation:
LDH expects to continue progress with the VBP program through the implementation of advanced VBP requirements in the new Medicaid managed care program, effective January 2020.

Accomplishment #6: Community Health Worker (CHW) Blueprint:
Now that MCOs have been identified and in the process of contracting with LDH for the new Medicaid managed care contracts, the progress described in the Blueprint for the CHW demonstration can continue. There is a site visit planned in the near future to connect key leaders in Medicaid and CHVE with PCCHW to assess next steps in the development of the demonstration.

Accomplishment #7: Electronic Visit Verification (EVV):
As described under accomplishments, LDH has made significant progress in combating fraud, waste, and abuse with the implementation of EVV. Additionally, the department has made significant progress with compliance of the 21st Century Cures Act.

Accomplishment #8: Transformed Medicaid Statistical Information System (T-MSIS) Data Quality Initiatives:
We have started making significant progress toward building the state's capacity to handle T-MSIS data quality priorities, documentation requirements, and improving the overall quality of Louisiana's data submissions to CMS.

Louisiana requested and received 90/10 enhanced system funding through the Advanced Planning Document (APD) process, which assists in funding necessary systems enhancements to comply with T-MSIS data quality requirements. LDH will invest in recruiting and building staff's ability to meet T-MSIS data reporting requirements.

The state T-MSIS team has closely collaborated with federal and state partners by setting up a biweekly data quality meeting to discuss, understand, research and timely resolve identified T-MSIS data quality issues.

Louisiana T-MSIS team has also raised awareness and ensured that T-MSIS reporting considerations and requirements are included in current and future MMIS modular implementations. In that regard, both Eligibility and Provider Modular implementations in Louisiana are actively incorporating T-MSIS data reporting requirements.

The current success has been a collaborative effort across federal and state partners (DXC), and multiple Sections within the LDH Medicaid program.

LDH expects to continue progress in improving and growing personnel understanding of T-MSIS data quality issues and resolving issues in a timely manner.

- **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 #6: Community Health Worker (CHW) Blueprint:
  The MCO procurement process delayed the progress of this accomplishment.

  Accomplishment #7: Electronic Visit Verification (EVV):
  While the department has largely implemented EVV ahead of the January 1, 2020 deadline outlined in federal legislation, we continue to monitor new and additional guidance released by CMS and will assess whether this will require changes to any established policies and procedures.

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

  Accomplishment #1: Medicaid Eligibility and Enrollment System (LaMEDS):

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

  Updates to the strategic plan move beyond the LaMEDS implementation to the stabilization of operations and focus on superior customer service.

  Accomplishment #2: Code for America Text Messaging Platform:

  ☒ No. If not, why not?

  No strategic plan revisions are necessary for this accomplishment.

  Accomplishment #3: Medicaid Quality Dashboard:

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

The five-year strategic plan does reflect the expanded focus on Quality Improvement that will improve health outcomes and lower health care costs through performance metrics.

Accomplishment #4: Single Preferred Drug List (PDL):

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

LDH reconsidered its approach to the Single PDL implementation and involved stakeholders at each step of the process.

Accomplishment #5: Managed Care Organization (MCO) Delivery System Reform and MCO Value-Based Payment (VBP) Program Implementation:

Managed Care Organization (MCO) Delivery System Reform:

☒ No. If not, why not?

No strategic plan revisions are necessary for this accomplishment.

MCO Value-Based Payment (VBP) Program Implementation:

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

The five-year strategic plan does reflect the expanded focus on Quality Improvement that will improve health outcomes and lower health care costs through value-based payments.

Accomplishment #6: Community Health Worker (CHW) Blueprint:

☒ No. If not, why not?

No strategic plan revisions are necessary for this accomplishment.

Accomplishment #7: Electronic Visit Verification (EVV):

☒ No. If not, why not?

No strategic plan revisions are necessary for this accomplishment. Implementation of EVV is on target to meet the federal deadline of January 1, 2020 for in-home personal care services.

Accomplishment #8: Transformed Medicaid Statistical Information System (T-MSIS) Data Quality Initiatives:

☒ No. If not, why not?

No strategic plan revisions are 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?** Use as much space as needed to explain fully.

  On a Department-wide level, Performance-Based-Budgeting activities (including strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the Louisiana Department of Health Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. Recommendations are made directly to the Assistant Secretaries or the Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

  Additionally, the Medicaid Director requests management and program staff to periodically review the agency's strategic plan to ensure that goals and objectives are shared with staff and monitored and adjusted accordingly.

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

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

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

A. Problem/Issue Description

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

The nature of the problem or issue is under-resourcing due to budget constraints.

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 unable to recruit viable candidates in many areas including data analytics, benefits management/clinical policy development, systems, quality and innovations, and program operations including managed care oversight and compliance. Our salaries are not competitive with the commercial and private sectors. In addition, Civil Service constraints on Medicaid result from restricting hiring to the program manager series. Medicaid is in itself a singular program. It is the largest state budget and has evolved beyond the program manager series due to its complexity and expansive federal regulations. 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. For example, we require the skillset of data scientists to comply with federal and state reporting requirements and to identify areas to advance the program along with national initiatives and other states (e.g., health outcomes, utilization trends, expenditure forecasting, etc.); however, we cannot recruit data scientists because we must fit them into the salary and job constraints of the program manager series. This specialized skillset needs to have its own job series. These recruiting delays also result in long-standing vacancies that are vital to program modernization and development and compliance with federal requirements such as systems modernization.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   Providers and Medicaid recipients are affected by our inability to recruit key vacancies. For example, this has led to deficits in provider network management and provider relations staff along with encounter/claims oversight, creating additional burden on providers seeking redress of payment issues. Another example is the LaMEDS implementation. With high turnover and many vacancies in the regions, Medicaid recipients may not receive the standard of customer service that we have historically demanded.

5. **How long has the problem or issue existed?**
   It has become particularly prevalent in the past four years.

6. **What are the causes of the problem or issue? How do you know?**
   One cause is budgetary constraints, which do not allow for additional state hiring. Additionally, Civil Service has been very flexible and supportive.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   If the problem persists, LDH will not be able to comply with federal requirements along with provider and Medicaid member abrasion.

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.

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
☐ 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**: Uncompensated Care Costs Report
2. **Date completed**: December 2018
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Provide amount and type of uncompensated care provided, and amount and type of other services and activities financed by uncompensated care cost payments.
4. **Methodology used for analysis or evaluation**: Myers and Stauffer compiles this report based on schedules submitted by hospital providers.
5. **Cost (allocation of in-house resources or purchase price)**: $14,742.50
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)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/1454
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 2:

1. **Title of Report or Program Evaluation**: Year End Financial Report for SFY 2017/18
2. **Date completed**: September 2018
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Provide a comprehensive overview of Medicaid spending.
4. **Methodology used for analysis or evaluation**: Expenditure data is gathered 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)**: http://ldh.la.gov/index.cfm/newsroom/detail/4989
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 3:

1. **Title of Report or Program Evaluation**: Causes of re-hospitalizations of infants born premature at less than 37 weeks gestational age who are within the first six months of life
2. **Date completed**: January 2019
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Legislative requirement: Act 311 of the 2013 regular legislative session. Report the incidence and causes of all re-hospitalizations of infants born premature at less than 37 weeks of gestational age and who are within the first six months of life.
4. **Methodology used for analysis or evaluation**: 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 who are 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 2107 who were born premature at less than 37 weeks gestational age and are in their first six months of life is 4.85 percent. The calendar year 2016 re-hospitalization rate was 4.79 percent. This indicates that the re-hospitalization rate in this group of newborns has remained fairly stable 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)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/2928
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 4:

1. **Title of Report or Program Evaluation**: Medicaid Forecast Reports SFY 2019/2020
2. **Date completed**: Monthly, October 2018 – May 2019
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Provide a comprehensive overview of Medicaid spending, including projections for future revenues and expenditures for the state fiscal year.
4. **Methodology used for analysis or evaluation**: Program staff develop budget projections based on utilization trends, enrollment trends, and other known factors affecting the management of the Medicaid program. Actual year-to-date expenditures are gathered 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)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/4989
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 5:

1. **Title of Report or Program Evaluation**: Louisiana Medicaid Diabetes and Obesity Report
2. **Date completed**: March 2019
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Per Louisiana Revised Statute (RS) 46:2616 and RS 46:2617, the Louisiana Department of Health (LDH) is required to submit an annual diabetes and obesity action plan 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 are aggregated across the five plans to yield 12 reports for Healthy Louisiana. The Healthy Louisiana reports are described 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 further impact the obesity and diabetes epidemic.

7. **Major Recommendations**:
    - Seek legislative appropriation of funds for a new Medicaid covered service to allow Medicaid recipients to receive nutritional consultations and services provided by registered dietitians.
    - Encourage the use of outpatient nutritional services provided by registered dietitians for all patients and all diagnoses, not just those diagnosed with diabetes and obesity.
    - Promote the use of diabetes self-management education (DSME) programs or incorporate elements of these programs into case management activities for patients diagnosed with diabetes. DSME programs have been associated with improved health outcomes for patients diagnosed with diabetes.
    - Implement reforms in the education system aimed at improving diabetes and obesity outcomes in Louisiana.
8. **Action taken in response to the report or evaluation**: Not Applicable
9. **Availability (hard copy, electronic file, website)**: http://ldh.la.gov/index.cfm/page/2115
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 6:

1. **Title of Report or Program Evaluation**: Medicaid Annual Report, SFY 2017/18
2. **Date completed**: August 2019
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: This annual report for state fiscal year (SFY) 2018 provides a snapshot of the strides made to improve the health outcomes and quality of care for the more than 1.9 million men, women and children enrolled in Medicaid.
4. **Methodology used for analysis or evaluation**: Annual compilation of Medicaid operations data for SFY 2018.
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)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/1699
10. **Contact person for more information, including:**
    Name: Erin Campbell

Title: Chief of Staff to the Medicaid Director
Agency & Program: Bureau of Health Services Financing (Medicaid)
Telephone: 225-342-1353
Email: Erin.Campbell@LA.GOV

Report # 7:

1. **Title of Report or Program Evaluation**: Medicaid Managed Care Quarterly Transparency Report SFY 2019
2. **Date completed**: February 2019, April 2019 & July 2019
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.
4. **Methodology used for analysis or evaluation**: Compilation of specified monthly and quarterly data on Medicaid Expansion Program and Medicaid Managed Care Pharmacy Benefits Manager revenues.
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)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/5061
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 8:

1. **Title of Report or Program Evaluation**: Medicaid Managed Care Transparency Report – State Fiscal Year 2018
2. **Date completed**: June 2019
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 are being 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)**: http://www.ldh.la.gov/index.cfm/page/3658
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 9:

1. **Title of Report or Program Evaluation**: Healthy Louisiana Claims Report
2. **Date completed**: October 2018, April 2019, July 2019
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" is 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 be used to generate an initial report to the legislature and inform the contents of ongoing quarterly reporting.
4. **Methodology used for analysis or evaluation**:
5. **Cost (allocation of in-house resources or purchase price)**: Compiled by Burns & Associates
6. **Major Findings and Conclusions**: Not Applicable
7. **Major Recommendations**: LDH should
   - develop a common set of definitions for claims and encounter adjudication terms that would be used by all MCOs as well as the LDH fee-for-service payment system.
   - review the MCO reports that focus on claims and consider modifying, consolidating or eliminating existing reports, consider adding a report on encounter submissions.
   - build guidance or requirements about the expectations that the MCOs will perform root causes analyses pertaining to claims adjudication and/or encounter submissions.
   - develop an audit protocol and conduct a periodic audit of a sample of claims denied by the MCOs to ensure that the claims are not being denied in error by the MCO.
8. **Action taken in response to the report or evaluation**:

- New quarterly reports for claims and encounter submission, including standardization of terms and definitions, were developed with stakeholder and MCO input. Data collection and reporting was implemented for calendar year 2018 forward.

9. **Availability (hard copy, electronic file, website)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/4894
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 10:

1. **Title of Report or Program Evaluation**: Medicaid Eligibility Reform: Reasonable Compatibility & Tax Data
2. **Date completed**: Published monthly beginning in August 2018
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: In response to House Bill 1 of the 2018 Second Extraordinary Legislative Session, LDH is required to publish a monthly report to the Joint Legislative Committee detailing the progress made in the implementation of Medicaid reform.
4. **Methodology used for analysis or evaluation**: Used Medicaid eligibility system data to determine the number of individuals who went through additional review as a result of reasonable compatibility reform.
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)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/4710
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 11:

1. **Title of Report or Program Evaluation**: Potential Implementation of Mandatory Case Management in Medicaid
2. **Date completed**: February 2019
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: In response to House Concurrent Resolution 65 (HCR 65) of the 2018 Regular Legislative Session, which requires the Louisiana Department of Health (LDH) to study potential implementation of mandatory case management for Medicaid

enrollees identified as high-risk due to either health status or socioeconomic factors, for the purpose of improving health outcomes and lowering healthcare costs.

4. **Methodology used for analysis or evaluation**: Examined existing case management practices in Medicaid, further details CMS' rules around case management as a component of a state's Medicaid program and explores alternative options for improving case management opportunities for Louisiana's Medicaid enrollees
5. **Cost (allocation of in-house resources or purchase price)**: Compiled by internal staff.
6. **Major Findings and Conclusions**: Per code of federal regulations, states are specifically prohibited from mandating or compelling individuals to participate in case management. LDH reached out to CMS Regional and Central Offices to request guidance on how a state could potentially secure an exemption to the rule prohibiting mandatory case management for high-risk Medicaid enrollees. CMS representatives from the 1115 Waiver Division, Managed Care Division and the State Plan Division in the CMS Central Office confirmed a CMS standing rule against mandatory case management and expressed their awareness that no authorities exist to waive the requirements in order to permit mandatory case management. They reiterated existing law, stating that under State Plan 1905(a) Case Management, states cannot condition the receipt of any Medicaid services on the receipt of case management per 42 CFR 441.18(a)(2) and (a)(3), or mandate the receipt of case management per 441.18(a)(3).12. CMS also confirmed that no other states have requested to mandate that a Medicaid enrollee receive case management via a demonstration.
7. **Major Recommendations**: While mandatory case management in the Medicaid program may not be feasible, other opportunities exist to enhance and strengthen the availability of services offered to Louisiana Medicaid enrollees to improve their health and lower costs.
8. **Action taken in response to the report or evaluation**: Not Applicable
9. **Availability (hard copy, electronic file, website)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/5049
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 12:

1. **Title of Report or Program Evaluation**: Medicaid Managed Care Quality Incentive Payment Program Report
2. **Date completed**: December 2018
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: In response to House Resolution 252 of the 2018 Regular Legislative Session, the Louisiana Department of Health (LDH) is required to submit the Medicaid

Managed Care Quality Incentive Program report.

4. **Methodology used for analysis or evaluation**:
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)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/4993
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 13:

1. **Title of Report or Program Evaluation**: Medicaid Buy-In Program Report
2. **Date completed**: August 2018
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: In response to SB 305 of the 2003 Regular Session, LDH is required to submit certain information regarding the Medicaid Buy-In Program to the legislature, including the status of the buy-in program, a report relative to the estimated value of the state, federal and FICA taxes paid by the participants in the buy-in program, and any recommendations for expanding coverage in the buy-in program.
4. **Methodology used for analysis or evaluation**: Compilation of eligibility program data.
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)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/1397
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 14:

1. **Title of Report or Program Evaluation**: HCR 8 Quarterly Report – (Payment for coverage of expansion of the Louisiana medical assistance program)
2. **Date completed**: August 2018
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: In response to House Concurrent Resolution 8 of the 2017 Regular Legislative

Session, LDH is required to publish on a quarterly basis a report on reimbursement enhancements paid to hospitals pursuant to the stabilization formula.

4. **Methodology used for analysis or evaluation**: Compilation of operational data**.**
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)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/4371
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 15:

1. **Title of Report or Program Evaluation**: Response to SR 163 of the 2017 Regular Legislative Session
2. **Date completed**: July 2018
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: This report represents the last in the series produced in response to Senate Resolution 163 of the 2017 Regular Legislative Session. As per Act 482 of the 2018 Regular Legislative Session, expansion reporting will move to a quarterly basis to be included in the Medicaid managed care transparency report required under R.S. 40:1253.2. This report contains information on the Medicaid expansion population and the experience of other state Medicaid programs with work requirement and cost sharing initiatives.
4. **Methodology used for analysis or evaluation**: Compilation of operational data from the Medicaid eligibility system and Medicaid data warehouse.
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)**: http://www.ldh.la.gov/index.cfm/newsroom/detail/4326
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 16:

1. **Title of Report or Program Evaluation**: LaCHIP Mid-Year Report
2. **Date completed**: June 2019
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: This report is submitted per the guidelines in LA-R.S. 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**: In SFY19, 131,735 children and pregnant women had access to much needed healthcare coverage.
7. **Major Recommendations**: Not applicable.
8. **Action taken in response to the report or evaluation**: Not Applicable
9. **Availability (hard copy, electronic file, website)**: http://ldh.la.gov/index.cfm/newsroom/detail/2238
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Report # 17:

1. **Title of Report or Program Evaluation**: Response to HCR 69 of the 2018 Regular Legislative Session
2. **Date completed**: April 2019
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: This report is submitted to provide research findings and feedback received from other states relative to the legislature's request as outlined in HCR 69.
4. **Methodology used for analysis or evaluation**: Comparison of Louisiana policy to other state Medicaid agency policies on the estate recovery process.
5. **Cost (allocation of in-house resources or purchase price)**: Compiled by in-house staff.
6. **Major Findings and Conclusions**: Louisiana's estate recovery program has collected less money than other state programs due to the strong statutory emphasis on protecting inheritance rights rather than recovering Medicaid funds expended on an individual's behalf.
7. **Major Recommendations**: Removal of the half-median value exemption on homes would greatly improve the amount of money collected through the estate recovery program.
8. **Action taken in response to the report or evaluation**: Not Applicable
9. **Availability (hard copy, electronic file, website)**: http://ldh.la.gov/index.cfm/newsroom/detail/5120
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director

Agency & Program: Bureau of Health Services Financing (Medicaid)
Telephone: 225-342-1353
Email: Erin.Campbell@LA.GOV

Report # 18:

1. **Title of Report or Program Evaluation**: Response to HCR 6 of the 2018 Regular Legislative Session
2. **Date completed**: June 2019
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: This report is submitted to provide a Medicaid assessment report to JLCB prior to calculating, levying and collecting an assessment for each assessed hospital.
4. **Methodology used for analysis or evaluation**: Compilation of operational data**.**
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)**: http://ldh.la.gov/index.cfm/newsroom/detail/4970
10. **Contact person for more information, including:**
    Name: Erin Campbell
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-1353
    Email: Erin.Campbell@LA.GOV

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

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

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

Undersecretary: **Cindy Rives**

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: Maternal Mortality:

A. What was achieved?
The Louisiana Department of Health (LDH) is leading a comprehensive effort to address alarming maternal mortality statistics in Louisiana and, as a result, LDH leaders are at the forefront of the national conversation about the national maternal mortality crisis.
Maternal mortality is a pregnancy-related death occurring up to 42 days following the end of a pregnancy.

B. Why is this success significant?
Based on estimates of maternal mortality by the National Center for Health Statistics,

Louisiana ranks 47th out of 48 reportable states. A LDH study shows that there were 47 confirmed maternal deaths occurring between 2011 and 2016 that were pregnancy-related or due to causes directly related to pregnancy, producing a six-year mortality ratio of 12.4 deaths per 100,000 births in Louisiana. Non-Hispanic black women are 3 to 4 times more likely to experience maternal death than non-Hispanic white women are.

Each maternal death has far-reaching ramifications for families and communities. Maternal mortality is a crucial indicator of healthcare quality and gender equity, nationally and internationally. Therefore, maternal deaths are sentinel events that serve as a call to action for public health professionals, health systems, providers, and communities.

C. Who benefits and how?
This benefits women of reproductive age. Studying maternal mortality can help reveal health and social challenges that women of reproductive age face, and systemic responsiveness to these challenges. In the United States, maternal mortality is rising, with significant variation by race and ethnicity.

D. How was the accomplishment achieved?
This was achieved through the Department's coordination of the Louisiana Perinatal Quality Collaborative, Pregnancy Associated Mortality Review Committee, a statewide Maternal Mortality Summit, and bringing together healthcare administrators, stakeholders and experts to analyze data, develop solutions, and implement changes in policy and practice to reduce maternal deaths.

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

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

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 as it demonstrates successful collaboration with community partners to address alarming maternal mortality statistics in Louisiana and to improve standards of care for our state.

As a result, LDH-led efforts are already revealing promising improvements in clinical outcomes in Louisiana's birthing hospitals.

Accomplishment #2: Louisiana Launches Hepatitis C Innovative Payment Model:

A. What was achieved?
The Louisiana Department of Health (LDH) and the Louisiana Department of Corrections (DOC) announced an agreement that will allow the implementation of an innovative payment model for hepatitis C treatment, part of Louisiana's plan to eliminate the disease.

This five-year agreement was achieved through a partnership with Asegua Therapeutics LLC, a wholly-owned subsidiary of Gilead Sciences, Inc. (Nasdaq: GILD). Gilead Sciences is a research-based biopharmaceutical company that discovers, develops and commercializes innovative medicines in areas of unmet medical need. The company strives to transform and simplify care for people with life-threatening illnesses around the world. Gilead has operations in more than 35 countries worldwide.

This innovative payment model allows the state to provide an unrestricted amount of Asegua's direct-acting antiviral medication, the authorized generic of Epclusa® (sofosbuvir/velpatasvir) to treat patients within Louisiana's Medicaid and DOC populations. It also caps the State's medication costs.

With this model to purchase hepatitis C medications, those within the state correctional facilities who have this life-threatening illness can be cured and we can prevent the spread of the illness within the facilities. The Louisiana Department of Corrections will also work closely with LDH to implement a plan to screen and treat the local level population while incarcerated or upon their release into supervision.

According to LDH Secretary, Dr. Rebekah Gee, "The Department of Health's goal is to treat at least 31,000 people by the end of 2024 and eventually eliminate this disease."

B. Why is this success significant?
In the United States, hepatitis C kills more people than all other infectious diseases combined. At least 39,000 people in Louisiana's Medicaid program and prison system suffer from hepatitis C infection.

An elimination plan and innovative payment model will ensure that we can cure this deadly disease and prevent long-term illness and disability in those who have it.

C. Who benefits and how?
This partnership will have a direct and immediate impact on the most vulnerable populations with hepatitis C – people who are on Medicaid or who receive care through the state corrections system. These populations are disproportionately affected by hepatitis C and often face the greatest difficulty in accessing care.

The Department of Health continues to implement an elimination plan that engages partners across the state to educate the public on the availability of a cure and reach out

to high-risk populations for screenings; connect people living with hepatitis C to care; expand provider capacity; and establish partnership across the state to eliminate hepatitis C in Louisiana.

D. How was the accomplishment achieved?

After extensive research and work with policy experts across the nation, the Department released a solicitation of offers in January of 2019 in search of a pharmaceutical company willing to partner with Louisiana on a subscription model. The Department of Health and Asegua completed and signed a formal contract for the purchase of Asegua's hepatitis C medication, the authorized generic of Epclusa, over five years, and for people enrolled in the Medicaid program and incarcerated people in Louisiana.

The Department of Health continues to implement an elimination plan that engages partners across the state to educate the public on the availability of a cure and reach out to high-risk populations for screenings; connect people living with hepatitis C to care; expand provider capacity; and establish partnership across the state to eliminate hepatitis C in Louisiana.

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

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

In addition, the innovative payment model for Louisiana addresses the needs of patients and joins the goals of both Louisiana and Asegua to extend a cure to those in 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. This accomplishment represents a Best Management Practice as it demonstrates successful collaboration with community partners to reduce disparities in care across populations and to improve standards of care for our state.

<u>Accomplishment #3: Creation of the LDH's Health Equity Unit</u>

A. What was achieved?
LDH created a new section, Community Partnerships (Health Equity), within the Office of the Secretary. Community Partnerships serves as a support unit focused on community partnership-relations and health equity efforts. Community Partnerships also provides oversight and guidance to LDH's Bureau of Minority Health Access and Promotion (BMHAP), while also supporting (i.e. operationalizing components of) LDH's Public Health Accreditation Board (PHAB) accreditation, which supports,

ensures the PHAB accreditation is approved for renewal every five years. PHAB accreditation indicates a health department's capacity to carry out the ten Essential Public Health Services (EPHS).

Health equity means that every person in a community has a fair and just opportunity to reach their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

Community Partnerships' work center in ensuring that LDH practices, protocols, and services are fair and equitably accessible and informed by the barriers that affect people, populations, and communities' wellness and well-being. This newly created unit will also develop a Health Equity Policy to provide guidance, agency-wide, on health equity procedures for cross cutting public health policy, trends and emerging issues.

B. Why is this success significant?
The existence of a positive correlation between social/economic status and life expectancy is an indicator of health inequity. Health inequity results when the social gradient is shaped by economic and social conditions that are not only unfair but also avoidable. Examples include unequal distribution of societal burdens such as unequal distribution of resources (i.e. capital, laws, regulations, etc.) to vulnerable communities; disproportionate placement of toxic landfills near low-income communities; lack of inclusionary zoning laws to promote mixed-income housing and discourage de-facto housing segregation; and the existence of economic policies and social norms and inequalities that result both in the widening income inequality gap and contribute to health inequities.

This is significant in order to increase awareness of the significance of health disparities, their impact on the state, and the actions necessary to improve health outcomes for racial, ethnic and underserved populations.

C. Who benefits and how?
Low income and racial, ethnic and underserved populations will benefit, by operationalizing health equity practices and protocols within LDH – Health Equity Plan, these efforts will support improvements with LDH staff professionalism, while also supporting improvements in LDH programming, services, and thus aiding improvements in the health outcomes of the people, populations and communities LDH serves.

D. How was the accomplishment achieved?
LDH executive leadership developed an agency Health Equity Policy to provide guidance on health equity procedures for cross cutting public health policy, trends and emerging issues. It is a priority of the Department to lead and continually improve a public health system that identifies and reduces health disparities and inequities to improve health outcomes and quality of life in Louisiana.

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

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

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: National Health and Activity Program Modeled after Louisiana's Physical Activity Competition:

A. **What was achieved?**

Louisiana Department of Health's Bureau of Minority Health Access and Promotions co-sponsored the National Active and Healthy Challenge that encourages individuals, especially racial and ethnic minorities, to work physical activity into their daily and weekly schedules.

The Active and Healthy Challenge is a nationwide effort by the U.S. Department of Health and Human Services' (DHHS) Office of Minority Health and is part of National Minority Health Month. This national challenge builds on Louisiana's Own Your Own Health Physical Activity and Nutrition Challenge.

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

The U.S. Department of Health modeled their nationwide activity challenge based on the Bureau's Own Your Own Health (OYOH) program. DHHS utilized the OYOH online physical activity and nutrition wellness center to track their progress that ultimately encouraged competition among federal agencies.

C. **Who benefits and how?**

In both Louisiana and throughout the country, this event allows fitness enthusiasts or anyone seeking a healthy lifestyle change to create a public or private challenge. Participants earn points through exercise, weight loss and healthy eating selections.

In addition to the activity challenge, the Bureau collaborated with the Louisiana Primary Care Association, community groups, faith-based organizations, regional and local health departments and other public-private entities to initiate health and wellness activities during National Minority Health Month. Issues addressed by these activities will include health outcome disparities, cancer, heart disease, diabetes, HIV/AIDS, mental health, cultural awareness, urban and rural health needs and gender issues.

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

Participants are encouraged to form groups of two or more people or they can participate as individual participants. Group and Individual participants can choose from one of the two challenges:

- Steps Challenge
- Weight Loss Challenge

Captains will be selected for each group, and his/her responsibility is to:

- Motivate and encourage group members
- Keep members updated regarding changes in the program when necessary
- Disseminate motivational materials, share weekly nutrition and activity to members
- Collect confidential team information such as the individual and team weight totals

To earn points, teams or individuals enter their steps if using a pedometer, or enter the amount of time it takes them to complete activities. Teams' progress is constantly updated and can be viewed by clicking on 'Challenge Progress' then scrolling to the bottom of the page and seeing the rankings. Team captains and individual participants can report their totals via the website or can send an email to: oyoh@la.gov.

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

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

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 as it demonstrates successful collaboration with community partners to reduce disparities in care across populations and to improve standards of care for our state.

<u>Accomplishment #5: Agreement to Resolve the Department of Justice Investigation</u>

A. What was achieved?

In 2014, the United States Department of Justice (DOJ) initiated an investigation of the State of Louisiana in regards to compliance with Title II of the Americans with Disabilities Act (ADA) for persons with Serious Mental Illness being placed in nursing homes. Following this investigation, in 2016, the DOJ alleged that Louisiana unnecessarily relies on nursing facilities to serve people with serious mental illness instead of serving them in the most integrated setting appropriate to their needs as

required by the ADA.

In June of 2018, the State of Louisiana and the Louisiana Department of Health (LDH) entered into an Agreement with the DOJ to resolve its investigation. Under this Agreement, the State is required to create and implement a plan that will transition or divert individuals with mental illness from nursing facilities by expanding the array of community-based services including crisis services, case management, integrated day services, and supportive housing.

Since the Agreement was signed, progress has been made in various areas:

- ✓ Finalization of the Initial Implementation Plan to cover activities during the first 18 months of the Agreement,
- ✓ Development of initial transition protocols/processes for individuals in the Target Population interested in transitioning from nursing facilities,
- ✓ Development of In-reach and Outreach plans,
- ✓ Recruitment, hiring, and training of Transition Coordinators,
- ✓ Implementation of initial stakeholder engagement strategies,
- ✓ Initiation of service planning activities regarding crisis and supportive housing,
- ✓ Development of a community case management model, and
- ✓ Forty-seven (47) people transitioned from Nursing Facilities in Fiscal Year 19.

B. Why is this success significant?

The requirements set forth in the Agreement align with LDH's mission to protect and promote health and to ensure access to medical, preventive and rehabilitative services for all citizens of the State of Louisiana. Development and implementation of a plan that will transition or divert individuals with serious mental illness from facilities and the expansion of community-based services allow LDH to achieve our vision that every Louisiana citizen is able to access the right care, at the right time, in the right place.

C. Who benefits and how?

Individuals with serious mental illness and their families will benefit from the expansion of the array of community-based services delivered by a person centered service delivery system that is coordinated, responsive, and efficient. This will allow individuals to receive the supportive services they need to live in the setting they choose reducing the need for more restrictive and more expensive settings.

D. How was the accomplishment achieved?

The accomplishments were achieved by collaboration between multiple program offices within LDH. Programs and services were assessed, which lead to the

development of an initial implementation plan with specific goals and strategies. Those goals and strategies have become instrumental to successfully executing the obligations set forth in the Agreement. The use of an array of stakeholder groups to provide feedback/input as it relates to initiatives/activities surrounding the agreement include members of the target population and their families, advocates, the Core Advisory Group, small stakeholder led work groups, the Louisiana Housing Corporation, local housing authorities, Local Governing Entities (LGEs), the Advocacy Center, community providers, and healthcare providers.

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

The approach contributes to achieving LDH's overall mission and vision. It has also assured that Louisiana citizens have choice related to both where they live and services received in a cost effective manner.

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

The approaches utilized in tying a comprehensive system analysis to a multi-phase strategic action plan while involving stakeholders and incorporating national best-practice recommendations are consistent with nationally recognized strategies for success in large-scale system transformation.

<u>Accomplishment #6: LDH Offers Department-wide LEAN Six Sigma Executive Yellow Belt Training</u>

A. What was achieved?
As one of the LDH's five agency priorities, or "Big Bets," is a commitment to "demonstrate good stewardship through a culture of Continuous Quality Improvement (CQI)." As such, LDH leaders offered employees an opportunity to learn the basics of LEAN Six Sigma (LSS) and to become certified in the methodology. This level of training, referred to as a "Yellow Belt," required employees to attend eight hours of training over a two-day period.

Continuous quality improvement, or CQI, is a management philosophy that organizations use to reduce waste, increase efficiency, and increase internal (meaning, employees) and external (meaning, customer) satisfaction. CQI is an ongoing process that evaluates how an organization works and ways to improve its processes.

The program features levels instruction that match the roles of staff. Training, integrated with execution of projects, has given our staff a "laboratory and lecture" style of learning. We have trained 46 Executives (designated as Yellow Belts in LSS), who sponsor and support the projects. More extensive project leader training was provided for 14 project leaders. These are "Green Belts" in level of instruction. They have led 5 different projects within a 6 month sprint.

The five projects have focused on reducing the time to complete Medicaid eligibility for long-term care applicants; increasing the ability to recruit talent; increasing the retention of that talent; improving vendor compliance with federal nutritional services programming (WIC); and reducing the time that it takes for a waiver recipient to begin to receive services from either the Office of Aging Services and the Office for Citizens with Developmental Disabilities. The 14 Green Belt candidates have incorporated their training into leading project teams that drive the improvement pilots with measureable results.

Course objectives included:

- Understanding distinctions among key change management tools (LEAN, Six Sigma, Change Acceleration Process, and Rapid Process Improvement Workshops) and how each can be applied to unique challenges within the organization.
- Identifying roles and responsibilities in LEAN Six Sigma projects and cultural transformation.
- Obtaining practical tools for successfully serving as a LEAN Six Sigma project champion.

The department will continue this training structure to multiply the knowledge and grow our capacity for measured improvement. Projects are selected to support departmental priorities. The program provides the "how" to make and manage effective change rapidly. Once trained, the Green Belts are equipped to lead additional projects for continuous quality improvement.

B. Why is this success significant?
The Lean Six Sigma method is a proven improvement method used by successful companies such as Toyota, General Electric and Motorola, as well as other state governments. LSS is also used in many healthcare institutions, not just manufacturing companies, with great success. Our own state has had success, but it has not been within such a structured program to ensure replication for magnified benefit. To our knowledge, we are the only state agency that has created such a structured foundational program of performance improvement, with such a large span and scope, poised to multiply both efficiencies and improved quality of services.

In addition, this curriculum and interactive learning exercises equip leaders with pertinent information needed to lead complex change and provide practical approaches to fulfilling critical project sponsorship and champion roles.

C. Who benefits and how?
State consumers benefit from increased quality of services and improved costs for services by reducing overhead through efficiencies gained. More importantly, the services can be delivered to vulnerable populations in a timelier manner. LDH Staff benefit from professional development and increased morale by learning how to perform their duties in a more efficient and effective manner. Management benefits

from solving challenges in a data driven, documented fashion, and from growing their "thought athletes" within their organizations. Improved processes often result in the ability to shift gained resources to address other priorities.

D. How was the accomplishment achieved?

LDH launched the initiative to build a CQI system, which included building infrastructure around the Lean Six Sigma (LSS) methodology of improvement. Participants were required to attend a two-part course offering in order to receive Yellow Belt certification.

The LDH executive management team selected the projects, identified applicants for the Green and Yellow Belt process, and supported the commitment of time for all involved. All LDH agencies were incorporated into all the projects and all had representatives in the training cohorts, spreading the initiative throughout the organization.

LDH also brought in an external consultant, who is a certified Master Black Belt who works with providers, health plans, boards, management, physicians, frontline staff and hospital associations to deliver standardized training to the Yellow and Green Belt candidates. LDH's deputy assistant secretary, who is also a Master Black Belt, provided internal guidance and oversight in Lean Six Sigma management during program development.

This training opportunity has created an excitement about accomplishing and managing work in a different manner. LDH is seeing a positive culture change, which engages every level of staff in the ideas and execution of change; staff adoption leads to greater participation and magnifies the impact of the program.

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

One of LDH's Big Bets is to be good stewards of state resources. Creating a Continuous Quality Improvement Program ensures that a foundation is created to eliminate waste and improve quality of services. Within LDH, agencies and departments have used Lean Six Sigma tools to accomplish their more specific strategic goals. The impact effects the current fiscal year, but the infrastructure is in place for continued return on investment.

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

The use of Lean Six Sigma as an improvement methodology is a best practice that provides quality and efficient processes. The data driven approach, with attention to customer focused service requirements, provides an objective method to solve challenges. Using a method to address opportunities for improvement in a standardized, pragmatic manner, as well as leveraging staff expertise, to maximize efficiencies and provide operational direction in the management of processes is a best practice.

The system of training staff in the course of project execution has been a best practice and ensures that the skills taught can be demonstrated, while providing efficiency gains.

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, which was revised in May of 2019, provides: (1) a general picture of intended performance across the agency, (2) a general discussion of strategies and resources the agency will use to achieve its goals, and (3) general confidence and reliability that agency performance information will be credible.

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

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

Emergency Preparedness Section: The overall strategic goal of the LDH Emergency Preparedness Section is to sustain sufficient infrastructure to respond to all-hazards' events. The number, type, scope and scale of events to occur within a given year are unknown. LDH, in conjunction with the Governor's Office and the Governor's Office of Homeland Security & Emergency Preparedness, makes available up-to-date information during times of emergencies. Disasters are no-notice events and require a network that is response-ready. Maintaining this focus in a feast and famine environment can be challenging to any multi-agency system.

Within the Health Standards Section (HSS) of the Office of the Secretary, this unit continues to addresses efficiencies in processes to work smarter in order to utilize staff in an increasingly productive manner, and to achieve more automation to relieve time

consuming, hand driven acts. HSS continues to meet the mandates of the Centers for Medicare and Medicaid Services (CMS) compliance and workload as evidence in the success shown through state performance standards. This is also evident in the results shown on departmental performance indicators.

- **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:

  HSS has been re-focused to utilize all available electronic processes to improve efficiencies. This forward progress has contributed with the electronic process by increase accountability, enhanced training and communication has created an open dialog to problem solve, identify concerns and resolutions has contributed to the consistency in the survey process.

  Progress is expected to continue at a steady result driven 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?

Strategic plan revisions occur within each office/section on a continuous basis to efficiently address critical needs and issues within each office. Our offices continue to identify and quantify electronic processes to improve efficiencies (Health Standards); address needed rule revisions for consistency with processes and new statutes (Legal & Internal Audit); 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 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 are made directly to the Assistant Secretaries or the Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

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

("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

- 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.

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

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

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

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

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

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

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

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

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive 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 2018-2019

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

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

Undersecretary: **Cindy Rives**

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: Title of significant accomplishment:

A. What was achieved?
The South Central Louisiana Human Services Authority (SCLHSA) focused on expanding its Prevention Services provided to the residents of Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne parishes in this past year. Prevention is defined as the proactive outcome-driven process of promoting healthy lifestyles and improving quality of life by empowering individuals, families, and communities through an integrated system of evidence-based policies, programs and practices. Ideally, prevention is intended to prevent or reduce the risk of developing a behavioral health problem such as underage drinking, prescription drug misuse and abuse,

and illicit drug use. SCLHSA believes that early intervention is the key to preventing the onset of substance abuse usage issues and that community involvement is vital to ensure that the issue of prevention is being tackled at every level. SCLHSA provides the following prevention services in the community:

1. **Life Skills Training (LST)** aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This program is offered in Grades 2-8.
2. **Project Alert** is a school-based prevention program for middle school students that focuses on alcohol, tobacco, and marijuana use. It seeks to prevent adolescent nonusers from experimenting with these drugs, and to prevent youths who are already experimenting from becoming more regular users or abusers. This program is offered in Grades 7-8.
3. **Kids Don't Gamble, Wanna Bet** is a school-based prevention program designed to discourage underage gambling through improved critical thinking and problem solving. This program is offered in Grades 3-8.
4. **Students Against Destructive Decisions (SADD)** is a peer leadership organization dedicated to providing students with the best prevention tools possible to deal with the issues of underage drinking, other drug use, risky and impaired driving, and other destructive behaviors. This program is available to all high schools.
5. **SYNAR** is a program designed to educate and reduce retailer violations of the law which prohibits the sale and distribution of tobacco products to persons under 18.

All of these programs are evidenced based and give SCLHSA an opportunity to diversify education to children and adolescents in the school setting and for the general public.

B. Why is this success significant?

The expansion of prevention services to the SCLHSA program structure enhances the agency's work product and the quality service delivery provided to our clients on a daily basis. These service expansions are also important because they were developed from input with other community providers in our catchment area that identified needs and approached our agency about ways to help fill identified service voids. SCLHSA has learned over the years that successful prevention decreases risk factors and enhances protective factors and that utilizing prevention strategies within school systems work. Research has proven that systems of prevention services work better than isolated efforts and that it is important to to share information and tools across service systems. SCLHSA has had success in this area because of the strong link we have with our prevention coalitions and contracted services partners. As a group, we believe that substance use should be addressed comprehensively throughout all phases of a child's education (elementary through high school) and on into the college framework as well. SCLHSA has had the opportunity to add both the SADD high school initiative this year, compliance checks in the bar rooms and at community events

focused on underage drinking with law enforcement agencies and summer camps that all educate young individuals on the risks and outcomes of underage drinking, drug use and other destructive behaviors.

C. Who benefits and how?

The SCLHSA clients, school settings and community benefit by receiving outpatient services and education that are evidenced-based and represent best practices for treatment/services delivery, client satisfaction, and performance improvement. The particular service expansions The SCLHSA expansion of prevention services allowed our agency to improve communication with persons served; create person-centered standards that emphasize an integrated and individualized approach to services and outcomes; provide accountability to funding sources, referral agencies, and the community; instill management techniques that are efficient, cost-effective, and based on outcomes and consumer satisfaction; supply evidence to federal, state, provincial, and local governments of commitment to quality programs and services that receive government funding; and guidance for responsible management and allow for professional growth of personnel. .

D. How was the accomplishment achieved?

The SCLHSA Board of Directors and staff are committed to hold the agency to the performance improvement standards included in the Strategic Goals and Objectives focusing on the unique needs of each person the agency serves, and monitoring of the results of services we provide. SCLHSA began with an internal examination of its prevention program and business practices. The examination consisted of the SCLHSA staff conducting an in-depth self-evaluation review of agency policies, procedures, documents and contracts to make improvements in protocols and procedures to improve service delivery. We worked with our prevention coalition partners, prevention service providers and school personnel to look at what services could be expanded to reach more students in the school setting. We saw an increase in enrollment in all of our prevention programs for FY 18/19, increased our SYNAR checks from 500 – 650, started SADD programs in four high schools and started on campus services at Nicholls State University to provide education of underage drinking, other drug use, risky and impaired driving, and other destructive behaviors. The result was that more students benefitted from education, more schools participated in the prevention training process and the community came together to help take on the responsibility of reaching out to the younger generation about making wiser choices for their lives.

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

As a service provider, SCLHSA has the advantage of utilizing clearly defined and nationally accepted standards to ensure that our services maintain excellence. Through our CARF accreditation, we are compelled to focus our agency to focus on best business practices to include: business improvement, service excellence, competitive

differentiation, risk management, funding access, positive visibility, accountability and peer networking. All of these factors contribute to our strategic plan by assisting us in the development of policies, procedures and the initiation of services that are aligned nationally with best practices in the fields of behavioral health and developmental disabilities. SCLHSA also participates in programs funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) to further its mission to reduce the impact of substance abuse and mental illness on America's communities. **SAMHSA** provides leadership and devotes its resources - programs, policies, information and data, contracts and grants- toward helping the Nation act on the knowledge that behavioral Health is essential for health and that prevention works (CSAP). SCLHSA has also included prevention to its Strategic Plan with the following verbiage "Prevention is an anticipatory process that prepares and supports individuals and systems in the creation and reinforcement of healthy behaviors and lifestyles. In addition, prevention is a process that utilizes multiple strategies designed to preclude the onset of the use of alcohol, tobacco and other drugs by youth. Prevention principles and strategies foster the development of social and physical environments that facilitate healthy, drug-free lifestyles. Prevention strategies target universal, selective, or indicated populations". SCLHSA has benefitted tremendously from focusing our prevention services on the short- and long-term benefits of investing in our youth through education and linkage throughout the community which is the key to having success in preventing substance misuse.

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

According to national datasets, the prevalence of alcohol, tobacco, and other drug use increases rapidly from early to late adolescence, peaks during the transition to young adulthood, and declines though the remainder of adulthood. Furthermore, there is accumulating evidence showing that the initiation of substance use early in life contributes to higher levels of use and abuse later in life. School-based efforts are efficient in that they offer access to large numbers of students. The programs SCLHSA uses were derived from psychosocial theories on the etiology of adolescent drug use and focused primary attention on the risk and protective factors that promote the initiation and early stages of substance use. Their approaches to school-based prevention of substance use can be categorized into three types: a) social resistance skills training; b) normative education; and c) competence enhancement skills training. Within a single preventive intervention, one or more of these approaches or components may be combined. It is important to note that education can only go as far as an indiviudal's support system. Drug abuse prevention has to start with parents. The programs offered at schools, through sports, and other groups can support what parents have started. To borrow from a quote by Hillary Clinton "it takes a village" to make prevention work. Everyone from the student, parents, schools, law enforcement and community need to be on board with prevention for it to work properly!

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: **NONE Noted**
     - 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 Noted**

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

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

South Central Louisiana Human Services Authority's implemented additional strategies specific to: expansion of eligibility criteria, strengthened collaboration with community partners/stakeholders;

intensified focus on evidence-based and best practices for treatment/services delivery; increased access to social support systems; increased monitoring; increased technical assistance to contractors; and, pervasive performance and quality improvement activities. All strategies were geared to assure sustainability, increase capacity, and continue the delivery 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.

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

- 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.

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

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

4. 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.

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 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.

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 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. SCLHSA 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.

☒ **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:

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

Kristin Bonner
Deputy Director
South Central Louisiana Human Services Authority (SCLHSA)
985-876-8886
kristin.bonner@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

Department:	**Louisiana Department of Health (LDH)** 09-310 Northeast Delta Human Services Authority
Department Head:	**Rebekah E. Gee, MD, MPH** LDH Secretary
Undersecretary:	**Cindy Rives**
Executive Director:	**Dr. Monteic 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?

Through implementation of the agency's Five-Year Strategic Plan and in alignment with the overarching vision, mission, and tenets, Northeast Delta Human Services Authority (NEDHSA) experienced continual growth and realized numerous outstanding accomplishments during FY2019. 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.

Accomplishment #1: 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)".

B. Why is this success significant?

Behavioral Health and Primary Care Integration is 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 allowed NEDHSA 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.

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 expansion of our existing integrated care model. NEDHSA clients in need of one or more services are eligible to enroll into 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. Hard work and dedication of staff made these accomplishments possible.

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

Yes, one of the primary strategic initiatives outlined in NEDHSA's Strategic Plan for FY 2015-2020 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.

<u>Accomplishment #2: Developmental Disabilities Services:</u>

A. What was achieved?

The Northeast Delta Human Services Authority Developmental Disability Services Department (NEDHSA DD) continues to take an active part in the systems transformation initiative for developmental disability service delivery. During FY19, the NEDHSA DD department served over 1,700 individuals. As the single point of entry for the NEDHSA service area, the NEDHSA DD department provided 374 individuals with developmental disabilities $1,289,613 in services, supplies, and home and vehicle modifications that allowed those individuals to remain living in their homes and communities. The NEDHSA DD Medicaid Waiver program unit provided programmatic oversight including certification and accountability of over 1,300 Medicaid Waiver participants.

Additionally, the department closed out its first year for Partners in Employment, PIE, after its development last fiscal year. PIE is an initiative for promotion, education and placement of people with developmental disabilities in the workforce. Ongoing activities through this initiative include partnering with agencies in the community willing to learn, hire, and promote employment of individuals with developmental disabilities. PIE improves employment outcomes

for people with developmental disabilities by implementing direct contact and education with potential employees, the business community, and agencies that support people with developmental disabilities that want to work. Initiated in December 2017, the PIE program has made 83 contacts with potential employers to discuss the program and employment opportunities. Successful working relationships have been established with 7 businesses (8% of contacts) related to employment of individuals with developmental disabilities, with 3 employers identified for job shadowing opportunities. Six clients have been assisted with employment applications, with one clients being employed.

B. Why is this success significant?

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 need 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 be in place to assure quality and compliance to maintain funding, cost efficiency, and sustainability. The PIE initiative, in particular, is significant to NEDHSA's efforts to take a lead role in making systematic changes that will lead to improving the success for people with developmental disabilities that want to go to work. Statistically, people with disabilities are significantly unemployed or underemployed, and NEDHSA has determined that something must be done to change this outcome.

C. Who benefits and how?

People with developmental disabilities within out state, specifically within the NEDHSA area, benefit from 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 home 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?

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 improvement of the lives of people with developmental disabilities.

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

YES (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 #3: Behavioral Health and Addiction Services:

A. What was achieved?

NEDHSA successfully implemented numerous special initiatives that stem from our integrative behavioral health and primary care approach. The key component of NEDHSA's innovative approach to our client-centered integrated healthcare program involves the formal establishment of partnerships with community-based agencies and programs, as well as with primary healthcare programs and facilities. Development and maintenance of a successful integrated service network is 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:

Faith-Based Outreach

Through the Faith Partnership Initiative, NEDHSA engaged faith-based community leaders in order 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.

As part of this initiative, NEDHSA held three individual trainings. Readiness Training was provided to 36 faith leaders in the community and helped to assess both clergy readiness and denomination leadership support. Leadership Training provided faith leaders and clergy with a congregational readiness kit and promotional materials, and focused on building congregational support as well as developing the ministry by equipping the leadership with specific training and ministry guides. Thirty-eight community faith leaders were provided with this leadership training. Team Training was provided to 34 faith leaders in the community and was aimed at developing dedicated congregational team ministries. NEDHSA believes that adding faith-based organizations into the discussion of integrated care helps provide an even more meaningful sense of purpose, hope and faith for our citizens.

Addict: A Psychodrama

Given the growing epidemic of opioid misuse and abuse in the state of Louisiana as well as steady increases in drug and alcohol addiction, NEDHSA hosted "Addict", an emotional psychodrama aimed at educating the public about the dangers and realities of alcohol and substance abuse. A first of its kind, "Addict" was a theatrical production

depicting the devastating consequences of drug and alcohol abuse. NEDHSA's Executive Director desired to incorporate the arts into the agency's outreach in order to reach and engage the public in a unique, powerful way. Over 750 people attended the production. NEDHSA continues to explore creative ways to reach the community in order to disseminate important messages concerning behavioral health and substance use issues.

First-Responder Crisis Intervention Training

NEDHSA worked in collaboration with the Region 8 Mental Health Community Response Task Force to sponsor a series of Crisis Intervention Team (CIT) training courses for public safety professionals and first responders. Three One-Day Dispatcher/First Responder classes were held during FY19 aimed at educating dispatchers, firefighters, emergency medical technicians, and crisis counselors in recognizing and understanding signs and symptoms of mental/behavioral illness and co-occurring disorders to assist them in safely deescalating situations when individuals are in crisis. Additionally, three 40-hour, week-long Officer Classes were held in FY19 specifically designed for law enforcement officers by providing them with critical mental health and addictive disorder training and awareness to increase their ability to recognize and interact with those in crisis who suffer from mental health and addictive disorders and provide resource information to those individuals to get them the help they need.

Prison Reentry Summit

A free "Stop the Cycle" prison reentry summit was hosted by NEDHSA during FY19. In partnership with Goodwill Industries of North Louisiana, local, regional, and state leaders gathered to address the state of prison reentry and discuss solutions. The summit included plenary sessions, testimonies from people formerly incarcerated, and a panel of specialists who provided helpful information, resources, and contacts. Plenary talks were given by Corey Acosta, Assistant Director of Probation and Parole, Louisiana Department of Public Safety and Corrections; Rhett Covington, Assistant Secretary, Louisiana Department of Public Safety and Corrections; and NEDHSA's Executive Director. This summit was held to facilitate conversations concerning Louisiana's prison system and recidivism, as well as to provide information about NEDHSA's Louisiana Reentry (La-Re) Program.

Louisiana Reentry Program

A pilot program created by NEDHSA in partnership with Goodwill Industries of Northeast Louisiana, the Louisiana Reentry Program, LA-Re, is an ex-offender re-entry program that seeks to address the socioeconomic issues that increase recidivism among the formerly incarcerated. The goal of LA-Re is to give nonviolent, mentally ill and addicted ex-offenders an opportunity to receive the help they need post-incarceration so that they can build and maintain a positive social role within the community thereby avoiding the high individual, family, community and societal costs of recidivism. Following the direction of the state, NEDHSA drafted a template based on the need of the communities served as these services are considered vital to this area. Participants are matched with case managers who will work with incarcerating facilities to establish individualized treatment and life plan options for the individual. LA-Re services will begin upon immediate release in order to build a solid framework for re-entry back into

society. LA-Re is an example of NEDHSA working across governmental systems to help meet the mental, physical, addiction and workforce needs of citizens being released to our region from Louisiana's overburdened prisons and jails. LA-Re is modeled after the Louisiana Prisoner Reentry Initiative (LA-PRI) which utilizes evidence-based practices in its approach to reducing the rate of those returning to prison and Northeast Delta's award-winning integrated approach to healthcare. Treatment includes admittance to any one of NEDHSA's seven outpatient mental health and addiction clinics or one of three inpatient addiction service providers supported by NEDHSA. Furthermore, participants have access to NEDHSA's tobacco cessation, gambling, developmental disability, prevention, and workforce training and placement services. Additionally, they are referred to one of NEDHSA's many regional primary health care partners for medical, dental and vision care.

Since its inception in September 2018, 34 clients have been referred to the La-Re community re-entry program, with 85.3% of referrals enrolled. Of the 29 clients admitted into the program, 24.2% have successfully completed; 17.2% were administratively closed due to prison transfers, re-sentencing, or non-compliance; and 58.6% are ongoing. To date, no La-Re participants have returned to prison at 30-day, 60-day, and 90-day follow-up. Nearly 14% of ongoing La-Re clients have also been referred to the SOWs program for job training and placement assistance. One has secured gainful employment and one was referred to a local 4-year college for financial aid assistance.

SOWS 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. SOWS 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 FY 17, 160 clients have been referred to SOWS, with 97 clients being admitted to the workforce program. Of these, 34% maintained employment for at least 30 days; 32% maintained employment for at least 60 days; and 28.9% maintained employment for at least 90 days.

Operation Golden Years

In FY19, NEDHSA launched a new initiative focused on helping seniors with addiction, drug, and mental challenges. Operation Golden Years was initiated to provide increased awareness and support to individuals in our region who are aged 60 and above. The program provides education and information to seniors about prescription medications, as well as NEDHSA's existing behavioral health and substance abuse and addiction services. Twice a year, the agency partners with other organizations to provide prescription take back boxes as part of National Prescription Take Back Day, which allows seniors to safely dispose of unused prescription medications. Further, home and community-based services are provided to seniors in need.

Louisiana Opioid Summit

During FY18, NEDHSA hosted the Louisiana Summit, Louisiana's Opioid Crisis: Its Realities and Solutions. The purpose of the conference was to inform Louisiana citizens about prescription drug and opioid misuse and abuse and how this public health concern affects millions of people across America and thousands of Louisianans every day. It offered an opportunity for behavioral health professionals, healthcare workers, law enforcement, federal, state, and local officials, clergy, and advocates to come together and collaborate on how to meet this complex societal issue with action. This summit was well attended and brought much awareness and information to the attendees. In continuing the agency's efforts in providing ongoing education about Louisiana's opioid crisis, NEDHSA's Prevention services for FY19 focused on educating community leaders, school-aged children, and the general community.

Prevention Program and Services

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 services include: Information dissemination, formation and implementation of community coalitions, community education, alternative activities for youth, school-based interventions, tobacco retailer (SYNAR) compliance checks, and an EAP program (Employee Assistance Program). Below is a brief summary of prevention activities for the current fiscal year:

Generation XR

The Generation XR education program increases public awareness of prescription drug abuse and provides prevention services and information to healthcare and community leaders, parents and their children, and others in order to prevent abuse of prescribed medication. During FY19, the program was presented to over 1,000 9^{th} to 12^{th} grade students.

LaSOR NARCAN Training and Kit Distribution

NEDHSA hosted 21 NARCAN Training and Kit Distribution events during FY19. The events were held across five different parishes in the service area, and 424 kits were distributed during these events. 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.

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. NEDHSA completed 428 SYNAR checks in FY19 with a 94% compliance rate.

School-Based Opioid Education
During FY19, NEDHSA provided opioid education to over 1,500 students in 3rd to 11th grade.

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.

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 to fill healthcare gaps.

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

YES (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.

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 FY2015-2020 Strategic Plan. Continued progress is being tracked, documented, and reported. Performance improvement processes were implemented in FY19 to address the number of referrals to NEDHSA partner agencies, and referrals for this fiscal year have now surpassed last year's referrals. Increases in the number of persons receiving individual and family support services are also noted for FY19, as well as an increase in number of persons receiving Flexible Family Fund services and number of persons receiving developmental disabilities services. 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.

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 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.

     NONE

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

     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?

  As the completion of the 5-year strategic plan for FY2015-2020 approached and the end-of- fiscal-year reports were being completed, NEDHSA revisited its strategic plan to make sure it properly reflects the goals and the objectives of the agency and also captures areas for improvement for the upcoming years. 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. While current objectives will be maintained, new strategies will 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.

A. Problem/Issue Description

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

DD service programs through NEDHSA for people with DD (ex. Louisiana Rehabilitation Services funding closed new applications for employees seeking job placement assistance).

Additionally, there is a need for additional staff to reach more people, address barriers, provide technical assistance and advocate.

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

   NO

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

   The developmental disability department is experiencing these issues.

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

Internal staff are often overwhelmed with the needs of customers and expectations of contractual outcomes vs. staff capacity. Our customers are affected by not receiving attention to some of their needs. This includes person-specific needs and global needs of the group.

5. How long has the problem or issue existed?

   This issue has been ongoing for 2-3 years.

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

   Every year there are new customers and new additional duties, requirements for contracted services that NEDHSA is to perform; however, the number of staff to address the increase in customers and new requirements do not increase.

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

   The impact is a reduced number of persons served; however, consumers are still being served. We strive to serve as many as possible and would like to provide to all that could benefit**.** Another impact is that staff become burned out and struggle to keep up with the expectations. Some customers may not receive or have access to services. The overall health of both staff and customers is at risk. Failure to meet contract requirements means lost revenue, increased turnover, and increased absence from work. This only compounds the problem in meeting the needs of our customers and our agency's ability to advocate on behalf of them.

B. Corrective Actions

- 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.

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

   N/A

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

   N/A

3. 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?

4. 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

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 2018-2019

Department: **Louisiana Department of Health (LDH)**
09-320 Office of Aging and Adult Services

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

Undersecretary: **Cindy Rives**

Assistant Secretary: **Tara A. LeBlanc**

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

For each accomplishment, please discuss and explain 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: Statewide Incident Management System (SIMS):

A. What was achieved?
In 2019, Office of Aging and Adult Services (OAAS) completed the implementation of the Statewide Incident Management System (SIMS), which is a web-based critical incident reporting application.

B. Why is this success significant?
The new reporting application will boost user efficiency and improve information and data collection and reporting for state agencies, health care providers, Home and Community

Based (HCBS) support coordination agencies and the Adult Protective Services (APS) program. The system also interfaces with language reporting requirements of the Administration on Community Living's National Adult Maltreatment Reporting System (NAMRS).

C. Who benefits and how?

SIMS provides state agencies, health care providers, HCBS support coordination agencies and APS an online method for submitting state and federally required reports of alleged neglect, abuse, injuries of unknown origin, misappropriation of client property and critical incidents. This system will be used by approximately 3,300 individuals statewide once everyone is trained and credentialed on the system.

D. How was the accomplishment achieved?

OAAS completed extensive testing of system function and provided hands on training to a "super user" in each of OAAS's nine regions. Training videos were recorded and a comprehensive user manual provided to all registered users. OAAS followed a regional roll out schedule starting in May and ending in July. Over 1,500 users (providers and internal LDH users) have been credentialed and have logged into SIMS.

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

Yes, it contributes to improving quality and outcomes for populations receiving and at risk of needing long-term supports and services and helps to ensure vulnerable adults are protected from abuse and neglect while living in community settings.

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

We believe that LDH is at the forefront of innovatively using software technology to report, manage and track critical incidents with a system design that allows collaboration across LDH program offices, as well as, users outside of LDH; OAAS Waivers, OCDD Waivers, ICF/DD Group Homes, Nursing Facilities, Health Standards, OBH Inpatient Settings, Adult Protective Services and Local Sheriff Departments statewide. Implementation of this statewide system is a management best practice.

<u>Accomplishment #2: Permanent Supportive Housing (PSH) Expansion:</u>

A. What was achieved?

Louisiana PSH implemented two new rental subsidy programs that significantly increase the options for housing in the PSH program. In addition, the program worked with the Louisiana Housing Corporation (LHC) and created new requirements in the Low Income Housing Tax Credit (LIHTC) program to increase the number of PSH "set-aside" units in multi-family housing created through LIHTC. PSH has made several successful programmatic changes to increase access to housing for people transitioning from institutions, and the program continues to be recognized as a national model by federal agencies and leading health policy organizations.

The new rental subsidy programs implemented within PSH provide the program's first opportunity to use tenant-based (as opposed to project-based) rental subsidies statewide. Tenant-based subsidies are particularly flexible and useful for persons transitioning from institutions to PSH.

B. Why is this success significant?
All of these efforts constitute an expansion of PSH and have increased the program's capacity to serve people transitioning from high-cost institutional care. This is important to 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) to create 1,000 additional housing units and/or subsidies to transition and divert persons with Serious Mental Illness from nursing homes by 2023.

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?
One of the new rental assistance programs was the result of a successful application to the U.S. Department of Housing and Urban Development (HUD) for Non-Elderly Disabled Mainstream Housing Choice vouchers. HUD awarded the state 50 vouchers and is expected to award further subsidies in FY 20 and FY 21. The other rental assistance program is a state-funded program created to comply with the state's agreement with DOJ. Program staff at OAAS and LHC worked with court-approved technical assistance providers to create program guidelines and procedures consistent with HUD subsidy guidelines and other rental assistance used in the PSH program. The existing infrastructure of the PSH program facilitated the timely deployment of these additional resources.

The new requirements in the LIHTC program were created with the assistance of the LHC and were approved by the LHC Board. The PSH program's history of successful performance was key to that approval. Property developers, landlords and (therefore) board members know that the program is successful in keeping units occupied and promptly addressing any tenant issues that arise.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, it contributes to program goals to "Achieve and maintain a legally compliant and appropriately balanced LTSS system, which assures choice within a sustainable, cost-effective continuum of community-based and facility-based services" and "Improve access, quality, and outcomes for populations receiving and at risk of needing long-term supports and services." The OAAS strategic plan calls for continued statewide expansion of PSH, and these accomplishments have measurably expanded PSH.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
The interagency collaboration between OAAS/LDH and the LHC and Louisiana Housing Authority is valuable; but Louisiana PSH is more a national model than a model applicable to other Louisiana state agencies.

Accomplishment #3: Waitlist Reduction Plan Implementation:

A. What was achieved?
The LDH Office of Aging and Adult Services (OAAS) has undertaken an effort to reduce the number of applicants waiting for a service on the Community Choices Waiver (CCW) Request for Services registry. The CCW Project began with 26,622 individuals on the registry. LDH has already been successful in eliminating the wait for services for people with developmental disabilities and wants to extend this success to older adults and those with adult-onset disabilities and their families. As of November, 2019 there are 12,201 individuals on the registry, which is a 46% reduction. Currently there are 7,401 individuals waiting for a HCBS service of the 12, 201 individuals on the registry.

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?
Individuals requesting support from the CCW. The CCW 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.

D. How was the accomplishment achieved?
OAAS began assessing, the individuals whose Medicaid type case indicates possible financial and/or functional eligibility for another home and community-based program, Long Term Personal Care Services (LTPCS). LTPCS does not provide the full array of services available through the CCW, but it does provide the primary service needed by most individuals, namely a personal care attendant in the home who can assist with daily tasks. It also offers the opportunity for people who need a higher level of service to immediately transition to CCW in order to avoid outcomes such as nursing facility placement.

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 allows 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. Historically, about 35% of people on the registry for CCW are already receiving another form of home and community based care.

In SFY20, OAAS will begin offering 500 additional CCW slots to applicants who are not receiving another form of home and community based assistance.

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

Yes, it contributes to achieving an appropriately balanced LTSS system, which assures choice within a sustainable, cost-effective continuum of community-based services and improves access, quality and outcomes for populations receiving and 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?

OAAS's strategy to reduce the waitlist is a best management practice for budget rebalancing in a manner that utilizes OAAS's full array of home and community based services to serve as many individuals as possible within the approved budget.

Accomplishment #4: Rate Restoration:

A. What was achieved?

Medicaid rates were restored to SFY 2008 levels for in-home personal care attendant services delivered under the Community Choices Waiver (CCW) and the Long-Term Personal Care Services (LTPCS) programs. Rates for Adult Day Health Care (ADHC) providers were rebased (i.e., recalculated based on the most current audited cost-reports submitted by providers). Efficiencies realized in FY19 were used to implement the higher "restored" rates retroactive to January, 2019.

B. Why is this success significant?

Beginning in 2008, rates for personal care attendant (PCA) services in these programs have been cut several times. ADHC providers have not been rebased since 2011. The fact that rates have not kept up with rising costs and inflation has made it difficult for both types of providers to attract and retain good quality staff, and many PCA agencies and ADHC centers have gone out of business altogether. Low rates also make it difficult for the state and providers to maintain and improve quality. CMS requires states to assure access to services statewide, and is increasingly attentive to how rates are developed and whether they are adequate to assure access. Low rates make it difficult for the state to meet these federal assurances, particularly in the ADHC waiver where several regions of the state are without a provider.

C. Who benefits and how?

These services provide an alternative to nursing home placement for individuals and families. The primary beneficiaries are service recipients who are able to retain good, in-home personal care workers and service availability. The economic survival of agencies is another benefit, as well as the benefit to workers who may be offered higher wages and/or improved benefits. There are also benefits to taxpayers and the general economy in that

these services provide a low-cost alternative to expensive nursing home placement, and these agencies are a significant employer of lower wage workers.

D. How was the accomplishment achieved?
The rate restorations and rebasing were sought by LDH administration and approved by the legislature. Consumer and provider groups were active in advocating for these increases. The ability to retroactively implement the increases in FY 19 was due to continued prudent management of the Medicaid LTSS programs operated by OAAS.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. This accomplishment contributes to OAAS's ability to offer an array of good quality 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?
Although the rate restoration is not a Best Management Practice, home and community based providers should be compensated at a level that is adequate to provide quality services.

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

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.**
  The accomplishments above contribute significantly to the OAAS strategic progress. They correspond to OAAS strategies 1.3, 2.1, 2.3, 3.1, 5.1, 5.3, 5.4, 5.5, and 5.6 as outlined in the OAAS Strategic Plan and have helped the agency make progress on Program Goals including:
    - 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.
    - Improve access, quality and outcomes for populations receiving and at risk of needing long-term supports and services.
    - Ensure vulnerable adults are protected from abuse and neglect while living in community settings.
    - Administer and operate OAAS programs in a cost-effective manner while achieving high quality outcomes.
- **Where are you making significant progress?**
  Rate Restorations, Waitlist Reduction, and Permanent Support Housing (PSH) Expansion are helping OAAS make progress on maintaining an appropriately balanced LTSS system and will help the office improve on LAPAS measures related to the

percentage of LTSS recipients who are served in the community. The implementation of the new Statewide Incident Management System is a significant contribution to improving the quality of all LTSS, both institutional and community-based.

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?)**
     Technology has played a significant role in improving critical incident reporting. The other accomplishments were achieved through both allocations of new resources and strategic use of existing resources.
   - **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.**
   - Most efforts were joint with other agencies, but the accomplishments highlighted were led by OAAS. Waitlist Reduction was undertaken entirely by OAAS.
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?**
  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.

1. To what do you attribute this lack of progress? **See answers to questions below, in paragraph above.**
   - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
   - Is the lack of progress due to budget or other constraint?
   - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
   - Other? Please specify.
2. **Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?**
   The lack of progress in rebalancing more towards community-based care and away from use of nursing homes is due primarily to budgetary constraints 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 revisions to its strategic plan in FY 19, and the plan is good through 2025. It was not necessary to make substantial revisions this fiscal year.

  - **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, 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?

("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?**
   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.)** Not applicable.
3. **What organizational unit in the department is experiencing the problem or issue?** Not applicable.
4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)** Not applicable.
5. **How long has the problem or issue existed?** Not applicable
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?** Not applicable

B. Corrective Actions

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

☒ No. If not, skip questions 1-4 below.
☐ Yes. If so, complete questions 1-4 below.

1. What corrective actions do you recommend to alleviate or resolve the problem or issue?
2. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
3. Are corrective actions underway?
    a. If so:
        - What is the expected time frame for corrective actions to be implemented and improvements to occur?
        - How much progress has been made and how much additional progress is needed?
    b. If not:
        - Why has no action been taken regarding this recommendation?
        - What are the obstacles preventing or delaying corrective actions?
        - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?
4. 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 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 2018-2019

Department:	**Louisiana Department of Health (LDH)** 09-324 Louisiana Emergency Response Network
Department Head:	**Rebekah E. Gee, MD, MPH** LDH Secretary
Undersecretary:	**Cindy Rives**
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?

<u>Accomplishment #1: Lafayette General Hospital verified as Level II Trauma Center:</u>

A. Lafayette General Medical Center was verified as a Level II Trauma Center by the American College of Surgeons and then designated as such by the Louisiana Health Standards Department.
B. Why is this success significant?
Provides "Golden Hour" access to a Level II trauma center to 407,320 Louisiana citizens that previously did not have access to a trauma center within a 60-minute drive time – the Golden Hour.
C. Who benefits and how?

Citizens or visitors injured within the geographical benefit. Care at a trauma center lowers by 25 percent the risk of death for injured patients compared to treatment received at non-trauma centers, according to the results of a nationwide study conducted by researchers at the Johns Hopkins Bloomberg School of Public Health and the University Of Washington School Of Medicine.

D. How was the accomplishment achieved?
In 2011, the LERN Board set a goal to establish an ACS verified trauma center in every region of the state. At the time, we only had two trauma centers – one in Shreveport and one in New Orleans. Now we have seven ACS verified trauma centers. We achieved this by hiring a trauma medical director to consult directly with hospitals in building their centers. We also established the "trauma program" process, which allows hospitals seeking trauma center verification to receive trauma patients once they have met certain benchmarks. The hospital CEO signs an attestation and the requirements are verified by the LERN trauma medical director on an ongoing basis. The trauma program process is a stepping-stone to verification. LERN facilitated Lafayette General in achieving verification every step of the way – from consideration of embarking in the process, to Trauma Program Development, to finally achieving verification.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes – Strategy 1.1 in our 5-year plan is to 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 2025.
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.

<u>Accomplishment #2: Ochsner LSU Health Shreveport first Level II Pediatric Trauma Program:</u>

A. What was achieved?
Ochsner LSU Health Shreveport committed to the development of a Level II Pediatric Center. They achieved the first step by attesting to meeting the LERN defined requirements and the LERN Executive Committee approved their Program effective July 1, 2019.
B. Why is this success significant?
There are zero pediatric trauma centers in Louisiana.
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. Pediatric

trauma centers, however, 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 other hospitals specializing in pediatric medicine. We made the case for the need and community benefit. There are several hospitals committed to this endeavor, but Ochsner LSU Health Shreveport is the first LERN validated Pediatric Trauma Program.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes – it contributes to strategy 1.1 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 2025.

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.

<u>Accomplishment #3: Formalized Burn System in Louisiana</u>

A. What was achieved?
Collaborated with the burn medical directors from the four burn hospitals to formalize the burn system in Louisiana. The group developed a burn destination protocol. The protocol was adopted by the LERN Board and promulgated in rule. The group also developed:
    - Pre-hospital Burn Care Guideline
    - ED Burn Care Guideline

B. Why is this success significant?
There was no destination protocols for EMS for burn patients. The American Burn Association (ABA) updated their resuscitation guidelines, but the updates were not communicated to hospitals and EMS. This was resulting in fluid over-load in patients. We also needed to formalize pediatric burn care to prevent out of state transfers when possible.

C. Who benefits and how?
    - Burn patients in Louisiana
    - EMS benefits from the established protocols and education provided by LERN
    - Hospitals benefit from education related to ED Burn Care Guidelines.

D. How was the accomplishment achieved?
We followed the same process as when we developed the trauma, stroke, and STEMI systems. We engaged our stakeholders and listened to their input throughout the process. We collaborated with the four Burn Medical Directors from the Baton Rouge General Burn Center, Ochsner LSU Health Shreveport, Our Lady of Lourdes and University Medical Center New Orleans to develop a Destination Protocol for Burn and a Pre-Hospital Burn Guideline. These documents were vetted through the LERN

Regional Commissions. We presented all questions from the regional commissions to our burn experts. We published a Q & A document based on the burn medical director's answers. The board approved pre-hospital burn protocol and pre-hospital guideline on January 17, 2019. The LERN Tri-Regional Coordinators provided education related to the destination protocol and guidelines as requested.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes – it contributes to Goal III: Ensure that all citizens gain access to the statewide networks for trauma and time sensitive related illnesses. By definition, burn is a subset of trauma and depending on the degree/severity is time sensitive.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes – anytime you seek to develop or change a system, it is imperative to include the effected stakeholders.

<u>Accomplishment #4: Reduced Median Door to Needle Time in Level III Acute Stroke Ready Hospitals to 60 minutes:</u>

A. What was achieved?
Reduced median Door to Needle time from 90 minutes in 2014 to 60 minutes, which is the national benchmark. Door to needle is the time a stroke patient presents to the ED to the time the tPA clot-busting drug is administered.

B. Why is this success significant?
Every minute a patient experiences a stroke 2 million brain cells die. Every minute matters because time is brain. The faster you open the artery or dissolve the clot, the more brain function is saved.

C. Who benefits and how?
All stroke patients in Louisiana. See above. Time is brain.

D. How was the accomplishment achieved?
This was achieved for many reasons, but first due to the LERN Board's vision and understanding that we needed to build a state stroke system that had accountability for performance. The LERN Board mandated that all Level 3 stroke centers submit data to LERN and the Board approved a process to hold hospitals accountable. This achievement would not have been possible without Dr. Martin-Schild's, the LERN Stroke Medical Director, working closely with hospitals across the state to help them improve their processes. We started collecting data in 2014. Our Stroke Medical Director reviews the data and provides each hospital with a report card that indicates if they are meeting metrics, how the compare to the aggregate and feedback on how to improve deficiencies. Our hospital partners value this feedback and the number of participants increased over time. We used the aggregate data to help communicate to the LERN Board the need for more accountability for these L3 stoke centers. Especially since we route patients to them based on the attestation, and clearly some of the data contradicted what they attested to being able to perform. Our initial recommendation to the LERN Board was two-fold: 1. to require hospitals not meeting benchmarks to submit Action Plans on how to improve performance. 2. To require centers with less than six patients/quarter who present with a LSN <2 hours to conduct

monthly mock stroke codes. This is to ensure their processes are hard-wired as that is hard to do in low volume centers. The LERN Board approved those recommendations, and took it a step further requiring all L3 centers to submit data to LERN or be demoted to a level 4 Stroke Bypass Hospital. The board commissioned a stroke sub-committee to provide recommendations for when demotion would apply and when a center could re-attest after demotion. The sub-committees recommendations were approved at the April 2018 board meeting. This was accomplished by strong leadership from our state stroke medical director, engagement and collegial relationships with our stoke centers, and by strong Board leadership.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
   Yes – contributes to the following strategies:
   - 2.1, work with the Level III Acute Stroke Ready Hospitals to achieve 100% participation with required data collection.
   - 2.2, provide support and remediation to help prevent demotion of Level III Acute Stroke Ready Hospitals to a Stroke Bypass Hospital.
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: Participated in Mass Casualty Drills (MCI) in all nine LDH Regions:</u>

A. What was achieved?
   The LERN Call Center participated in MCI in all nine LDH regions.
B. Why is this success significant?
   LERN plays a significant role during MCI events. In order for the LERN Call Center (LCC) to perform at the level expected, we have to practice with our regional partners. Luckily, real MCI events do not occur often. For this reason, it is imperative that we drill to ensure optimal performance during a real event.
C. Who benefits and how?
   All Louisiana citizens. Simulating a real event is necessary to polish disaster plans. If an organization fails to plan, then it is planning to fail. Drilling with the LCC fosters smooth communication and accurate delivery of patients to hospitals during a real event.
D. How was the accomplishment achieved?
   We added "conducting regional drills in every region" as a goal in our strategic plan and to our annual performance metrics. We work through the nine LERN Regional Commissions to communicate our desire to participate in regional drills. We report this process measure at every regional commission.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
   Yes – Objective IV.1: Adoption of LERN MCI procedures by each LDH region indicated by inclusion in their regional disaster plans.
   - 4.1, Strategy → Utilize the regional commission structure and regional partners to ensure involvement in one MCI/Disaster drill annually in each region of 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?

- Yes

Accomplishment #6: Continued Stop the Bleed Education in all 9 Regions:

A. What was achieved?
   Continued to teach the ACS course "Stop the Bleed" in all nine LDH Regions.
B. Why is this success significant?
   This an educational program which teaches a layperson to become competent in stopping bleeding. not just from an explosion or gunshot, but from any cause, because it is far more common for someone to be cut with a chainsaw, cut with a kitchen knife, fall on a stake, have a very bad motorcycle accident, etc. This is significant due to the increase in active shooters across the country.
C. Who benefits and how?
   All citizens who take the course. They benefit by having the knowledge of how to stop life-threatening bleeding until EMS or medical help arrives. Through grant funding, we have placed Stop the Bleed Wall Mount kits in 30 schools.
D. How was the accomplishment achieved?
   Grass roots efforts through the LERN 9 Regional Commissions. We have received a $26,000 in grant funding from the Living Well Foundation. We also received three training kits for each of the nine LDH Regions funded by the Hospital Preparedness Grant. The regional commission members and the three LERN Tri-Regional Coordinators presented the program to Rotary, Chambers of Commerce, local schools, churches, etc. Through this network, we continue to teach the program.
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
   Yes – contributes to strategy 1.7, teach Stop the Bleed courses in every region.
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
   Yes- using local champions helps to promote engagement and establish relationships. The hardest part was getting in the door. Now we have classes scheduled weekly. CY 2018 through July 2019 we have conducted 121 classes and 3,651 students completed the course.

Accomplishment #7: LERN funding bill presented in 2019 Regular Legislative Session:

A. What was achieved?
   We worked with the Commissioner of the Office of Motor Vehicles and the Secretary of the Department of Health to propose a bill to provide dedicated funding for LERN.
B. Why is this success significant?
   This is the first time LERN was given the green light to pursue external funding. We had support from LDH and the Commissioner of OMV. While the bill did not pass, we were able to establish relationships for future opportunities.
C. Who benefits and how?
   The bill did not pass, but through the process, we were able to obtain approval and funding for a Data Analyst to facilitate utilization and validation of data in the state trauma registry, state ems registry, level III stroke data set, and the call center database.

This new position will use our data to help better inform board decisions related to trauma, stroke, STEMI and injury prevention.

D. How was the accomplishment achieved?

The bill did not pass. Getting to the point where we present the bill was accomplished by working collaboratively with our state partners and building a case for funding needs.

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

Yes – Objective II.1: Identify and pursue potential dedicated funding options external to the State General Fund.

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?

  Yes, we are progressing towards meeting the goals and objectives set forth by our strategic priorities. Returns on investment are being met, but without a comprehensive trauma, stroke and STEMI 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.

  - Six Louisiana Trauma Centers are participating in the Trauma Quality Improvement Program (TQIP). We are in the early stages, but 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 now have 10 hospitals submitting data to the state trauma registry. This is up from seven in CY 16.
  - We now have seven designated trauma centers in the state.
    - University 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 3 Trauma Center

- By the end of the year, it is highly likely that we will have two more level 3 trauma centers.
- We were approved an additional FTE with funding to hire a data manager. This additional staff will help us better use the data we do have in order to inform decision making and improve systems.

All of these efforts are improving morbidity and mortality, but we need a comprehensive registry 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 is 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, for the past 3 years, have a 3% secondary transfer rate. In CY 2018, patients not directed by the LCC had a 24% secondary transfer rate. 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 a second grant from the Living Well Foundation for $12,000 to continue implementation Stop the Bleed Education in region 8.
- 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 received approximately $130,000 from the Hospital Preparedness Grant to replace the LERN Call Center phone system, which was at end of life.
- We continue to look for grant funds.
- 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 7 in 2019 provides 77.4% 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 high to level trauma care. Three hospitals have attested to meeting trauma program status:
    - Lake Charles Memorial Hospital (Level III Trauma Program – Scheduled for ACS-Committee On Trauma (ACS-COT) survey on November 4th and 5th, 2019)
    - St. Tammany Parish Hospital – Had ACS-COT survey July 7 and 9th.

Await final report. All signs during the exit interview indicate they will pass and be verified, moving from Level III Trauma Program status to Trauma Center status.
    - Ochsner LSU Health Shreveport attested to meeting Level II Pediatric Program requirements. Anticipate ACS-COT survey in July 2020.
- When considering the seven Verified Trauma Centers and the three trauma programs, 82.7% 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.
- 100% of the population has access to the LERN Call Center for assistance with direction to the most appropriate resourced hospital for trauma, 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 recently 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 level 4 stroke center 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.
- LERN established criteria for STEMI Receiving centers which require 24/7/365 access to a cardiac catheterization lab. There are 36 STEMI Receiving Centers in the state. These 37 hospitals provide 96.6% of the population with access to a STEMI Receiving Center within a 60-minute drive time.
- LERN also formalized the burn system in Louisiana, helping to provide timely burn care statewide.
- In addition, LERN continued education efforts across the state. For CY 2018, those courses included:
    - Trauma Nurse Core Curriculum (TNCC) = 37 classes, 375 students
    - Emergency Nurse Pediatric Course (ENPC) = 10 classes, 78 students
    - 12 Lead EKG Course = 15 classes, 403 students
    - Rural Trauma Team Development Course = 1 class, 28 students
    - Hemorrhage Control Training = 9 classes, 125 law enforcement agents and we provided 40 tourniquets
    - Stop the Bleed Course = 81 classes, 2313 students
    - AIS Course – 1 class, 21 students
- EMS Registry continues to be developed. We now have 40 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 3.1 requirements.

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 has been included in disaster drills throughout the state
- Will continue to offer the safety class for the Governor's detail focused on: stopping bleeding, choking, CPR and LERN logistics. The first classes were conducted in August 2018.
- Conducted tabletop exercise with the EMS Surge Ambulance contractor to test our processes and procedures.
- Conducted tabletop exercise with Burn leaders to test burn surge capacity in 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:

1. To what do you attribute this success? For example:
   - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
     We have been very successful moving systems forward due to leadership from our physician medical directors and due to clear direction provided by the LERN Board. The positive results would not be possible without our physician leaders and our LERN staff implementing the Board's directives. The engagement and participation of our nine LERN Regional Commissions also contribute to our success. Support from LDH is also related to our success.
   - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
     The LERN Board mandated data submission by all Acute Stoke Ready Hospitals (54 hospitals). This change not only helps the Board hold hospitals accountable for the stroke care they attest to being able to provide, but it also helped hospitals identify process problems in their work flow. Our stroke Medical Director also provides feedback reports, on-site and phone consultation to help hospitals build the best stoke programs possible. We have utilized webinars to facilitate statewide stroke education. We promulgated additional rules related to trauma programs that require a review by the LERN Trauma Medical Director for any trauma program who fails an ACS survey and focused review visit. After loss of trauma program status for failing the ACS verification visit and focused review visit, trauma

program status may be regained provided the following conditions are met:

- A LERN designee and either the LERN trauma medical director or a trauma surgeon must review the deficiencies and findings of the ACS at a site visit;
- The hospital must develop a remediation plan and apply to the LERN board for approval of trauma program status;
- The LERN board will review the LERN team assessment of deficiencies and the hospital's remediation plan;
- The LERN board must vote to approve the trauma program status report.

These policy changes are resulting in increased accountability and performance.

We also worked with subject matter experts to formalize the burn system in Louisiana. This is a new initiative for LERN.

- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
  Specific department actions have directly related to the success of LERN. Examples include: Continued support from the Secretary and Under Secretary as it relates to funding (approved new FTE for data manager), Bureau of Health Informatics continues to provide stroke data as available and Vital Records provides mortality data related to trauma, stroke and STEMI. Collaboration with LDH Office of Community Preparedness on disaster response has been very helpful. Louisiana Highway Safety Commission provides GIS mapping support.
- Other? Please specify.

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

   Progress is not the result of a onetime gain. Building and maintaining systems of care takes time and is a long-term commitment. Progress will continue at a steady pace.

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

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

Section III below.
We have made little progress lessening or eliminating LERN's reliance on state general fund dollars. Representative Chaney sponsored a bill in the 2019 Regular Session to provide dedicated funding for LERN via an additional fee on driver's licenses. The bill did not pass. We have received some grant funds, but we have not been successful in identifying larger grants that fit LERN's mission and strategy. LERN has still made significant progress in the last year. We understand the funding alternatives utilized by other state trauma systems and we understand existing state dedications that could serve as practical alternative sources of recurring funding for LERN.

Data collection/registry development for STEMI and Trauma has been difficult, but we are making gains. We now have voluntary participation in the trauma registry from 10 hospitals. Hospitals have a hard time collecting data due to competing priorities. It cost money to hire a data entry person.

LERN STEMI medical director stepped down from his position. Without physician leadership for the STEMI system, I am unsure of next steps. This will be discussed at the August 15, 2019 LERN Board Meeting. There is very little funding available for this medical director position, further complicating system and registry development.

- Other? Please specify.

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

   The reliance on the state general fund will continue until 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. State trauma systems funded via fees or fines use this revenue to fund the state trauma registry.

   The STEMI System is stagnant. I do not see this changing without hiring a medical director with a vision to move the system forward. Funding is a limiting factor.

- **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 5-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 2018, we developed new strategic priorities for 2019-2023.

  ☐ 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 and the LERN Administration & 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.

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?
      Education requests from our stakeholders exceed our ability to meet them.
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
      Yes, it is difficult to provide statewide education without an Education Coordinator and a learning management system (LMS).
   3. What organizational unit in the department is experiencing the problem or issue?
      LERN only has one department – education affects all of our four core components (Trauma, Stroke, STEMI, and Disaster Response)
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.
      Our hospital and EMS providers are affected by the problem. We provide as much education as we can, but with a limited staff we cannot reach everyone.
   5. How long has the problem or issue existed?
      It has just become an issue in the last two years. What are the causes of the problem or issue? How do you know?
      As LERN takes on more responsibility (ex: addition of burn) and our education

resources have not increased – neither staff nor technology.

6. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   The consequences are that we are not meeting the needs of our stakeholders. We will continue to provide the highest level of education we can, but the addition of an education coordinator and an LMS will help us expand our outreach.

B. Corrective Actions

- 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.

1. What corrective actions do you recommend to alleviate or resolve the problem or issue?
   Add one new position, a statewide education coordinator, to the LERN staff. Also, procure a learning management system to provide on-line education and continuing education units. This software will support our current and future educational initiatives by making learning assessable and meaningful, optimizing costs, and providing us with the tools we need to effectively manage our training programs.
2. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   No, we have not made this recommendation before.
3. Are corrective actions underway?
   Yes, corrective action is underway. We are researching LMS vendors to determine which one best fits our needs.
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
        Uncertain at this point. It will depend upon final cost estimates and if we can accommodate within our existing budget.
      - How much progress has been made and how much additional progress is needed?
        We have seen demonstrations from five LMS vendors.
        We will request funding for both the additional TO and the LMS in the FY 21 budget request.
   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?

4. 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.

Additional TO = $138,000 (includes benefits/fringe)
LMS = $12,000

b. How much has been expended so far?
Zero to date.

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?
The additional TO cannot be managed with our existing budget. Part of the LMS system can be managed within our existing budget. It will not affect other departmental 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.
     Yes. See above. We need one additional TO which will cost approximated $138,000. Our only funding source presently available is State General Fund. We tried to pass legislation this past session to generate a dedicated funding source for LERN outside of SGF, but that effort failed.
   - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?
     We will request this funding in the FY21 budget request. We have not requested it in the past.

A. Problem/Issue Description
1. What is the nature of the problem or issue?
   The STEMI Medical Director did not renew his contract.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   Yes. We need a STEMI leader in order to continue to ensure quality access to STEMI Receiving centers statewide. The STEMI Medical Director is instrumental in guiding the quality/performance of the STEMI System.
3. What organizational unit in the department is experiencing the problem or issue?
   LERN only has one department – This affects the LERN STEMI System.
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?

He stepped down in May 2019. Even before that, we have had issues developing quality metrics for STEMI. That has been an issue for 3 years. Without quality metrics or a statewide reporting structure, it is difficult identify system problems or promote system improvements.

6. What are the causes of the problem or issue? How do you know?
   STEMI Medical Director is returning to school for an advanced degree, therefore he needed to step back from his duties at LERN. The lack of a statewide quality report is due to the partnership ending between the registry and the agency developing the report. The two entities reported this to us.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   Without quality metrics or a statewide reporting structure, it is difficult identify system problems or promote system improvements.

B. Corrective Actions

- 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.

5. What corrective actions do you recommend to alleviate or resolve the problem or issue?
   Hire a new STEMI Medical Director.
6. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   No – STEMI Medical Director stepped down in May 2019. The issue regarding the STEMI report was included in past reports. Last year we thought we had a remedy, but that fell through.
7. Are corrective actions underway? No
   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?
        Will be discussed at August LERN Board Meeting.
      - What are the obstacles preventing or delaying corrective actions?
        Funding is an issue. We only have $18,000 for this position.
      - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?
        Unsure

8. 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.

Unsure at this point. If the LERN Board directs me search for a new STEMI Medical Director, I will know if the $18,000 is a barrier to filling the role.

b. How much has been expended so far?
None in FY 2020.

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?
- I have $18,000 allocated to this for this FY. This will not affect other departments.

d. Will additional personnel or funds be required to implement the recommended actions?
As indicated above, I am unsure if funding will be a limiting factor in fulfilling the position.

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 → LERN Case review process.
☐ Other (please specify):

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

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

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

1. Title of Report or Program Evaluation
   LERN Annual Report FY 17-18
2. Date completed
   March 2019
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 trauma registry, stroke registry, and education-tracking log.
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
   tPA administration has increased 5timrs since 2010. In 2010 1 in 25 patients with acute ischemic stroke received recanalization therapy. In 2017, 1 in 5 patients with acute ischemic stroke received recanalization therapy.

7. Major Recommendations – none
8. Action taken in response to the report or evaluation - none
9. Availability (hard copy, electronic file, website) http://lern.la.gov/wp-content/uploads/LERN-Annual-Report-FY-2017-2018_ReducedSize.pdf
   Hard copy available upon request

10. Contact person for more information, including
    Name: Paige Hargrove
    Title: Executive Director
    Agency & Program: Louisiana Emergency Response Network
    Telephone: (225)756-3440
    E-mail: Paige.Hargrove@La.Gov

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

Department: **Acadiana Area Human Services District**
09-325 Acadiana Area Human Services District

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

Undersecretary: **Cindy Rives**

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?

<u>Accomplishment #1: Three-Year CARF Accreditation</u>

A. What was achieved?
National accreditation – a three-year award from CARF International, the highest level of accreditation possible, for the third year in a row.

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

<u>Accomplishment #2: Partnership with Lafayette Consolidated Government (LCG) to provide a Christmas Party for people with developmental disabilities and the community</u>

A. What was achieved?
Partnered with LCG to provide a "Christmas Extravaganza" for the community.

B. Why is this success significant?
It allowed the community and people with developmental disabilities to interact in a community function. Also provided individuals with DD the same opportunities available to all.

C. Who benefits and how?
Individuals with developmental disabilities, their families and the community. It helped build relationships and showed the community the abilities of people with DD.

D. How was the accomplishment achieved?
AAHSD collaborated with LCG. LCG provided the community center and AAHSD staff decorated and created fun and games for the community to enjoy

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: Funding a staff person at "Camp We Can Do":

A. What was achieved?
Assist in funding a staff person at "Camp We Can Do."

B. Why is this success significant?
This assistance allowed individuals with developmental disabilities to attend a summer camp by the Lafayette Parks and Recreation Department. The staff allowed the kids to enjoy therapeutic assistance while attending a summer camp.

C. Who benefits and how?
Children with developmental disabilities were allowed to attend a summer camp with other individuals (with and without disabilities) It allowed them to participate in a program with their peers.

D. How was the accomplishment achieved?
Family Supports funds through the AAHSD-DD section in conjunction with a staff hired and trained by the Lafayette Parks and Recreation Department.

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: 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 a 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 #5: Became first LGE DD section in the state to become CARF Accredited in the Community Services Standards for all DD programs:

A. What was achieved? Three year CARF accreditation for the Developmental Disabilities Section under the Community Services Standards.

B. Why is this success significant?
It validates the services and supports provided are through an individualized, person-centered process and the individuals are given an opportunity to achieve their desired outcomes.

C. Who benefits and how?
Individuals with developmental disabilities and their families. It ensures people are treated with dignity and respect and their choices are achievable.

D. How was the accomplishment achieved?
AAHSD-DD staff reviewed all policies and procedures to ensure CARF standards were taken into account, then carried out with person centered principles to the individuals served.

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: Establishment of direct-care productivity standard:

A. What was achieved?
Improved client accessibility to care.

B. Why is this success significant?
To decrease wait times from client's initial screening to actual intake assessment.

C. Who benefits and how?
Prospective clients benefit by not needing to wait as long to enter services, improving treatment response. Show rates for assessments are projected to improve, facilitating more clients' entry into treatment.

D. How was the accomplishment achieved?
By removing blocked scheduling for new client assessments.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, by improving appropriate clinical response to prospective client needs, as well as the ability to serve more clients.

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

Accomplishment #7: AAHSD staff provide ASIST Training:

A. What was achieved?
Two AAHSD staff members were able to provide three ASIST trainings to address suicide prevention.

B. Why is this success significant?
AAHSD has five parishes out of the 20 Louisiana parishes with the highest suicide rate per capita.

C. Who benefits and how?
Persons in AAHSD catchment area benefit via ASIST training offered to professionals in the community.

D. How was the accomplishment achieved?
Training was provided via contracted consultant and with assistance from OBH.

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

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

Accomplishment #8: AAHSD staff trained to become certified Tobacco Cessation Specialists:

A. What was achieved?
Two staff members were trained to become certified Tobacco Cessation Specialists.

B. Why is this success significant?
These staff members will facilitate evidence-based tobacco cessation training to AAHSD clinicians, who will then implement cessation at all AAHSD clinics.

C. Who benefits and how?
All AAHSD clients who wish to receive Tobacco Cessation assistance.

D. How was the accomplishment achieved?
Training was accomplished via grant from OBH.

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 #9: Successful completion of reviews by State Civil Service and the Office of Risk Management

A. What was achieved?
AAHSD received successfully completion of reviews by State Civil Service and the Office of Risk Management.

B. Why is this success significant?
AAHSD has been able to maintain a level of excellence for not only its employees but also the clients as well.

C. Who benefits and how?
Client's benefit because AAHSD is providing a safe place for them to receive treatment and Staff and clients benefit by AAHSD providing quality staff to provider services.

D. How was the accomplishment achieved?
Meeting quarterly to make sure reviews are being accomplished and maintaining great documentation.

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

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

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

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

AAHSD submitted our initial five-year Strategic Plan in June 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?

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.

<u>No significant management or operational problems exist.</u>

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   3. What organizational unit in the department is experiencing the problem or issue?
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)

5. How long has the problem or issue existed?
6. What are the causes of the problem or issue? How do you know?
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions

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

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

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

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

5. Do corrective actions carry a cost?

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

- Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

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

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

☐ Internal audit

☒ External audits (Example: audits by the Office of the Legislative Auditor)
Office of the Legislative Auditor every two years.

☒ Policy, research, planning, and/or quality assurance functions in-house
QI Team reviews client quarterly.

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

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

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

☒ Performance-based contracting (including contract monitoring)
Contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

☒ Peer review
Medical Doctors and OCDD peer review process

☒ Accreditation review
CARF Accreditation—AAHSD received a 3-year accreditation

☒ Customer/stakeholder feedback AAHSD completes quarterly client satisfaction survey and an annual Stakeholder Survey.

☒ Other (please specify):
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: AAHSD Management Report

2. Date completed:
June 2019

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.
- 2018/2019 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.

This report was made available to the Governing Board, all staff, and copies were available in all service locations for clients/visitors. A copy was sent to senior LDH officials as well as the entire 'Acadiana Delegation'. Additionally, this report is posted on our website for public view.

7. Major Recommendations:
   None

8. Action taken in response to the report or evaluation:
   None

9. Availability (hard copy, electronic file, website):
   Located in the policy and procedure manual and website

10. Contact person for more information:
    Name: Brad Farmer
    Title: CEO
    Agency & Program: AAHSD
    Telephone: 337-262-4190
    E-mail: Brad.Farmer@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

Department:	**Louisiana Department of Health (LDH)** 09-326 Office of Public Health
Department Head:	**Rebekah E. Gee, MD, MPH** LDH Secretary
Undersecretary:	**Cindy Rives**
Assistant Secretary:	**Alexander Billioux, MD, DPhil**

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: Achieved accreditation by the Public Health Accreditation Board (PHAB)

A. What was achieved?

The Office of Public Health achieved national accreditation through the Public Health Accreditation Board (PHAB). PHAB is the nonprofit organization that administers the national accreditation program for tribal, state, local, and territorial health departments.

PHAB is jointly funded by the Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation.

The national accreditation program sets standards that governmental public health departments can continuously work toward to improve the quality of their services and performance in order to improve and protect the health of the public.

To receive accreditation, the Office of Public Health underwent a rigorous, multi-faceted, peer-reviewed assessment to ensure it met or exceeded a specific set of quality standards and measures. Public health department accreditation standards address a range of core public health programs and activities, including environmental public health, health education, health promotion, community health, chronic disease prevention and control, communicable disease, injury prevention, maternal and child health, public health emergency preparedness, access to clinical services, public health laboratory services, management/administration, and governance.

The Department's Office of Public Health is one of fewer than 300 health departments that have achieved accreditation through PHAB since the organization launched in 2011. There are nearly 3,000 governmental public health departments in the U.S.

B. Why is this success significant?

Accreditation demonstrates that the state health department has been rigorously examined and meets or exceeds national standards that promote continuous quality improvement for public health. With accreditation, the programs and services offered by our Office of Public Health have been recognized as performing at the highest national standards.

Accreditation has been shown to provide numerous benefits for accredited health departments. The initial evaluation of the national accreditation program — conducted by NORC at the University of Chicago — found that more than 90 percent of health departments that have been accredited for one year indicated that accreditation has helped them to:

- Better identify strengths and weaknesses,
- Document capacity to deliver the three core functions and the 10 Essential Public Health Services,
- Stimulate greater accountability and transparency,
- Improve management processes used by leadership, and
- Stimulate quality improvement and performance improvement opportunities.

About 80 percent of health departments that have been accredited for one year reported improved accountability to external stakeholders, and almost three-quarters report improved relationships with their governing entities. Additionally, about half reported improved competitiveness for funding. Among health departments surveyed immediately after being accredited, 100 percent indicated that they have implemented, or plan to implement, new strategies for quality improvement as a result of accreditation.

C. Who benefits and how?

The public at large – including residents of and visitors to Louisiana – benefits from OPH's accreditation, as it enhances OPH's ability to protect, promote and improve the public's health. It demonstrates to the Louisiana taxpayers and other funders that it is a good steward of resources. It is also a point of pride for OPH staff, the Department of Health as a whole, the State of Louisiana, and our partner organizations.

D. How was the accomplishment achieved?

Over the past several years, OPH went through a rigorous and systematic process to ensure that it met PHAB's standards and measures and to produce the documentation required for accreditation. OPH's journey to accreditation began in 2011 when it completed a preliminary assessment of organizational readiness for accreditation. In 2014 and 2015, OPH developed the prerequisites for applying for accreditation, including an agency strategic plan, a state health assessment, and a state health improvement plan, and expressed its interest to PHAB in applying for accreditation.

OPH established an accreditation infrastructure consisting of domain captains and committees for each of PHAB's twelve domains. Domain captains were responsible for ensuring OPH met the requirements for producing the documentation required. This ensured that there was agency-wide representation and involvement in preparing for accreditation. OPH designated an accreditation coordinator to lead the agency through this process and created a bureau (the Bureau of Policy, Planning and Performance, formerly named the Bureau of Performance Improvement) whose primary responsibilities included overseeing the accreditation process and some of the critical functions required for accreditation including performance management, quality improvement, strategic planning, state health assessment and improvement planning, and workforce development.

OPH submitted its documentation to PHAB in 2017, received a site visit from PHAB in 2018, and received accreditation in 2019.

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

Yes, and the reverse is also true in that the success of our strategic plan has contributed to our achieving this accomplishment.

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

National accreditation is certainly a best practice. In addition, performance management and continuous quality improvement initiatives promoted by PHAB are best practices.

Accomplishment #2: Expanded the Quality Assurance Program in Sanitarian Services to ensure statewide coverage and increased activities to perform inspection audits to ensure consistency in inspection quality

A. What was achieved?

Sanitarian Services expanded the Quality Assurance (QA) Program to provide statewide coverage for the primary functions of field staff: retail food inspections, onsite wastewater inspections, and building and institutional inspections. Now we have three tenured sanitarians that provide training instruction, shadowing, and auditing of sanitarians who conduct field inspections. The QA program has not interfered with the ability of the department to stay current with inspections as scheduled, but rather has enhanced the ability of sanitarians to systematically complete inspections in an organized and quality manner.

We have grown the program from our initial focus. Initially we focused on standardized training in lab-like kitchens, inspection "boot camps" for new employees, and shadowing, with coaching and instruction for new hires. Training and outreach has been multiplied because of the additional staff resources for the following sanitarian trainings statewide: new-hire sanitarian training schools, airgap/backflow training, "boot camps" on a variety of Sanitarian subjects, six efficiency projects, and four region specific training sessions on how to use the current tracking system to generate reports to monitor directive compliance.

By adding two additional QA Sanitarians, the program has been able to expand the shadowing and auditing function to include, not just newly hired sanitarians, but tenured sanitarians, as well. 64% of our Field Sanitarians have been shadowed (88) within six months to one year of their hire date

In addition, the audits include both field audits and electronic audits. Field audits (51 completed) involve performing an inspection in the same establishment after the sanitarian has performed an inspection and comparing results. The staff and their supervisors are informed of the results and are also engaged in coaching for improved performance.

Internally over 123,000 electronic audits have been performed to compare inspection data to the Regulatory Performance Directives issued for compliance. When performing electronic audits, there appears to be a downward trend in the number of times a sanitarian is cited for not following a directive prior to uploading the inspection. We are working to find ways to monitor this in a more automated fashion.

Electronic anonymous surveys are sent to all shadowed sanitarians at the end of each month. Thus far, all responses have been positive regarding the experience. There have been a few shadows that identified serious gaps in a sanitarian's ability or desire to perform at an acceptable level. When gaps are identified, additional training or training experience (such as working in a more urban area to gain a variety of experience) is provided. Additional shadow days are also offered. When indicated, programmatic memos or clarifications are issued to achieve consistency or staff performance improvement plans are used.

In addition, we have added a food safety fundamentals workshop for food service establishments to educate the industry. QA has conducted 15 Fundamental Food Safety Workshops that are held in the establishments, with classroom and onsite kitchen demonstrations. Workshops have also been held for organizations. Industry education also involved participation and collaboration with the Louisiana Restaurant Association. At the 2019 Restaurant Expo the QA Team organized "Agency Avenue" where the food service business could interact with the various state agencies that regulate food establishments: the Fire Marshall, DEQ, LDWF, LDAF, Chief Building Officials and ATC. This "one stop shop" concept was very well received and led to effective education. At the request of retail establishment regional management, QA held two classroom trainings for over 50 management level employees to cover food safety in meat markets, seafood markets, deli's and grocery for a grocery chain. Over 35 inspections and onsite training sessions were conducted with the stores in the southern region to assist in compliance education.

B. Why is this success significant?

When the Sanitarian Services Department completed a Lean Six Sigma efficiency improvement project, they were confident that the inspection schedules were being conducted at a frequency recommended by the Food & Drug Administration. However, management had concern about whether the focus on productivity would impact the quality of the inspection. In addition, the new predictable scheduling of inspections did not ensure consistency of the inspections across different sanitarians. This quality assurance program has proven that investment and thoughtful change management can provide impactful and effective results, both internally with staff and externally with industry partners. Sanitarians are clear on their role, the regulations, and how they are to be applied in the field. Developing new techniques and venues of education has helped meet the needs of our tech-savvy audiences. Engaging customers directly has shown that meeting customers where they are, and providing what they need, is more effective than just publishing the rules.

C. Who benefits and how?

The public at large benefits from food safety. The sanitarian work force benefits by understanding their role and the regulations clearly, which leads to a happier and more effective work force. Sanitarian supervisors and management have clear accountabilities for their employees, which has allowed gaps to be addressed and consistent proactive management of staff performance.

D. How was the accomplishment achieved?

Creating a structured QA program was accomplished by hiring three experienced sanitarians in dedicated position roles for exclusive focus on consistent quality. The phased roll out to manage the change was intentional and gradual. Feedback has been a part of every activity, allowing staff to anonymously provide suggestions for improvement. The management structure with Sanitarian Services completely endorses the program and uses the information learned during shadows and audits to know how to improve their staff's performance. Having one of the QA staff members certified as a Green Belt in the Lean Six Sigma improvement methodology has allowed efficiencies to be identified and implemented in the course of the program build.

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

In addition to contributing to the financial stability of the organization by increasing efficiencies and reducing waste of state resources, the ability to provide quality inspections allows Sanitarian Services to more effectively enforce Title 51 of the State Sanitary Code. In addition, this approach weaves into the quality program a function of educating the public, which provides a preventative approach to increase food safety.

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 establishment of a routine quality assurance structure, which provides management feedback, coaching and training is a best practice. The accountability is one that is approachable, expandable, and actually increases the morale of the staff. While it may seem counterintuitive, the staff have been appreciative of the attention and investment in honing their inspection skills. It is also a form of succession planning by leveraging some of our most experienced sanitarians in an intentional program for knowledge transfer. The shadowing, while time consuming, has proven to be a very effective use of time when compared to time spent correcting errors or explaining inconsistent results between regions or sanitarians.

The use of Lean Six Sigma as an improvement methodology is a best practice that provides quality and efficient processes. The data-driven approach, with attention to customer focused service requirements, provides an objective method to solve challenges. Using a method to address opportunities for improvement in a standardized, pragmatic manner, as well as leveraging staff expertise, to maximize efficiencies and provide operational direction in the management of processes is a best practice. Having embedded certified LSS staff provides the skillset to identify and execute efficiencies within other initiatives.

<u>Accomplishment #3: Efficiencies and Accreditation achieved in the Office of Public Health (OPH) Laboratory</u>

A. What was achieved?

The OPH Laboratory successfully achieved accreditation from several national organizations in 2018: Environmental Protection Agency, The NELAC Institute through the National Environmental Laboratory Accreditation Program, the United States Food and Drug Administration and the Centers for Medicare and Medicaid Services (CMS) for compliance with the Clinical Laboratory Improvement Act (CLIA).

In the course of the accreditation process, the OPH Laboratory identified an opportunity to improve the integrity of clinical specimens submitted for ensured quality of analysis. The OPH Laboratory used the Lean Six Sigma methodology to reduce rejection rates of specimens that are delivered to the OPH Lab for analysis.

Best practices and accreditation standards require that lab testing protocols have very specific time and temperature requirements for the transport of the lab specimens. Specimens that do not meet those narrow requirements must be rejected. Rejection leads to a patient having to have a sample collection repeated, which can either delay or hinder treatment. In addition, rejecting specimens requires time consuming efforts for both the lab and the provider's staff.

The project reduced the rejection rate of specimens by 12% to 2.8% for specimens submitted to the OPH Lab, within the target of <5%.

The data driven improvements implemented included over 100 customer communications. Improvements were implemented which reduce rejected specimens:

- The courier process was changed from a hub-handoff system (with long travel times for specimens) to more direct routes which provide same day delivery.
- The OPH Lab validated wider ranges of temperature acceptance for several tests.
- The OPH Lab standardized and updated 37 lab standard operating procedures (SOP) to ensure they align with all test requirements as provided by the manufacturer.
- The OPH Lab Quality Assurance Unit incorporated specimen integrity into the internal technical audit process.
- The OPH Lab worked with the Parish Health Units to replace 62 pieces of field equipment used for specimen storage.
- The OPH Lab retrained the staff who prepare the samples for transport.
- The OPH Lab eliminated use of coolers that were not effective in temperature management and thereby eliminated a huge "factory" of work that was required to wash, relabel and return coolers daily.

The Lab continues to audit sample transport temperatures and employ additional improvements to further reduce the rejection rate.

One of the challenges in the specimen integrity project was the inability to monitor rejection rates on a daily basis. The lack of accessible data was due to an outdated Laboratory Information Management System (LIMS). During fiscal year 2019, the OPH Lab completed the upgrade to the LIMS system that tracks the receipt, analysis and reporting of lab samples.

B. Why is this success significant?

Accreditation with these organizations require quality standards of operations and analysis for both clinical and environmental sample testing. Improved specimen integrity reduces rejected specimens while employing checks to ensure that quality results will be obtained by accepted samples. The updated technology enables more efficient workflows, electronic reporting and allows for the capture of data in management reports for data driven operational improvements and monitoring for sustainment of improvements.

C. Who benefits and how?

Quality testing practices, as ensured by accreditation and specimen integrity, benefits all customers of the OPH Lab. By reducing rejected specimens (due to unacceptable temperatures during transport), we effectively reduce patient inconvenience, reduce a delay of providers receiving clinical information, and reduce any delay in patient treatment. The process to reject specimens is a time consuming process for both lab staff, as well as the clinical provider's staff. In addition, wasted supplies and transport costs are eliminated by reducing rejected specimens.

An upgraded LIMS system provides automated process of requesting lab testing for customers; provides automated workflows for analysis and reporting for OPH Lab staff; and provides for real-time resulting through electronic reporting.

D. How was the accomplishment achieved?

Accreditation preparation and the technology upgrade were accomplished by OPH laboratory project teams. Customer requirements for the upgrade were gathered prior to configuration to ensure the LIMS system would meet their operational needs. A collaborative workgroup of laboratory, program, and clinical field staff met to identify "critical to quality" needs. Test configurations, testing, and training were executed by the various laboratory subject matter experts within the OPH Laboratory, with vendor technical assistance.

The Lean Six Sigma initiative to increase specimen integrity was also accomplished by an internal laboratory project team, led by an internal Master Black Belt project lead. The six month project achieved acceptable rejection rates; however, additional efforts continued to target even further improvements, such as a change to a same day courier; enhanced temperature monitoring during transport; and the LIMS upgrade which provides tracking and monitoring in a more automated manner.

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

In addition to contributing the financial stability of the organization by increasing efficiencies and by ensuring that we are good stewards of state resources, the ability to provide clinical testing ensures that other health outcome based initiatives are supported in a quality manner. The OPH Lab provides testing for health outcome initiatives for the reduction of HIV, elimination of Hepatitis C, and the reduction of Congenital Syphilis. In addition, environmental testing, which include samples also transported by the courier with specific integrity specifications, supports the Safe Drinking Water Program, which is a priority of the department as well.

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

The use of Lean Six Sigma as an improvement methodology is a best practice that provides quality and efficient processes. The data driven approach, with attention to customer focused service requirements, provides an objective method to solve challenges. Accreditation through nationally

recognized organizations ensures a standard level of quality. Using a method to address opportunities for improvement in a standardized, pragmatic manner, as well as leveraging technology to maximize efficiencies and provide operational data for management of processes is a best practice. Engaging customers and understanding their "critical to quality" requirements is also a best practice to be shared.

Accomplishment #4: Expanded the newborn screening panel to add testing for Severe Combined Immunodeficiency (SCID) and improved process efficiencies in newborn screening testing

A. What was achieved?

The OPH Laboratory added the screening test for Severe Combined Immunodeficiency (SCID) to the Louisiana newborn screening panel, as recommended by the United States Department of Health and Human Services' Advisory Committee on Heritable Disorders in Newborns and Children as provided in the Recommended Uniform Screening Panel (RUSP).

B. Why is this success significant?

The Centers for Disease Control (CDC) awarded Louisiana a two-year grant to assist with start-up of adding the test, as doing so required new testing supplies, equipment and protocols. Several obstacles, including projected recurring costs, were identified as barriers to adding the test. By 2018, Louisiana was one of only three states who were not screening for SCID.

OPH formed a collaborative workgroup to not only add the test, but to understand all aspects of this added functionality. The workgroup was able to work both internally across agencies and departments, and with the CDC, to add SCID testing to the newborn screening panel and fulfill the grant deliverables. The OPH internal workgroup was able to create efficiencies which ultimately generated efficiency gains that allowed the test to be added.

C. Who benefits and how?

Families with babies who have this genetic disorder benefit from early detection. If not detected early, then SCID babies can die from otherwise simple infections, as their immune system is not able to respond. Early detection can result in a bone marrow transplant and correct the problem. While there is a cost for the screening of all babies, and for the bone marrow transplant when a case is identified, the cost of not detecting the disorder can not only cost a life, but the treatment of the multiple health issues exceeds the cost of testing and treatment for those affected. SCID typically leads to death within the first year without treatment and incidence rates are projected to result in one case per year based on Louisiana's birth rates.

D. How was the accomplishment achieved?

An internal workgroup was formed to include the genetic program, laboratory, budget revenue, and OPH leadership staff to dissect and understand all aspects of the process from birth of the baby to billing of the charge for newborn screening testing. By thoroughly reviewing the process,

efficiencies were identified which resulted in enough cost savings to allow OPH to mitigate the cost of adding the new test. Key in this process was working with the CDC to utilize a more cost effective testing protocol that was being used by other states. The non-commercial test resulted in the cost of the testing being much lower and allowed OPH to perform testing within the additional reimbursement rate for adding SCID. The Lab Developed Test required additional validation and scientific rigor, but the result was an equally effective screening tool for much less cost of supplies.

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

Yes, there are several of the OPH Laboratory's strategic priorities that were achieved in the process of adding SCID to the newborn panel. The process of issuing laboratory reports in a paperless manner was achieved, as electronic reporting was a part of the improvements to reduce costs, both in postage and manpower. Ensuring testing is appropriate for the industry served was an underlying reason for expanding the panel to meet national standards. Lastly, developing the lab developed test supports LDH's priority to be good stewards of state resources.

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

Several aspects of the solutions are best practices. Forming a work group that engaged all aspects of the process was key to understanding the testing from collection to billing. It was only through this in depth review that the efficiencies could be identified and executed, understanding and preventing unintended consequences. The process mapping and costing, using a newly developed cost calculator tool, were critical to projecting costs. While positive screens are resulted and clinicians are notified immediately, electronic reporting allows for negative results to be reported more timely than mailed lab reports, providing the clinician and the provider facility timelier results. Electronic reporting, development of an electronic interface to eliminate manual data entry for specimens ordered, billing coding verification and developing a lab developed test to reduce testing costs were all best practices that should be shared.

<u>Accomplishment #5: Developed and implemented online portals for Bureau Sanitarian Services and Bureau of Community Preparedness</u>

A. What was achieved?

Bureau of Sanitarian Services: Through a Division of Administration statewide contract, OPH collaborated with Louisiana Interactive to provide electronic portal access for private well water test requests. This online portal was created to provide the public an easier method to request their private well water testing. On the online portal, a test can be requested, a test kit shipped to the residence and payment collected. While there is a small convenience fee, this eliminates the public's need to visit the parish health units or laboratory to obtain testing materials. The "old" process is still available. The results are electronically delivered and create a collateral efficiency for Sanitarian Services, who would otherwise have to prepare and send a paper report. One of the biggest benefits to all offices involved has been the reduction in the number of paper checks that

are received, tracked and processed. This model is being expanded for other processes.

Bureau of Community Preparedness: Implemented an advanced online portal for sharing emergency preparedness data during event responses. Two custom-developed software systems are utilized for incident management in LDH emergency response operations. These web-based applications, WebEOC and the MSNS App, are accessible from any computer with an internet connection.

WebEOC incident management software is being used in the LDH Emergency Operations Center (LDH EOC), as well as remote incident response sites. The software has been customized to match LDH EOC incident management procedures and to support LDH emergency operations throughout the state. The integration of WebEOC into LDH incident management practices has eliminated several manual processes that were more susceptible to data loss or misinterpretation.

The primary features of WebEOC are creation and tracking of resource requests, collection, revision, and archiving of incident situation reports, tracking of medical special needs shelter (MSNS) status and population numbers (including evacuation transports en route to MSNS), and maintaining a digital repository of incident –related information.

The Medical Special Needs Shelter Application tracks a variety of information useful for MSNS operations. Data include shelteree medical conditions, transportation needs, discharge planning tools, staff medical specialties, staff scheduling and attendance, and a variety of reporting tools for analysis of data. This application consolidates many manual information collection processes into a single platform. The MSNS app can be rapidly customized to meet evolving data collection needs based on the type of incident.

B. Why is this success significant?

The electronic portal access for private well water test requests is significant because it allows more convenient 24/7 public access to this service.

The MSNS App makes it possible to answer many questions regarding sheltering operations that were difficult (or impossible) to answer using previous methods. The software makes it practical to build both broad and narrow characterizations of MSNS populations and resource needs. The application makes the documentation of shelteree medical care and the planning for shelteree discharge a simple matter, replacing paper records and manual spreadsheets that took excessive staff time to create and update.

C. Who benefits and how?

Anyone who wants to test their private water well benefits by having easier 24/7 access to this service.

The MSNS App benefits staff working in a medical special needs shelter by making important information easily accessible. The software is useful for decision makers ate the shelter, regional, and state level because it provides an accurate and detailed picture of current sheltering operations. This leads to better-informed decision making.

D. How was the accomplishment achieved?

The accomplishment was achieved by working with a third party (Louisiana Interactive) that specializes in online purchases within government agencies.

Gaps identified through after action reports (exercises and real-world events) were used as a base requirement list for new software systems and several potential platforms were assessed for suitability. Once specific technology platforms were selected, LDH emergency preparedness staff worked closely with vendors to develop the software to match the specific needs of LDH emergency response activities.

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

This is an example of expansion of services. Offering 24/7 online access to this service eliminates the need for our citizens to drive to our health units for an appointment during office hours.

The MSNS application and WebEOC implementation represents a best practice for the agency and contributes to the overall 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. Online services are the way in which consumers interact with businesses today to save time and effort. The more services can be accessed online gives the public more convenience and easier access to the services we provide.

Yes. The MSNS application was uniquely built to meet the needs of Louisiana based on lessons learned from past events. This data collection tool provides a host of information regarding MSNS patients and resource needs.

<u>Accomplishment #6: Launched a new online portal for use by all licensed EMS Practitioners</u>

A. What was achieved?

On November 26, 2018, the Bureau of EMS launched a new online licensing Information Management System. The IMS is for use by all licensed EMS Practitioners. Individuals can obtain an initial license and renew licenses online now. Prospective EMS Practitioners apply to take the National Registry psychomotor exam using the IMS. EMS Educators will use the IMS to document each course and the students' outcomes for each course. This new system is more efficient for the Bureau of EMS in that it provides more specific reports regarding information about EMS Practitioners.

B. Why is this success significant?

The Bureau of EMS is charged with the overall planning, coordination, licensing, and regulation of Louisiana's EMS system. Prior to the development of the new Information Management System (IMS), an "off-the-shelf" data management system that was not customizable to the unique statutes and data collection necessary for the Bureau of EMS to fulfill its obligations. Working with DBSysgraph, the Bureau of EMS developed a customized IMS platform that is quicker, more robust, reliable, and most importantly, user-friendly for both the front and back-office user. The successful implementation of the IMS is noteworthy as it allows for accurate and timely applications processes for education, examination and licensing for EMS Practitioners throughout the state and thereby, positively impacting the EMS industry in Louisiana as well as the citizens they serve.

In addition to the timely processing of applications, the IMS allows for the ability to correspond via electronic communication with the IMS any EMS Certification Commission information. This communication is tracked and logged into the system which documents the type of communication, the sender and recipient(s) of the communication and when the communication occurred. This tracking functions permits better coordination of EMS Certification Commission investigations.

C. Who benefits and how?

The use of the new IMS provides for better user experience, for front-office and back-office users. This includes EMS licensees, EMS service providers, EMS education agencies, and Bureau of EMS staff. Louisianans across the state benefit from having qualified and properly vetted practitioners respond to their out-of-hospital healthcare needs due to timely licensing of EMS Practitioners. Potential and existing EMS Practitioners benefit from the ease-of-use of the system. Employers benefit from access to their agency accounts. The State of Louisiana, as an employer, profits from the streamlined and efficient education, examination and licensing of the EMS Practitioners. The system allows the Bureau of EMS staff to better report and analyze quality improvement processes.

D. How was the accomplishment achieved?

In development for over a year, the IMS was a collaborative effort of Bureau of EMS personnel and the programmers, DBSysgraph. After the initial design, the system was beta-tested by both back-office personnel and EMS instructors. The Bureau of EMS delivered sixteen IMS instructional sessions across the state to credentialed EMS Instructors. Following the launch on November 26, DBSysgraph has provided on-going technical support and made system upgrades to fine-tune the IMS as it has moved from development to implementation. The system was specifically designed to address the needs of the Bureau of EMS in education, examination and licensing of EMS Practitioners.

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

The creation and subsequent launch of the IMS, while not a direct strategic planning goal, allows for better collection, monitoring, and tracking of data specific to the strategic plan. The IMS increases the efficiency of licensing EMS Practitioners throughout the state as well as coordinating all aspects of the Bureau of EMS functions.

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

The IMS has reduced several redundant processes between education, examination and licensing. This streamlining of these processes has made the Bureau of EMS more efficient with customer service.

Accomplishment #7: Updated the Louisiana Electronic Event Registration System (LEERS) system

A. What was achieved?

OPH updated the Louisiana Electronic Event Registration System (LEERS) system to allow coroners to report drug overdose deaths where the decedent's toxicology results indicated that an opioid was present at the time of death and the death was related to an overdose. This enhanced surveillance will allow OPH to obtain the data needed to shape, implement, and assess the success of the coordinated response to the opioid epidemic.

OPH updated the Louisiana Electronic Event Registration System (LEERS) and conducted extensive outreach to meet the mandates of Act 672 of the 2018 Regular Session of the Louisiana Legislature that required all physicians and coroners to electronically certify the medical information for death records beginning January 1, 2019.

B. Why is this success significant?

This update allowed for direct reporting of overdose deaths specifically where opioids are present in the toxicology report. Previously, if multiple drugs were present at the time of death, coroners would not necessarily specify all drugs listed in toxicology. This would result in extensive follow back for opioid surveillance to determine whether multi-drug overdoses included opioids.

While LEERS has been used by physicians and almost every coroner to electronically sign death certificates since July 2012, there was no requirement to certify the medical information on death records in LEERS prior to this law taking effect. The requirement to have all physicians and coroners to certify medical information on death records in LEERS results in death records filed with Vital Records more timely.

C. Who benefits and how?

The beneficiaries of the LEERS updates are those who rely on death record data to shape,

implement, and assess the success of the coordinated response to the opioid epidemic. In addition, the public benefits from these updates since death records are filed with Vital Records fully electronically and certified copies can be provided to the family closer to the date of death.

D. How was the accomplishment achieved?

The opioid updates were achieved through updating the LEERS Death Module and related databases, specifically the Medical Information tab, for coroners. A checkbox is available for coroners for any non-natural death to indicate whether opioids were present in the toxicology for drug-related deaths.

In order to implement Act 672 of the 2018 Legislative Session, the Bureau of Vital Records and Statistics conducted extensive outreach to the medical community that primarily certifies medical information on death records. Beginning in the Fall of 2018, the Bureau of Vital Records and Statistics began working collaboratively with the Louisiana State Board of Medical Examiners (LSBME) to inform every physician licensed to practice in Louisiana about the coming change in the statute. In December 2018, an email was sent to the email address on file with LSBME to physicians to explain the change in statute and provide helpful resources for new users of LEERS including a short video detailing the entire electronic certification process. This information was also posted on the LSBME website for physicians to reference.

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

A primary goal of the Bureau of Vital Records and Statistics is to continue to improve the quality and timeliness of vital event data. This initiative is directly in support of that goal.

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

The implementation of the death module updates provides for an efficient data surveillance process allows for data-driven quality improvement improving the utility of data obtained from Louisiana vital event records.

<u>Accomplishment #8: Developed the Louisiana Opioid Data and Surveillance System (LODSS)</u>

A. What was achieved?

In October 2018, the LDH-OPH Bureau of Health Informatics and a public sector software firm, GCR, Inc. through a grant from the Centers for Disease Control and Prevention (CDC) developed and launched the Louisiana Opioid Data and Surveillance System (LODSS) website to provide access to health professionals, researchers, and decision makers to understand, analyze, and apply data to statewide opioid abuse reduction efforts. The LODSS provides comprehensive data about opioid deaths, emergency room visits for an overdose, inpatient hospital admissions and the number of prescriptions written for opioids.

B. Why is this success significant?

The success is significant because it allows health professionals, researchers, and decision-makers the capability to evaluate the impact of programmatic and policy efforts and track the behavior of what is now considered a public health epidemic nationwide.
The availability of detailed data, which can be delineated by population and geographic factors, improves the capacity of researchers and decision-makers to produce, analyze, and evaluate policies aimed at addressing the opioid crisis in Louisiana.

C. Who benefits and how?

The LODSS online surveillance system is a tool designed to help state leaders, local officials and health care providers to best understand the extent of the problem in their communities and then target resources where needed to address opioid hospitalizations and overdoses. Ultimately, the people of Louisiana benefit, consistent with the Louisiana Department of Health's mission to protect and promote health statewide and to ensure access to medical, preventive, and rehabilitative services for all state residents.

D. How was the accomplishment achieved?

The LODSS website was developed under the leadership of the Louisiana Department of Health (LDH), by GCR, Inc. and funded through a grant from the Centers for Disease Control and Prevention.

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

Yes. The LODSS accomplishment contributes to the success of the strategic plan. The LODSS accomplishment aligns with OPH Agency Goal VII of the strategic plan, which aims to leverage health information technology to maximize use and integration of data to drive decision-making.

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

Yes. The LODSS accomplishment represents a best practice management practice because it demonstrates how collaborative state, federal, and private sector partnerships can work to benefit the public. The accomplishment should be shared with other executive branch departments as an example of what can be achieved through focused governance, dedicated leadership, and committed partners.

<u>Accomplishment #9: Increased up-to-date (UTD) vaccination rate for Human Papillomavirus (HPV)</u>

A. What was achieved?

The OPH Immunization Program reported a statistically significant increase of **11.1**% for HPV up to date (UTD) rate over 2016. This up-to-date rate of 52.9% teens ages 13-17 is above the national average of 48.6%, according to the CDC's Morbidity and Mortality Weekly Report (MMWR) published August 24, 2018.

B. Why is this success significant?

The HPV vaccine is safe, effective, and recommended by CDC to provide long-lasting protection against cancers caused by HPV. Every year about 14 million people, including teens, contract HPV, a group of more than 150 related viruses that cause nearly all cervical cancers and many cancers of the vagina, vulva, penis, anus, rectum and oropharynx. HPV is transmitted through intimate skin-to-skin contact. Increasing the up-to-date vaccination rate for HPV is vital to protect teens from nine HPV types. The HPV vaccine provides almost 100% protection from nine HPV types (6, 11, 16, 18, 31, 33, 45, 52 and 58), if all doses are received at the correct intervals, and if it is given before individuals have an infection with these types.

C. Who benefits and how?

Preteens ages 11-12 are encouraged to receive the vaccine so they are protected before ever being exposed to the virus. The vaccine is administered in a series of shots over several months. It is safe, effective and recommended by the CDC. The Louisiana Department of Health- Office of Public Health (LDH-OPH) continues to make a strong recommendation for the HPV vaccine for teens.

D. How was the accomplishment achieved?

According to LDH Secretary Dr. Rebekah Gee, "Activities geared toward improving vaccination rates have included working closely with partner organizations such as the Louisiana chapters of the American Academy of Pediatrics and the American Cancer Society to encourage their members to spread the word about the importance of the vaccine." OPH's Immunization program staff remain committed to encouraging the administering of safe, effective, and recommended vaccinations to protect the public from HPV through the following education, staff training and targeted media efforts including the following:

- Implementation of a Vaccine Coverage Rate Report Card in 2015 for providers with a summary of how their respective practices are progressing in HPV coverage compared to the Healthy People 2020 target

- Annual, quality-improvement site visits to >90% of Louisiana's eligible 745+ Vaccines for Children providers. Awarding high HPV coverage rates at each annual Shots for Tots Conference

- Targeted outreach to school-based health centers through *Louisiana Increasing HPV Vaccine Coverage by Strengthening Adolescent AFIX Activities* (Grant No: 6 NH23IP922567-01-01) funding for 2016-2018

- Staff trainings in 2018 utilizing concepts of motivational interviewing during provider visits to ensure more effective vaccine recommendations

- Launch and promotion of a Vaccinate Before You Graduate campaign in the Fall of 2018, including a website promoting adolescent immunizations

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

Yes. A hallmark of the mission of OPH's Program A, Public Health Services, as stated in its strategic plan, is to protect and improve the health and well-being of Louisiana's residents. The OPH Immunization Program protects health by encouraging timely immunization for prevention and control of vaccine preventable diseases, working to ultimately eliminate these threats. Staff work as health strategists to improve Louisiana immunization coverage rates as measured by the National Information Survey (NIS), OPH's Louisiana School Year Reports, and Louisiana's Immunization Information System, LINKS data.

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 provision of evidence-based practices is a best practice that should be replicated and shared with other executive branch departments or agencies. OPH encourages proven, safe, recommended, immunization practices to deliver effective immunization services to the people of Louisiana.

<u>Accomplishment #10: Deployment of LAWIN and EBT Systems statewide</u>

A. What was achieved?

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) received approval from USDA Food and Nutrition Service (FNS) to move from pilot to statewide deployment of the new LAWIN and EBT systems on Monday, June 24, 2019. This transition is set to begin in Region 8 with training on July 8, going live in clinics and authorized grocery stores on July 15. The last region, Region 1, will complete the transition in October 2019, ahead of the federal mandate for all states to be EBT compliant by 2020.

B. Why is this success significant?

USDA federal regulations require all WIC state agencies to issue benefits in electronic benefit transfer (EBT) systems by October 1, 2020. Louisiana WIC will complete this transition one year in advance of the federal mandate. This is a significant undertaking as Louisiana WIC is not only training 400+ local WIC staff on a new management information system (LAWIN) but also on a new process for issuing monthly benefits to 104,000+ WIC participants. This project also affects

approximately 510 WIC authorized grocery stores in the state who are learning the new WIC EBT transaction procedures.

C. Who benefits and how?

This transition to EBT and away from paper vouchers benefits WIC participants, staff, authorized grocery stores, and the state agency. The WIC participants and staff are benefiting from a more up-to-date system and process in clinics and improved shopping experiences at WIC authorized grocery stores. The state agency will benefit from further improvements in food cost containment and improved program integrity.

D. How was the accomplishment achieved?

Since the project began in 2015, the LAWIN/EBT project has been supported by LDH/OPH leadership, the federal funding agency (USDA Food and Nutrition Service), regional partners (New Mexico and Texas WIC), and internal project team resources. Louisiana was able to secure federal grant funds to support the transition to these two new systems (LAWIN and EBT).

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

This accomplishment contributes to the overall success of Louisiana WIC, adds to improved program integrity, and supports the goal of providing nutritious supplemental foods and benefits to low-income Louisiana women, infants, and children up to age five.

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 integration of technology, with the goal of improving efficiency, is a best management practice and should be a priority for every agency in the state.

<u>Accomplishment #11: Implemented Video Directly Observed Therapy (VDOT) for Tuberculosis (TB) Control</u>

A. What was achieved?

Directly Observed Therapy (DOT) is the standard of care for individuals taking medication for the treatment of tuberculosis disease. Healthcare workers watch patients take their medication throughout their therapy regimens, which can last from a minimum of six months up to twenty-four months for complex cases. This practice ensures that patients are getting the proper amount of medication to cure the disease, avoid adverse medication-related issues, and prevent development of drug resistance.

Directly Observed Therapy costs a significant amount of money in both travel-related costs and staff time. Disease Intervention Specialists (DIS), who conduct DOT, can spend a half of a day

traveling to and from a patient's home, if the patient lives far from the nearest Office of Public Health (OPH) Regional Office. If DIS use their own vehicles, mileage and fuel costs can add up quickly since patients receive medication daily for the first two weeks of therapy and then twice a week for the remainder of treatment. In some cases, such as HIV positive co-infected patients, daily medication is required for the entire course of therapy, for a minimum of nine months.

Video Directly Observed Therapy allows patients to use their smartphones or other mobile devices to record themselves taking their medication. Healthcare workers then review the patient videos the following day to ensure that all medication has been taken properly. Patients can connect directly with a DIS worker through the VDOT software on their mobile device if they are experiencing any side effects. Using the VDOT software, patients no longer have to meet DIS workers, interrupting their work or school schedules or having to take time off of work to receive DOT at a local Public Health Unit. Videos can be recorded at times that are most convenient for the patients.

The VDOT software application and program guidelines are being piloted in three OPH regions. Based on VDOT results in other states, the program is expected to produce a significant cost savings due to reduced travel expenditures and less DIS staff time per patient. Adherence rates are projected to increase, resulting in lower morbidity, which will reduce costs associated with patient care such as medication and staff time per patient.

B. Why is this success significant?

As patient care and operating costs increase, and funding levels remain static or are reduced, the importance of finding cost-effective ways to provide services and accomplish public health goals becomes even more important. VDOT allows the agency to achieve both mandates. Initial results of the pilot study show, that in a three-month period, there was a direct cost savings of $9244.44 in travel-related expenses, such as fuel and mileage reimbursement. The indirect cost savings in staff time was 591.2 hours equaling a savings of $10,937.00. As this program is expanded to other regions of the state, the cost savings is expected to increase proportionately to the patient populations in those areas of expansion.

Along with a significant cost savings, an additional benefit to the implementation of VDOT has been an increase in the number of people infected with tuberculosis infection, but without active disease, voluntarily participating in preventative therapy. The flexibility of VDOT allows them to participate in the 12-week short course, preventative therapy regimen, without having to meet DIS workers for traditional DOT. As more people are preventatively treated, fewer people will develop active disease later in life, reducing tuberculosis-related morbidity and mortality.

In addition to the number of people participating in preventive treatment, the actual number of those who complete that treatment, is an important indicator of program success. Traditional completion rates with the standard six month, self-administered treatment results in an average completion rate of 60%. With the 12-week short course regimen, combined with VDOT, patient completion rates are at 87%. As stated above, the more people that are preventatively treated results in less active disease cases in future years.

C. Who benefits and how?

As more people participate in preventative therapy regimens, the number of future tuberculosis cases will decrease. In response to the decrease in cases, the need for current levels of program funding will also decrease. With a reduction in the number of future active disease cases, the threat to public health is also be reduced.

The cost savings associated with VDOT directly benefit the agency and the state, allowing funds to be redirected to other areas of need.

D. How was the accomplishment achieved?

Patients, meeting program-specific requirements, were offered the option of using the VDOT software in lieu of traditional DOT.

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

Yes. The OPH Tuberculosis Control Program's mission is to reduce tuberculosis-related morbidity and mortality across the state of Louisiana. Early pilot study results show that in addition to cost savings, more people are participating in preventative treatment. People infected with tuberculosis have an estimated 7% chance of developing active disease in their lifetime. Preventative treatment can bring those percentages down to 1%-2% during a lifetime, directly impacting the number of future cases of the disease.

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 technology, with the goal of improving efficiency and public health outcomes, should be a priority for every agency in the state. This particular technology is limited in its scope and may only be useful in a healthcare or medical setting. While this type of software may not be of benefit to other state agencies, other video-based applications may be useful.

<u>Accomplishment #12: Decreased Human Immunodeficiency Virus (HIV) diagnoses</u>

A. What was achieved?

The Bureau of Infectious Diseases, STD/HIV Program (SHP) found that fewer people have been diagnosed with an HIV infection in the past year than in any of the previous 10 years. There were 989 people newly diagnosed with HIV in 2018. The number of people newly diagnosed with HIV in Louisiana has declined over 12% in the past three years from 1,124 new cases in 2016 to 989 in 2018. In the years since 2005, there have never been fewer than 1,000 people who were newly diagnosed.

B. Why is this success significant?

The U.S. Department of Health and Human Services (HHS) has developed a plan to "End the HIV Epidemic" in the US by reducing new HIV infections by 75% in five years and 90% in ten years. Louisiana is also developing a local plan to end the HIV epidemic in the state, with a focus on significantly decreasing new HIV infections. SHP has developed and funded interventions to improve outcomes across the HIV care continuum including 1) increasing the percentage of persons who are aware they are infected; 2) linking newly diagnosed persons to HIV-related medical care; 3) ensuring persons living with HIV are retained in medical care and have access to effective antiretroviral therapy; and 4) increasing the proportion of people who are virally suppressed which leads to a decrease in HIV transmission in the community.

C. Who benefits and how?

Persons at risk of HIV infection have benefited from interventions that have increased HIV screening, linkage to care and viral suppression, since these interventions decrease the level of virus in the community and reduce the potential for HIV transmission.

D. How was the accomplishment achieved?

The reduction in new HIV diagnoses was achieved through an integrated approach that focused on detecting new HIV infections earlier, linking persons to care within 30 days, re-engaging persons who have fallen out of care, increasing viral suppression and reducing health disparities. In addition, the provision of Ryan White services (i.e., case management, assistance with medications for uninsured individuals, and assistance with premiums and cost share for insured individuals) has helped improve retention in care and viral suppression. In Louisiana, viral suppression among persons in care has increased from 70% in 2013 to 85% in 2018. SHP has also focused on expanding PrEP awareness and PrEP navigation services and has increased the number of PrEP providers throughout the state in order to prevent new HIV infections.

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 SHP's major priorities: to decrease new HIV infections. This is also a goal of the CDC National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention Strategic Plan for 2020 (Goal I: Decrease Incidence of Infection) and the HHS "Ending the HIV Epidemic: a Plan for America."

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

Yes. The implementation of SHP's HIV prevention interventions were carried out by a large cross-unit team, and SHP has collaborated with many community partners. These interventions could be replicated to address other health issues in the state. Several of the interventions started out as pilot projects in a single region and have been expanded statewide. SHP

interventions have also been used as models for other state health departments.

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, OPH's strategic plan is on time and on target for accomplishment. Our achievements over the past several years, including those described in the previous section, have increased the effectiveness and efficiency of our agency, have increased our capacity to safeguard the public's health, have enabled us to provide better customer service, and have resulted in improved health behaviors and outcomes in targeted areas. These accomplishments are the product of a strong workforce that is dedicated to protecting and improving the public's health.

- **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.

As described in the previous section, an example of where OPH is making significant progress is with regard to HIV. In particular, the number of people newly diagnosed with HIV each year in Louisiana has declined over 12% in the past three years, from 1,124 new diagnoses in 2016 to 989 in 2018. OPH's STD/HIV Program (SHP) has developed and funded innovative interventions to improve outcomes across the HIV care continuum as mentioned in Section I. The reduction in new HIV diagnoses was achieved through an integrated approach that focused on detecting new HIV infections earlier, linking persons to care as soon as possible, re-engaging persons who have fallen

out of care, increasing viral suppression and reducing health disparities. SHP has expanded routine HIV screening and targeted testing of priority populations, and has designed and implemented very effective interventions to increase retention and re-engagement in HIV-related care. For example, the following interventions began as pilot projects, but were recently expanded to additional regions based on their success: 1) LA Links – using surveillance data to identify and relink persons into care; 2) Health Models – client incentives to improve health outcomes; and 3) Videoconferencing – linking persons to case management prior to release from a correctional facility to improve linkage to medical care and other social services. SHP has also focused on expanding awareness of and access to pre-exposure prophylaxis (PrEP) by implementing PrEP navigation services and increasing the statewide PrEP provider network.

In addition, the provision of Ryan White services and Medicaid expansion have significantly improved retention in care and viral suppression. Ryan White services provide case management, medication assistance for uninsured persons and assistance with premiums and cost shares for insured individuals. With Medicaid expansion, over 3,600 people transitioned from Ryan White services to enroll in a managed care plan where they could access primary care, specialty care, and a wide range of preventive screenings and services to prevent co-morbidities. An analysis by SHP staff showed that viral suppression among persons transitioning from Ryan White to Medicaid increased from 81% pre-transition to 83% post-transition. SHP has collaborated with numerous community partners, other state agencies and national organizations to develop and expand HIV prevention efforts across Louisiana.

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

OPH expects to see a continued reduction in the number of new HIV diagnoses. The U.S. Department of Health and Human Services (HHS) has developed a plan to "End the HIV Epidemic" in the U.S. by reducing new HIV infections by 75% in five years and 90% in ten years. Louisiana is also developing a local plan to end the HIV epidemic in the state, with a focus on significantly decreasing new HIV infections. SHP will continue to implement successful interventions and expand them to other parts of the state, which should lead to continued decreases of new HIV infections. In addition, SHP has recently been awarded CDC funds to expand interventions in Baton Rouge in order to end the HIV epidemic.

- **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?

OPH has revised its strategic plan to build on its successes and to reflect state-wide public health priorities and initiatives. Namely, we have developed and are implementing plans to address LDH's strategic priorities (known as "Big Bets") of eliminating Hepatitis C as a public health problem and demonstrating good stewardship through a culture of Continuous Quality Improvement. We have also enhanced our plans to achieve OPH's "Big Bets" which include reducing the burden of HIV in Louisiana and leading towards a smoke-free Louisiana. To accomplish these goals, OPH utilizes the approach of "innovate, partner, and lead" to align efforts and transform health outcomes.

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

OPH's organizational structure is comprised of departments (referred to as "Bureaus") grouped into three distinct "Centers," each led by a Deputy Assistant Secretary. The Assistant Secretary oversees the Deputy Assistant Secretaries in addition to providing oversight to the Assistant State Health Officer and the staff of the Office of the Assistant Secretary.

This structure has many advantages. It coalesces Bureaus with similar missions under one leader and has allowed all OPH programs to benefit from direction and guidance of a senior leadership team. This organizational structure and an accompanying meeting structure facilitates multi-directional communication and collaboration within the organization in service of OPH's strategic priorities.

In addition, OPH has prioritized increasing its capacity for performance management of its strategic plan and data-driven decision making. For example, it has increased the staffing of its Bureau for Policy, Planning and Performance, which has been charged with strategic plan tracking and performance management, and is utilizing Tableau software to develop performance dashboards for each of its strategic priorities ("Big Bets") to facilitate the regular use of data for decision making.

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 operational concern is the intermittent loss of network connectivity.

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

While we are able to make progress on our strategic plan, this issue is an obstacle to faster and more sustainable progress, as well as creating efficiency gains. Online portals are only saving resources if our customers and staff can utilize them.

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

This is experienced across our agency. Some areas where it has particularly impacted us include the regional clinical operations in both laboratory sample ordering and use of electronic health records. Most recently, email access during activation for a storm event made communications a challenge.

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

This issue affects internal staff and program productivity as well as our external customers and other stakeholders who rely on our services.

5. How long has the problem or issue existed?

This has been an ongoing issue.

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

It is beyond our scope to discuss causes of this issue.

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

In response to evolving public health needs, additional services often need to be provided to ensure the agency is providing the necessary support needed to address them. For example, with the Opioid epidemic, a dashboard of data has been instrumental in guiding the strategies to mitigate the issues.

In parish health units, often the network system is down which causes clinical staff, who are seeing patients, to resort to manual methods of completing paper documents instead of utilizing the electronic health record system. Then they later input the data into the system once it is functional again. Likewise, when lab samples are unable to be ordered in the portal, or patient demographics cannot be updated to match to the samples collected, manual forms and labels are completed. This time consuming, redundant and risks clerical errors.

The agency has adopted a strategy of leveraging technology and data, wherever possible and feasible, to create efficiencies; reduce resources required for services; make data driven decisions and to utilize evidence based practices. To achieve this, we are reliant upon the technology infrastructure that the state systems provide.

When systems utilized are down, operations are either paused or reverted to paper processes during downtime. The statewide network is not able to meet the need of the systems already in production and we lack confidence in the ability of the infrastructure to allow for expansion of technology solutions, which in many cases would reduce the need for additional staff and create cost efficiencies.

B. Corrective Actions

- 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.

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

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

- How much progress has been made and how much additional progress is needed?

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

4. 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?

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

We experience a lack of sufficient permanent TO positions to fully execute our mission.

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

While we are able to make progress on our strategic plan, this issue is an obstacle to faster and more sustainable progress.

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

This is experienced across our agency. Some areas where it has particularly impacted us include in implementing programs aimed at social determinants of health. The Community Health Worker has proven to be an invaluable resource in solving for the gaps that patients experience in obtaining the basic needs associated with their health.

In addition, the OPH Laboratory is working to return tests to the test menu that were discontinued when Hurricane Katrina destroyed the lab and it was rebuilt in Baton Rouge. While we have created efficiencies to marry with additional services, we are nearing our capacity given the TO currently provided.

Sanitarian Services once provided onsite sewer education and technical assistance to consumers. Downsizing eliminated those positions. With a few positions returned, we have offered some support to our communities, but in some cases, customers must wait to obtain technical assistance. The wait to get this specialized consulting is not at the service level we would aspire to provide.

Recent legislation mandated that Sanitarian Services will provide health inspection to manufacturers of industrial hemp derived cannabidiol products. In addition, all product labels will be reviewed by the same unit to ensure labeling is compliant with the U.S. Food and Drug Administration guidelines. There are no dedicated positions for this additional work load. Again, efficiencies will be pressed to ensure that the mandated function is performed timely and accurately, but the capacity is limited to provide excellent service.

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 are stretched. Typically, it is our more tenured staff who are tasked with more activities within their current schedule. 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?

This has been an ongoing issue.

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

The cause of the problem is insufficient permanent TO. When areas of priority require additional TO, then other area vacancies are either not filled, or they are replaced with a temporary employee or contracted employee.

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

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.

Lack of benefits, and even lack of access to some state systems, mean that these supplemented positions are not as stable and often the position access means the position is not fully able to fulfill the duties that would otherwise be done by the position. Employees who accept these positions are typically eager to find another more permanent position and turnover is the result. Again, turnover in positions is costly.

B. Corrective Actions

- 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.

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

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

4. 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
☐ 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 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:** 2017 HIV Surveillance Report, Vol 29
2. Date completed: 06/30/2019
3. Subject or purpose and reason for initiation of the analysis or evaluation:

This report includes HIV and STD surveillance data. Report includes all STD information entered at the STD/HIV Program (SHP) as of April 27, 2018 and all HIV information entered as of December 21, 2018. Chlamydia, gonorrhea, syphilis, congenital syphilis, HIV and AIDS cases diagnosed through 2017 are included in this report. In addition, HIV diagnoses in 2017 were matched against Hepatitis C and STD data to generate rates of HIV co-infection.

Included in the report are traditional analyses to report the morbidity of HIV and STDs by selected demographics and geographic areas. Additional analyses in the report focus on perinatal exposure of HIV and syphilis and highlighted populations of interest such as youth and transgender persons. Surveillance data are also used to calculate engagement in medical care and rates of viral suppression among persons living with HIV.

This report provides data on diagnoses of HIV Infection and infections classified as stage 3 (AIDS) in the United States and dependent areas for 2016 and 2017 as well as death and prevalence data through 2016. Louisiana's rankings for the state and the New Orleans and Baton Rouge MSAs declined.

4. Methodology used for analysis or evaluation

Data Analysts use various analytic procedures in SAS to create the varied analyses within the report. The most frequent analyses include frequencies and generating rates using the Census Population Data.

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

The total cost for graphic design production and printing of 1,000 hard copies was $14,500 in addition to Data Analyst time and Data Manager time.

6. Major Findings and Conclusions

HIV Surveillance

- At the end of 2017, 21,432 persons were living with HIV in Louisiana, of whom

10,979 (51%) have been previously diagnosed with AIDS. There are persons living with HIV in every parish in Louisiana.

- In the most recent *CDC HIV Surveillance Report (Vol. 29),* Louisiana ranked 4th in the nation for HIV case rates (22.1 per 100,000 population) and 10th in the number of reported HIV cases. The New Orleans MSA ranked 4th and the Baton Rouge MSA ranked 5th for HIV case rates (27.0 and 26.9 per 100,000, respectively), among the large metropolitan areas in the nation.

- According to the same report, Louisiana ranked 3rd highest in state AIDS case rates (10.8 per 100,000) and 10th in the number of AIDS cases in 2017. The Baton Rouge MSA ranked 2nd in AIDS case rates (15.3 per 100,000) and the New Orleans MSA ranked 6th in AIDS case rates (12.5 per 100,000) in 2017 among the large metropolitan areas in the nation.

- In 2017, 1,017 individuals were newly diagnosed with HIV in Louisiana.

- Blacks continue to experience severe health inequalities; the HIV diagnosis rate for blacks was over five times higher than among whites in 2017. Although blacks make up only 32% of the state's population, 69% of newly diagnosed HIV cases and 71% of newly diagnosed AIDS cases were among blacks in 2017.

- In 2017, 75% of persons newly diagnosed with HIV were linked to HIV medical care within 30 days of their diagnosis.

- In 2017, 26% of all persons living with HIV in Louisiana were considered to have unmet need for HIV medical care. These persons did not have a single CD4 count or viral load test conducted in 2017.

- Among persons living with HIV in 2017 who had at least one HIV medical care appointment, 83% were virally suppressed (last viral load < 200 copies/ml).

Perinatal HIV Exposure and Congenital Syphilis

- Perinatal HIV transmission rates have declined significantly from a high of nearly 16% in 1994 to less than 2% in 2016.

- In 2017, 59 congenital syphilis cases in Louisiana were reported to the CDC. Although congenital syphilis is on the rise across the country, Louisiana's congenital syphilis case rate in 2017 ranked 1st in the US for congenital syphilis with a case rate of 93.4 cases per 100,000 live births, four times the national rate of 23.3 cases per 100,000 live births.

STD Surveillance

- In 2017, Louisiana ranked 2nd in the nation in chlamydia rates (741.8 per 100,000), 3rd in primary and secondary (P&S) syphilis rates (14.5 per 100,000) and 3rd in gonorrhea rates (256.5 per 100,000). There were 34,749 new cases of chlamydia, 12,014 cases of gonorrhea, and 679 cases of P&S syphilis diagnosed in Louisiana in 2017.

- New STD diagnoses among blacks is a significant health disparity. Blacks accounted for 70% of chlamydia diagnoses, 76% of gonorrhea diagnoses, and 68% of P&S syphilis diagnoses in 2017.

- Persons under the age of 25 account for the majority of STD diagnoses in Louisiana: 70% of chlamydia diagnoses and 58% of gonorrhea diagnoses. Persons 15-29 years old accounted for 58% of P&S syphilis diagnoses.

HIV Co-Infection

- In 2017, co-infection with HIV was identified in 2% of chlamydia diagnoses (n=837), 7% of gonorrhea diagnoses (n=729), 30% of P&S syphilis diagnoses (n=203), and 3% of hepatitis C virus diagnoses (n=205).

7. Major Recommendations

Louisiana has some of the highest rates of HIV and STDs in the nation and continued emphasis must be placed on population-level screening, efficient linkage to medical care and treatment.

8. Action taken in response to the report or evaluation

Analyses within the report are used to educate communities and providers regarding the status of HIV and STDs in Louisiana. In addition, data within the report are used by the public for a multitude of trainings, grant applications, or health notices.

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

The report is available in hard copy, has been distributed as a PDF attachment through email networks, and is available for download from the SHP website (http://ldh.la.gov/index.cfm/newsroom/detail/1935).

10. Contact person for more information:

Name: DeAnn Gruber, Director, Bureau of Infectious Diseases
Agency & Program: Louisiana Department of Health, Office of Public Health STD/HIV/Hepatitis Program
Telephone: (504) 568-7474; E-mail: deann.gruber@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

Department:	**Louisiana Department of Health (LDH)** 09-330 Office of Behavioral Health
Department Head:	**Rebekah E. Gee, MD, MPH** LDH Secretary
Undersecretary:	**Cindy Rives**
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.

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?

<u>Accomplishment #1: Louisiana Promoting Integration of Primary and Behavioral Health Care (LaPIPBHC) Grant</u>

A. What was achieved?

In 2018, the Office of Behavioral Health (OBH) was awarded the LaPIPBHC grant.

B. Why is this success significant?

OBH supports a movement toward integrated primary care and behavioral health care. The purpose of the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) Grant is to promote the integration of primary and behavioral health care services to improve the overall wellness and physical health status of adults with mental illness who have co-occurring physical health conditions or chronic diseases and individuals with a substance use disorder. Offering behavioral health services in nontraditional settings encourages participation by people wanting to avoid the stigma surrounding mental health treatment. Studies have demonstrated possible effects of perceived stigma by showing that clients are less likely to follow up on referrals made to mental health settings than they are to in-house services.

C. Who benefits and how?

The Office of Behavioral Health (OBH) has identified two special populations of focus: Adults with a mental illness (MI) who have co-occurring physical health conditions or chronic diseases (COD) and individuals with a Substance Use Disorder (SUD).

D. How was the accomplishment achieved?

The overall goal of the program is to provide a coordinated, comprehensive approach and to improve the overall wellness and status of adults with co-occurring mental illness and physical health conditions or chronic diseases, and individuals with a substance use disorder through improved health care delivery. Target areas that were identified and chosen were the parishes of Morehouse, Terrebonne, Orleans, and East Baton Rouge were chosen. These providers have established their commitment to the initiative by signing contracts. To date, providers have been identified in the formerly mentioned areas and consist of community health centers (FQHCs) or community health plans (behavioral health centers). OBH has identified four provider organizations, geographically dispersed in the state, to provide integrated primary and behavioral health (BH) services. All providers are located in HRSA designated health professional shortage areas. The providers are Capital Area Human Services District (CAHSD) in Baton Rouge, LA (East Baton Rouge Parish); Start Corporation in Houma, LA (Terrebonne Parish); Northeast Delta Human Services Authority (NEDHSA), in Monroe, LA (primary care services will be provided in Morehouse Parish, the location of NEDHSA's partner provider); and Daughters of Charity Health Centers in New Orleans, LA (Orleans Parish).

OBH plans to accomplish the above by: 1) development of an integration team consisting of qualified community health programs, community health centers, family, youth, peers, and other consumer organizations to obtain guidance and feedback for quality improvement, sustainability, and scalability of increased access to health care services; 2) enhancement of integrated primary and behavioral health care services provided by four qualified community health programs (behavioral health centers) or community health centers (FQHCs); 3) provision of integrated primary and behavioral health care services to adults with co-occurring mental illness and physical health conditions or individuals with a substance use disorder; 4) implementation of

evidence-based practices/activities in four qualified community health programs or community health centers; and 5) development of policy changes as a result of coordinated, integrated care. OBH will monitor the provider organizations' performance through data collection and evaluation, conducted by the Louisiana Public Health Institute (LPHI).

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

No, however in March 2019, contracts were signed with the identified providers and the LPHI began the evaluation of the initial data that was collected the following month. Currently, efforts to develop a sustainability plan are underway.

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 among many entities represent a best management practice.

Accomplishment #2: Center for Evidence to Practice

A. What was achieved?

In 2018, the Center for Evidence to Practice: Expanding Access to Evidence-Based Practices in Behavioral Health was launched.

B. Why is this success significant?

The Center for Evidence to Practice: Expanding Access to Evidence-Based Practices in Behavioral Health is a joint initiative of the Office of Behavioral Health (OBH) and the LSU Health New Orleans School of Public Health. This is significant to citizens across the state as behavioral health evidence-based practices are therapies that have undergone the multiple, rigorous, randomized controls vital to determine whether a practice has proven to be effective.

C. Who benefits and how?

Louisiana citizens including behavioral health providers, and children, youth, and families.

D. How was the accomplishment achieved?

As noted above, this effort is a joint initiative of the Office of Behavioral Health (OBH) and the LSU Health New Orleans School of Public Health. The Center for Evidence to Practice is contracting with the Managed Care Technical Assistance Center of New York (MCTAC). This effort has also led to many tasks that are being implemented including the development, completion, and launching of a website, and further current, ongoing work towards the designing of a strategic plan and online map of providers available with training in evidence-based practices.

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

The purpose of the arrangement is for MCTAC to guide the Center for Evidence to Practice in the design of a strategic plan for supporting behavioral health agencies across the state of Louisiana in their transitions to the provision of Medicaid Managed Care. MCTAC's expertise and lessons learned from the implementation of a successful program in New York State will be essential to informing how the Center for Evidence to Practice approaches the design of technical assistance for behavioral health agencies 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 #3: Louisiana State Opioid Response (LaSOR) Program

A. What was achieved?

LaSOR funding was received on October 1, 2018. Between that time and the end of State Fiscal Year 2019 (June 30, 2019) those funds have been used to address the Opioid Epidemic on a variety of fronts with evidenced-based approaches to improve outcomes. In the formerly referenced time LaSOR has contracted with ten (10) Opioid Treatment Programs (OTPs) to provide Medication Assisted Treatment (MAT) to 209 individuals; distributed 3,406 Narcan kits throughout the Local Governing Entities (LGEs); provided 575 drug disposal bags for safe disposal of opioids; provided 636 prescribers with training and education, and Crisis Mobile Teams (CMTs) have reached 8,958 individuals and reversed 12 potential overdoses.

B. Why is this success significant?

LDH has received over 50 million dollars in opioid related grants that contribute to building out access and service deliver models to treat substance use disorders. The Louisiana State Opioid Response (LaSOR) Program will enhance existing statewide prevention, treatment, and recovery support services for individuals with or at risk for opioid use disorder (OUD).

C. Who benefits and how?

The priority populations to be served are: (1) the under- and uninsured, (2) the criminal justice population, (3) state-recognized tribes, (4) pregnant women or women with infants experiencing neonatal opioid withdrawal symptoms, and (5) school age children (for prevention).

D. How was the accomplishment achieved?

LaSOR supports MAT for over 2,000 unduplicated individuals, as well as recovery support

services for 80 individuals (40 per year for two years), and these individuals will be served over the two year grant agreement. The goals of LaSOR were: 1) increase access to Medicated Assisted Treatment (MAT) for the under- and uninsured with an OUD diagnosis; 2) increase access to recovery support services for patients on MAT and those reentering communities from criminal justice settings; 3) increase outreach to community programs; 4) identify and address needs of state-recognized tribes; and 5) increase public and professional awareness and education for prevention and treatment of OUD.

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

This list of coordinated prevention, treatment and recovery support services will increase Louisiana's capacity to address issues of opioid use across our state which is aligned with our strategic plan regarding substance use disorders prevention and enhancement of treatment efforts. LaSOR utilizes the existing Strategic Prevention Framework-based infrastructure as a basis to implement prevention EBPs and best practices statewide. Strategies include education through the new Prescription Drug Abuse Prevention Module of Life Skills Training and Generation Rx; strategic placement of prescription drop boxes statewide; distribution of Narcan Kits to first responders, jails, and emergency room departments for distribution to patients at discharge; and prescriber training and education. LaSOR will enhance and expand MAT treatment availability statewide by building the capacity of the 10 Opioid Treatment Programs (OTPs) and Office Based Opioid Treatment (OBOT) providers through the hub and spoke model, where the OTPs will be the hubs and the OBOT providers will be the spokes. OBOT providers will receive support from Spoke Care Teams, education and consultation from Tulane University through academic detailing and Project ECHO, and psychiatric consults from Louisiana State University Health Sciences Center. Crisis Outreach Mobile Teams will provide outreach services and offer mobile peer recovery services, including recovery coaching, within the state's communities. Women with OUD who are either pregnant or have a child with neonatal opiate withdrawal symptoms will be targeted through a Screening, Brief Intervention, and Referral to Treatment (SBIRT) pilot project at a local hospital. Recovery support for individuals with OUD will be enhanced by educating Oxford Home residents on MAT to discourage discrimination against persons on MAT, as well as the expansion of Oxford Houses statewide and referral of the state prisons' re-entry population to Oxford Homes. Finally, the needs of state-recognized tribes will be identified through a thorough needs assessment and addressed through strategy implementation.

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?

We are on-target with most of our goals, and have exceeded our goals for several of the milestones set in our strategic plan. Our strategies appear to be effective and rooted in evidence-based techniques and practices. We have attempted to identify the potential outcomes and anticipate yielding positive returns.

- **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 are making significant progress toward efforts for Opioid Response and the Department of Justice Agreement initiative, My Choice Louisiana. OBH has organized the response to the opioid crisis in several ways. OBH is addressing the epidemic through prevention, intervention, treatment and recovery.

In 2014, the Department of Justice (DOJ) initiated an investigation into the state of Louisiana's mental health service system to assess compliance with Title II of the Americans with Disabilities Act (ADA). Following this investigation, in 2016, the DOJ concluded 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. In June 2018, the State of Louisiana and LDH signed an agreement with the DOJ to help ensure compliance with the ADA, which requires that the State's services to individuals with mental illness be provided in the most integrated setting appropriate to their needs. Through My Choice Louisiana, the State began transition planning and support, as well as screening and evaluations, to all individuals with serious mental illness (SMI) who are currently living in a nursing facility. For individuals who may face nursing home placement, the State continues to improve on diverting these individuals to appropriate community-based 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?

Opioid Response Plan Progress is largely due to the efforts of LDH, and regarding the Opioid Response Plan OBH is leading the way and the initiatives surrounding opioids.

My Choice Louisiana: LDH, including OBH and OAAS, are working to transition as many citizens as possible with assistance from external entities. The leg-work and planning is solely on the LDH

agencies involved.

- 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?)

Opioid Response: OBH has allocated existing and new resources to fulfill the needs of responding to this epidemic. All available resources including media technology like Project ECHO contracting and evidence-based methodologies like the Hub and Spoke model and MAT are being engaged for the efforts.

My Choice Louisiana: Within OBH, additional positions have been hired and strategic actions have been employed to produce successful results. New policies and processes have been implemented related to the PASRR process.

- 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?

Opioid Response: While response to all health disparities, inequities, and issues affecting Louisiana citizens is the primary concern of LDH as a whole, OBH has been the chief agency and leader concerning responding to the opioid crisis working closely with the Office of Public Health. OBH has been successful in its endeavors thus far, and plans to continue the response are ongoing.

My Choice Louisiana: This effort – as mentioned earlier – has been a joint effort by all LDH agencies, with OBH and OAAS as the leading entities. OBH has contributed to the successful implementation of the planning and the achievement of goals.

- Other? Please specify.

NONE

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

OBH anticipates that progress will continue.

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

  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?

OBH is in the progress of revising and updating the strategic plan for FY 2020. Revisions will include opioid response efforts and the My Choice program, which are long term efforts needing ongoing and consistent resources in order to achieve success.

- **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.

Agency-level goals and objectives included in the strategic plan are further translated into comprehensive work plans which describe the action steps that will be taken to accomplish the objective, associated timelines, and person responsible for each action step; these work plans are reviewed and updated on a regular basis by gathering input from all levels of the agency's functional areas. Discussions are conducted with Team Leaders and participants representing functional areas essential to support agency priorities. Further, agency goals and objectives are embedded in the performance planning and evaluation process for employees.

III. What significant department management or operational problems or issues exist? 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

Staffing/Necessity to Increase Staffing

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

In consideration of OBH's current responsibilities, we are not staffed at the level necessary to adequately meet the monitoring needs associated with our Department of Justice Agreement for the My Choice program; federal grant-funded programs; Medicaid managed care funded programs, as well as our programs funded through statutorily dedicated tax revenue for gaming and tobacco. In addition, the rise in need for increased response to the opioid epidemic requires additional resources.

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

Yes. Limited staffing may impede OBH's ability to efficiently address the goals of the office set forth in our strategic plan.

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

All of the units within OBH are impacted by limited staffing. Our network, quality, clinical, data and fiscal staff are all tasked with monitoring state and federally funded programs across Louisiana. These staff cross all of our organizational units, resulting in deficits throughout the office. OBH has consistently worked to streamline processes, and maximize efficiencies in order to achieve the most successful outcomes. However, in light of limited human resources, we are forced to prioritize our areas of focus, and therefore, limit the scope of coverage that we would otherwise address, given adequate staffing.

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

In addition to staff burnout, our providers and contractors are at risk from this issue as well. This, in turn, places our recipients at potential risk of not receiving the highest quality and most effective prevention, education and treatment services to best address their needs.

5. How long has the problem or issue existed?

As both Medicaid and federal grant funded services have expanded over the last five plus years, and no additional funding have resulted in instances of reduced staff, this issue has continued to increase in volume and concern. Efforts to respond to the opioid epidemic have recently increased and the requirements associated with the My Choice program are evolving.

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

Limited staff, combined with shifting priorities of the agency have all contributed to our human resource shortage issues.

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

Without an increase in staffing levels, OBH is at risk of non-compliance with federal guidelines, litigation, legislation and contractual standards. Performance is subject to fail from both a staffing perspective, as well as a programmatic perspective.

B. Corrective Actions

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

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

The Administration and Civil Service should correct this problem.

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

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

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

- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

4. Do corrective actions carry a cost?

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

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

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

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

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

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

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

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

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

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

☒ Program evaluation by in-house staff

Program performance is monitored on an ongoing basis utilizing Strategic Plans and Operational Plans.

☐ 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 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:

1. Title of Report:

Prevention Management Information System Reporting on Prevention Services (Quarterly and Annual)

2. Date completed:

July 1, 2018 – June 30, 2019

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

The Office of Behavioral Health (OBH) is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the Substance Abuse Prevention and Treatment (SAPT), 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:

Data was analyzed 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 2019 Prevention Services provided evidence-based services to 96,330 enrollees.

FY 2019 block grant funded one-time services provided to the general population reached 21,442,442 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 Services
Agency & Program: LA Department of Health, Office of Behavioral Health
Telephone: 225.342.5705
Email: Leslie.BroughamFreeman@la.gov

1. Title of Report or Program Evaluation:

Synar Report: Youth Access to Tobacco in Louisiana

2. Date Completed:

December 21, 2018

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 $69,900.00 ($100.00 per compliance check x 699 checks). The total cost to prepare and complete the Annual Synar Report was $70,000.

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 2019 is 11.1%.

7. Major Recommendations:

OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2019 report and will adhere to any future recommendations, as warranted.

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

An annual report is generated by SAMHSA including a Table listing the Synar Retailer Violations (RVRs). Louisiana was ranked among the top states in compliance, in the FY 2013 report (most recent on file). The SAMHSA report can be viewed at https://store.samhsa.gov/shin/content//SYNAR-14/SYNAR-14.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 2019 Annual Synar Report is available by hardcopy, and may be accessed online at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1390.

10. Contact Person:

Name: Dr. Leslie Brougham Freeman
Title: Director of Prevention Services
Agency & Program: LA Department of Health, Office of Behavioral Health
Telephone: 225.342.5705
Email: Leslie.BroughamFreeman@la.gov

1. Title of Report or Program Evaluation**:**

SAMHSA Block Grant Annual Reporting (SAPT and CMHS)

2. Date completed:

Louisiana's CMHS and SAPT Behavioral Health reports must be submitted to SAMHSA no later than December 1st of each year. Some components of reporting are completed quarterly with an annual review prior December 1. If OBH misses the statutory date for submitting the reports, it will not receive any federal Block Grant funds for that federal fiscal year.

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:

Catherine Peay, Block Grant State Planner
LDH, Office of Behavioral Health
Telephone: 225.342.7945
Email: Catherine.peay@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

Department: **Louisiana Department of Health (LDH)**
09-340 Office for Citizens with Developmental Disabilities

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

Undersecretary: **Cindy Rives**

Assistant Secretary: **Julie Foster Hagan**

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: Completion of Developmental Disabilities (DD) Council Partnership with Providers Supporting People with Complex Needs and Development of Complex Needs Supplemental Service

A. What was achieved?
Collaboration with the Louisiana Developmental Disabilities (DD) Council concluded this year with completion of all four provider partnerships. Provider staff received training in person-centered thinking, positive behavior supports, medical/ nursing needs, and nutritional/physical supports followed by intensive technical assistance related to

supporting individuals with complex medical or behavioral health needs through the initiative. The initiative involved commitment on the part of the provider to a year-long partnership with the DD Council and OCDD, and provider agencies receive reimbursement for completion of training, implementation of recommendations for enhanced quality services,, and improved outcomes for participants with option for an extension of the partnership to a second year. Significant outcomes were achieved and maintained by all providers. Significant Health and Behavioral Health Outcomes achieved across providers included: 1) decrease in emergency room visits; 2) decrease in critical incidents; and 3) decrease in falls. Significant Personal Outcomes Improvements for Individuals for whom technical assistance was provided included: 1) increased community connections and family involvement for individuals; 2) increased independence (including reduction in needed support from staff for some individuals); and 3) focus on competitive employment and actions toward employment. Each provider also achieved some identified provider specific outcomes. OCDD's Team presented the outcomes of the project at this year's National DD Council Conference. Results of the pilot and analysis of the contributing factors and needed resources and associated costs to better meet the needs of individuals with complex support concerns was used to frame the complex care supplemental payment option for which OCDD just received Center for Medicare & Medicaid Services (CMS) approval. This option was drafted in conjunction with stakeholders and will allow for supplemental payments to providers who support individual's with identified complex needs (per outlined criteria) that require additional funding to meet identified needs. OCDD is currently operationalizing the criteria and process for approval, and implementation will occur in FY 2020.

B. Why is this success significant?
The success of the partnerships highlights the outcomes that are possible for individuals when these agencies are provided with foundational training and key tools for implementing agency changes aimed at supporting individuals with complex needs. It also assisted in defining and formalizing needed training, tools, and support that can be spread to other provider agencies, as well as provided data and information regarding recommendations for systems change considerations based on lessons learned in the project. The success of this project resulted in the DD Council successfully advocating for funding for an enhanced rate for individuals with complex medical and/or behavioral health needs.

C. Who benefits and how?
The provider and the participants supported by the provider benefit most directly with enhanced outcomes evidenced including significant improvement in quality of life. As the project shaped systems recommendations and as OCDD is able to develop methods for expansion and sustainability, the larger Developmental Disabilities Services System and all participants and their families will benefit through improved supports and outcomes. As individuals experience improved outcomes, cost shifting and avoidance may occur as individuals will need to access more costly, acute services less often and some individuals will gain independence resulting in less reliance on paid services.

D. How was the accomplishment achieved?
OCDD partnered with the DD Council to achieve this goal. The DD Council allocated funding for this project. Applications were taken by the DD Council for interested providers, and the DD Council chose providers based upon application information. OCDD designated teams including a team lead, person-centered thinking and planning expert, behavioral health professional, nurse, and allied health professionals for each provider agency. This team partnered formally with the agency's executive team throughout the project. The agency identified direct support staff who work with individuals with complex needs for participation as well as key participants in need of enhanced supports. Intensive training and technical assistance were provided along with guidance to develop agency protocols and quality practices to sustain enhanced outcomes. OCDD worked collaboratively with stakeholders to develop the supplemental payment option to enhance providers' ability to meet the complex needs of specific recipients.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. Components are aligned with goals II, III, and IV of OCDD's Strategic Plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. OCDD uses evidence-based approaches in person-centered thinking, positive behavioral supports, and intensive medical and allied health supports within its training content and support approaches. Tools developed for provider agencies support the implementation of these evidenced-based approaches. Supporting individuals with complex needs in community-based settings is consistent with national best practices.

Accomplishment #2: Implementation of Rate Restoration for Home and Community-Based Waiver Providers

A. What was achieved?
The Office for Citizens with Developmental Disabilities (OCDD), in partnership with families, advocates, and state-wide provider organizations, was able to secure funding for the Restoration of Home and Community-Based Service rates to be restored to their state Fiscal Year 2008-2009 levels.

B. Why is this success significant?
Louisiana saw significant reductions in available funding for all state services during state Fiscal Years 2008 through 2013. The state fiscal woes required the Louisiana Department of Health to make cuts to its Medicaid program. The state's Home and Community-Based Services (HCBS) Waivers were required to cut provider rates to help the state's Medicaid program stay within its budget as required by law. These cuts resulted in over $35 million dollars in reductions to HCBS providers without a corresponding decrease in service utilization. The restoration of these rates provided significant relief to the program's provider base as many were operating at reduced margins and some at an annual loss.

C. Who benefits and how?
The immediate beneficiaries of the Rate Restoration were the HCBS Waiver providers who can now remain viable financially. The secondary beneficiaries were the direct support staff many of whom received increased compensation for their hours of support provided to the program's participants. The higher compensation could lead to staff stability which would benefit the program's participants through consistency and competent care from long-term caregivers.

D. How was the accomplishment achieved?
The initial funding for the first six months of the Rate Restoration was drawn from the New Opportunities Waiver Trust Fund. This funding provided immediate relief for the program's provider base until the governor signed HB105 of the 2019 Louisiana Legislative Session into law. This Act provided permanent funding to continue the restored rates into the future.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. The increased rates should help to stabilize the current provider base and possibly reduce employee turnover, two things which contribute to the state's ability to provide 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: Full implementation of Developmental Disabilities Tiered Waiver System

A. What was achieved?
OCDD has fully implemented its Tiered Waive System. While there are still four distinct waivers, all new individuals who meet the necessity of a waiver are assigned to the most appropriate waiver. There are approximately 12,000 individuals in the four developmental disabilities waivers.

OCDD continues to work on consolidation of all four waivers (New Opportunities, Supports, Residential Options, and Children's Choice) by 2021. Then, the components of all four waiver will be in one waiver, which will allow for easier access and changes as individuals' life situations change over time.

Since the full implementation has begun, there have been some major achievements:

1. There is no longer a waiting list for individuals "waiting" for waiver services. (Note: At one time, there were over 16,000 individuals on the DD Request for Services Registry. Of those individuals who the Office was able to contact and still desired services, over 13,000 screenings were completed.) Individuals are screened timely, and other services (state plan, etc.) may be recommended that meet individual/family

needs at that particular time in his/her life.
2. Individuals requiring "emergent" and/or "emergent" services are screened and may be offered waiver/support services in a more-timely manner.
3. Individuals are choosing the most appropriate waiver (the one they need), rather than most going to the New Opportunities Waiver when they get a waiver offer. Many individuals are continuing to remain in the Children's Choice waiver after they turn age 19 because it is the waiver that best meets their needs.

B. Why is this success significant?
Full implementation of the Developmental Disabilities Tiered Waiver System is allowing individuals who most require waiver services to receive them and to acquire them in a timely manner. It has also allowed the education of family/stakeholders enabling them to access state-funded services that they qualified for and to receive the services that best meet their needs. The full implementation has the following benefits:

1. Individuals who have a Statement of Approval for Intellectual/Developmental Disabilities (I/DD) services are able to get a Screening of Urgency Need (SUN) screening that shows what an individual may need.
2. Individuals who meet the screening for a waiver are not put on a waiting list; they are being offered a waiver.
3. There can be some predictability concerning budgets - both waiver and state plan services.

C. Who benefits and how?
Individuals, families, stakeholders, providers, support coordination agencies, state offices, and Local Governing Entities benefit from the full implementation of the Tiered Waiver System. If an individual meets the screening for a waiver, then that person receives one. At this point in time, there is no waiting for a waiver. All are aware of the process, and individuals are assigned to the waiver that most appropriately meets their individual needs. The Tiered Waiver System allows for movement within the tiers as an individual's life changes.

D. How was the accomplishment achieved?
This was accomplished through continued training and feedback with the core stakeholder group, support coordination agencies, provider agencies, Local Governing Entities, and through work with other departments within Louisiana Department of Health (i.e., Medicaid, Medicaid Program Supports and Waiver, etc.). OCDD has monthly phone calls/meetings with support coordination agencies and quarterly provider calls to provide information concerning the Tiered Waiver process as well as other topics. In addition, work has been done with the data contractor, Statistical Resources, Inc., to ensure that all system requirements are in place such that each individual is receiving prior authorizations for services.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. This accomplishment aligns with OCDD goals.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. The implementation of the Tiered Waiver System incorporates national best practices. OCDD/LDH leadership have been invited to talk at national organizations' conferences concerning Louisiana's Tiered Waiver System and the elimination of our waiting lists.

Accomplishment #4: Automation of Request for Services Registry Prioritization Project

A. What was achieved?
Automation of the Developmental Disabilities (DD) Request for Services Registry (RFSR) Prioritization Project was completed. OCDD was able to move forward with automation of transmittal information from the Local Governing Entities (LGEs) into a Louisiana Service Reporting System (LaSRS) database developed by Statistical Resources Inc. (SRI). OCDD's RFSR manager now reviews the request for services documents and issues approval or rejection. The automation process affects current operations of LGE staff, including the following:
1. Addition of individuals to the DD RFSR;
2. Closure of individuals on the DD RFSR;
3. Re-opening individuals on the DD RFSR; and
4. Requesting Screening of Urgency of Needs (SUN) screenings.

B. Why is this success significant?
With the development of this automation, OCDD will have a strong audit trail of checks and balances. LaSRS will be able to identify individuals who are open and closed on the Request for Services Registry, as well as the screening scheduling. Additionally, OCDD will be able to generate reports of new individuals, regular interval re-screenings, and re-screenings based on a change in current support system.

C. Who benefits and how?
In addition to staff, individuals with intellectual/developmental disabilities and families will benefit from the automation of the Request for Services Registry. Having this information in a single system will allow efficiencies in tracking an approved request for services registry date and in scheduling of screenings. The automation system will be beneficial by aligning needs to individuals in a consistent manner.

D. How was the accomplishment achieved?
OCDD worked closely with Statistical Resources Inc. and the Local Governing Entities (LGEs) to develop this automated system. LGE offices will now have the ability to upload the information and receive timely information regarding approval or rejection status. LGE offices had requested a standardized process for submitting documentation for review to be added to the Request for Services Registry. Training on the automated system was conducted by SRI with LGE offices in December 2018 via webinar.

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

II below.)
Yes. This automation will improve the services delivery system aligning with goals in OCDD's Strategic Plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. This methodology represents a best management practice in terms of tracking service delivery for individuals.

Accomplishment #5: State-Wide Transition Plan for Home and Community-Based Services Settings Rule

A. What was achieved?
OCDD was able to bring providers closer to compliance with the Home and Community-Based Services (HCBS) Settings Rule by providing significant staff resources, including Local Governing Entity (LGE) staff; conducting onsite visits with providers; providing technical guidance and assistance; and hosting regional round table discussions with providers among other resources. Efforts were also focused on assisting with the development of transition plans for each provider who required such a plan; this transition plan is ultimately their plan to bring them into compliance with the Settings Rule. Additionally, through financial assistance of the Developmental Disabilities (DD) Council, OCDD was able to provide online training in the area of Community Employment to all vocational providers, support coordination agencies, LGE staff, and OCDD state office staff. Through partnering with the Governor's Office of Disability Affairs (GODA), OCDD was able to obtain the Employment First State Leadership Mentoring Program (EFSLMP) grant that has focused on Provider Transformation and Regional Capacity Building in two regions of our state. OCDD has worked with the GODA on the Employment First Task Force and also on the State as a Model Employer (SAME) Task Force in an effort to boost employment for individuals with intellectual/developmental disabilities.

B. Why is this success significant?
This progress has been significant as OCDD has put individual community employment at the forefront of its initiatives, and this progress is leading the services system in the right direction bringing us closer to compliance with the HCBS Settings Rule. The rule supports enhanced quality in HCBS programs, adds protections for individuals receiving services, and reflects CMS' intent to ensure that individuals have full access to the benefits of community living and are able to receive services in the most integrated setting. The state will be submitting the Statewide Transition Plan (STP) for final approval by the end of 2019.

C. Who benefits and how?
The individuals that are supported by the services system will benefit the most from this initiative as they will have the benefit of understanding what going to work can mean for them and will receive guidance in choosing a career path to get real jobs in the community. We believe that the benefits from these efforts will allow more individuals

to have a more integrated community life that is typical of those without disabilities.

D. How was the accomplishment achieved?
These efforts were achieved by dedicating significant staff resources, including the LGE staff, who conducted onsite visits with providers and provided technical guidance and assistance through many mediums. They provided training and a forum to share ideas and had discussions among providers who were already making progress in the way of compliance with those who were struggling to meet compliance. Efforts were also focused on assisting with the development of a transition plan for each provider who required a transition plan and providing guidance in how to accomplish compliance. OCDD was able to bring in technical guidance and assistance through a grant which provided technical assistance to four providers on provider transformation. Also, regional capacity building was part of this grant and allowed the regions to form teams to help strengthen the efforts of community employment. The information will be shared with other providers in the transformation process and will also help to build regional teams that will improve employment outcomes for individuals with intellectual/developmental disabilities. OCDD was also able to provide online training in community employment.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. This accomplishment contributes to the overall success of the strategic plan in providing service delivery in a more individualized and integrated manner and to efforts in the overall System Transformation.

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 progress that has been made toward compliance with the HCBS Settings Rule reflects best practices and aligns up with the CMS guidance and the Employment First philosophy. OCDD will continue to ensure that individuals have full access to the benefits of community living and are able to receive the services they choose in the most integrated setting.

Accomplishment #6: Intermediate Care Facility Programmatic Unit - Phase 2

A. What was achieved?
In 2018 to meet the intent of the Developmental Disability Law and to facilitate enhanced quality of life outcomes for individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) particularly those with behavioral and medical challenges, OCDD initiated a program to engage private ICF/IID provider agencies in a partnering to ensure programmatic oversight of their residential programs. The goal of the oversight is to ensure that supports and services are being planned and provided in a truly person-centered manner and that supports and that services are having the desired outcomes. The initiative provided technical assistance, guidance, and training to facilitate the successful collaborating with private ICF/IID provider agencies.

In FY 2018-19 following successful implementation of the pilot, the ICF/IID Programmatic Unit expanded the initiative. Additional staff for the Programmatic Unit

were incorporated into the unit from other areas within the OCDD services system as the Office continued with expansion of the initiative and further transformation of service delivery. In Phase 2, the unit began work with six new providers and accepted crisis cases. The unit successfully completed work with one provider, which concluded in training every staff person in the large private ICF/IID on the unit's five core areas.

B. Why is this success significant?
Through the unit's work during the pilot, vital information was gathered to assist in further program development and finalization of the process. The unit will continue to evaluate program outcomes and effectiveness to ensure the process enables the unit to achieve goals set through the unit's programmatic indicators.

C. Who benefits and how?
People supported in private ICFs/IID and their providers benefit from this initiative. Due to the success of initial outreach with providers regarding the unit, a number of providers volunteered to collaborate with the unit in Phase 2. This has led to success in a number of components of the unit's services, which includes training providers on how to deliver person-centered quality services. By providing oversight to ICFs/IID, OCDD has the ability to improve outcomes for people who reside in ICFs/IID statewide, through the unit's person-centered approach.

D. How was the accomplishment achieved?
The success attained thus far is largely due to OCDD's commitment to the Programmatic Unit through the reallocation of resources from a number of different areas within the Office to provide the necessary staff to fulfill the goals of the unit. The Programmatic Unit will further enhance the Office's efforts to meet its goals related to providing person-centered planning and enhancing the service system's ability to support people with complex behavioral, mental health and/or medical needs within their service setting.

OCDD also completed a preliminary survey with families of people who moved from the large Cooperative Endeavor ICF/IID facilities to gather their input for possible topics for future areas of training and areas to note during on-site observations based on their personal experiences post-move with their family member's current providers of ICF/IID services.

The unit established programmatic indicators which assisted in further program development. After the pilot ended, a thorough review of provider progress and program implementation assisted in making critical assessments of the program's effectiveness and incorporate major modifications to the process to ensure outcomes align with the unit's programmatic indicators.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, the accomplishments within the ICF/IID Programmatic Unit align with several of the OCDD Strategic Plan goals, with a specific focus on moving ICFs/IID to person-centered thinking and planning.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Focusing on the individual, a person-centered thinking and planning approach, is best practice. The ICF/IID programmatic unit's focus is moving providers to provide services driven by this approach.

Accomplishment #7: Developmental Disabilities Council Partnership on Grant to provide Training to Employment Providers and other Stakeholders on Coaching for Supported Employment

A. What was achieved?
In an effort to identify ways to promote Louisiana as an Employment First State, OCDD identified a training opportunity that would increase staff ability to assist individuals with obtaining individual, competitive integrated employment in the community. This training utilizes real-life, best practices to get people talking about the necessary information to assist people in identifying career paths and move people toward real employment in the community. The Developmental Disabilities (DD) Council provided financial assistance to train 600 people who provide support to the individuals served within OCDD. A contract with Elsevier Performance Manager was obtained, and the online training is being provided to participants.

B. Why is this success significant?
It is our belief that if people are empowered through this training, it will improve overall discussions and outcomes related to employment. OCDD believes that individual, integrated community employment is very important to the individuals we support and should be the primary option for employment. This belief aligns with the Center for Medicare & Medicaid Services (CMS) Settings Rule in that the intent of the rule is for individuals to have full access to the benefits of community living and receive services in the most integrated setting.

C. Who benefits and how?
The individuals who receive services through OCDD will benefit the most as they will have a greater success of achieving real jobs in the community and thereby enhancing their lives and allowing them to lead lives that are typical for those who do not have a disability. Also, providers were able to receive free training that is normally cost prohibitive for most as well as it was an online training and could be completed on their own schedule. This training will also allow everyone to understand and be consistent in discussing employment. The training was provided to staff from OCDD state office, LGE offices, support coordination agencies, and vocational provider agencies.

D. How was the accomplishment achieved?
The training was accomplished through a partnership with the DD Council and was provided over a span of six months to participants.

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

II below.)
Yes. This accomplishment supports integrated community employment for people with intellectual/developmental disabilities and aligns with OCDD's strategic plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. This training is recognized as best practices in community employment. Those who complete the training are prepared to assist individuals prepare for and get the job. The partnership with the DD Council was very beneficial and helped both the DD Council and OCDD accomplish a goal that was important to both agencies.

Accomplishment #8: EarlySteps' Success in Exceeding Performance Standards related to Development and Implementation of the State Systemic Improvement Plan

- **Development of Individual Family Service Plans (IFSPs) within 45 days of referral:**

A. What was achieved?
One of the primary program purposes of EarlySteps is to enhance the capacity of families to meet the needs of their infants and toddlers with disabilities. A key measure of success for addressing family needs is timely service delivery to eligible infants and toddlers.

A focus on improving the State's compliance related to this requirement has been in place since 2008. A performance indicator (#24664) is included in OCDD's Strategic Plan and Operational Plan to monitor compliance with this requirement. The current performance standard for this indicator is 97%. In FY 2018-2019, this standard was exceeded with achievement of 100%.

B. Why is this success significant?
The success is significant because it means that children and families will receive supports related to their child's developmental needs timely and in accordance with best practices.

C. Who benefits and how?
The benefit is direct to children and families. Since the children exit the program at age 3, timely development of the Individual and Family Plan (IFSP) maximizes the time children spend in early intervention and the subsequent developmental improvement measured from entry to exit.

D. How was the accomplishment achieved?
This EarlySteps' goal was accomplished by careful monitoring of system performance. EarlySteps can generate reports from its data system and closely track timelines for completion of IFSPs by its entry offices. During the previous fiscal years, when performance was less than 100%, monitoring was triggered to determine the reason for the delay. The system now tracks delays which are due to family reasons as compared to system or internal office reasons; if the delay is due to a system reason, a finding is issued, and the entry office receives technical assistance in managing its timelines. As a result of

this continuous review process, there were no system reasons for timeline delays identified in FY 2018-2019.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. Annually, the US Department of Education, Office of Special Education Programs, reviews state performance data against targets. Louisiana has shown continued improvement in meeting expected performance resulting in a higher determination from "needs assistance" to "meets requirements." This accomplishment aligns with OCDD goals.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. This accomplishment represents a best practice in terms of tracking and monitoring service delivery for individuals.

- **Implementation of the EarlySteps State System Improvement Plan (SSIP)**

A. What was achieved?
Fiscal year 2018-2019 marked Year 3 of the state's Individuals with Disabilities Education Act (IDEA), Part C Statewide System Improvement Plan (SSIP) to improve child outcomes through early intervention supports that are focused on family concerns, priorities, and resources and provided through a team-based approach. As a result of targeted implementation, EarlySteps has maintained the increase in the number of children who exit the system at the level of their typical peers as well as successful implementation of early intervention evidence-based practices, the Division of Early Childhood Recommended Practices (DECRPs, 2016), specifically in the teaming and collaboration practice area.

B. Why is this success significant?
Key outcomes for families whose children are in early intervention are that families report that early intervention helped the family help their children develop and learn. The focus for EarlySteps SSIP is to use evidence-based practices directed to family priorities to support this outcome. In a survey assessing this outcome, 99% of families responding reported that this was a benefit of early intervention for their family.

C. Who benefits and how?
Children and families participating in EarlySteps benefit from this success. Prior to implementation of the SSIP, service delivery in EarlySteps was fragmented and lacked coordination and communication across Individual and Family Plan (IFSP) team members. The focus on improving team practices using evidence-based practices of the DECRPs will continue to support child development and family priorities

D. How was the accomplishment achieved?
To accomplish improvement, EarlySteps targeted two main areas of system support: infrastructure improvements and practice area improvements.

- An improved child outcome measurement process was implemented in March 2017. This process was designed to result in a more sensitive measure of child improvement from entry to exit from early intervention. The previous calculation used was not sensitive enough to measure improvement resulting in too many children not showing measurable progress. The new measurement process resulted in a 20% improvement in the number of children exiting the system at the level of their typical peers in FY 2017-2018 and this level was maintained in FY 2018-2019. EarlySteps increased the number of 'entry to exit' scores available by 70%, or 51% of those children exiting to run comparison scores. These changes will align Louisiana's results with those of other states in these measures.
- The focus on team-based decision-making increased such that IFSP teams were trained and implemented a standard process for making service decisions based on child needs and family-identified priorities. The teaming and collaboration focus area of the DECRPs has resulted in an additional 4% increase in IFSP team meeting participation compared to the previous year.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. During the planning phase of the SSIP, EarlySteps developed an implementation and evaluation plan to assess its performance results. The outcomes achieved to date contribute to its ongoing success as shown by the determinations received from OSEP and positive feedback from EarlySteps families and other stakeholders.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. To implement practice change using the DECRPs, EarlySteps utilized specific components of the National Implementation Research Network Implementation Science methodology. That is that effective practice change depends on the key features of: stakeholder involvement and communication, careful practice selection and design, adult training practices including coaching, and ongoing measurement for fidelity of implementation.

Accomplishment #9: Flexible Family Fund Program Reform

A. What was achieved?
The Flexible Family Fund (FFF) Rule and Manual were updated, and the new process was implemented statewide. Some of the key changes implemented include addition to qualifying exceptionalities, addition of other ways to submit applications, and changes in financial eligibility criteria. The FFF Rule was promulgated on April 20, 2019, and the updated manual was approved by OCDD Assistant Secretary on May 1, 2019. As of May 15, 2019, all Local Governing Entities (LGEs) have completed training and implemented the new process.

B. Why is this success significant?
The FFF program reform is a significant success because many individuals with intellectual/developmental disabilities (I/DD) will benefit from the changes, and the

administration of the program has been simplified and clarified.

C. Who benefits and how?
The FFF program changes benefit individuals receiving the FFF stipend by widening the entrance criteria to include some children who may have previously been excluded and also provide clarification to administer the program more effectively.

D. How was the accomplishment achieved?
The Developmental Disabilities (DD) Council formed a committee to review the current FFF manual and make recommendations for improvement. These recommendations were accepted by LDH. OCDD took lead in rewriting the FFF Rule to reflect the requested changes. While the FFF Rule was being promulgated, the FFF manual was updated to reflect the requested changes. The FFF Manual revision was completed in conjunction with promulgation of the FFF Rule. OCDD Regional Operations Director created training module for the new FFF process. This training was then provided to all ten LGEs in the state. The new FFF process was implemented on April 1, 2019.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. Implementing the changes recommended by OCDD stakeholders does contribute to the success of OCDD's strategic plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
This accomplishment also positively affected the FFF program administered by OBH. The User's Guide created to assist those administering the FFF I/DD Severity Screening Tool is a Best Management Practice that will help ensure the tool is administered consistently statewide.

Accomplishment #10: Expansion of Operation House Call ~ Louisiana

A. What was achieved?
Operation House Call refers to a program concept developed at the Arc of Greater Boston, by parents, and The Arc's Medical Director, Dr. David Coulter, in collaboration with the Boston University School of Medicine for medical students in pediatric rotation in 1991. Over 5,000 Medical Students and 158 families have participated in the Boston program to date with an average of eight orientations a year with 22 medical students in each class. The program concept was adapted in Louisiana through the Louisiana OCDD Resource Center in collaboration with Families Helping Families, LSU New Orleans Pediatric Residency Program, and Tulane/Ochsner Pediatric Residency Programs (Andrea Starret, MD and Susan Berry, MD) in 2007. In August 2018, Operation House Call ~ Louisiana expanded to include LSU Shreveport Pediatric Residency Programs (Andrew Love, MD). Operation House Call ~ Louisiana, since its inception, has educated 383 Pediatric and Medical residents. The program has 39 families who have volunteered to participate as host families. Operation House Call ~ Louisiana provides disability awareness training to medical and pediatric residents in their Pediatric Development

Rotation. Residents are required to attend an orientation by the Operation House Call Director and/or Program Coordinator at the beginning of their rotation. Residents are linked with a family and are required to make a home visit within the month of their rotation. Residents and families are given guideline questions addressing both medical and nonmedical issues which are collected at the end of the rotation. Families act as the educators, providing the residents with their personal experiences which offer a more holistic view of the person with a disability. The 383 Medical Residents who completed Operation House Call all completed Pre and Post evaluations which evaluated their knowledge, attitude, and perception regarding intellectual/developmental disabilities in community settings. All 383 residents experienced an increase in knowledge, attitude, and perception (100%). They also completed a twenty-one question Family Survey which evaluates the effectiveness of parents as educators of future physicians. All 383 residents reported learning topics regarding intellectual/developmental disabilities that they did not know prior to the Operation House Call visit with the family (100%). Finally, the thirty-nine families completed a thirteen question Post Evaluation following the Operation House Call Visit. All thirty-nine families reported a feeling of satisfaction by participating in the program. All thirty-nine families reported they knew they had taught the Resident at least one thing they did not know about living in the community with an intellectual/developmental disability prior to their visit. (100%).

B. Why is this success significant?
The program expands medical professional education early in these professionals' training. This collaborative approach increases access to needed medical care throughout the state in a manner that is also consistent with family and person-driven practices. It promotes the alignment of provision of these needed medical services with the mission, vision and values of OCDD and in a manner consistent with supporting individuals with disabilities to live/work/play in their local communities and keeps families together.

C. Who benefits and how?
Residents benefit from this program by gaining: a) Respect for case management responsibilities for families, b) Appreciation of potential for isolation of parents and siblings, c) Understanding of financial concerns of families, d) Understanding of the need for family support services, e) Knowledge regarding the importance of community integration and acceptance, f) Understanding of Quality of Life issues, g) Knowledge of People First Language, and h) Change in attitude. Families benefit from this program by a) Gaining personal empowerment, b) Having the opportunity to demonstrate the extraordinary challenges families face in caring for a family member who has a disability, c) Demonstrating natural acceptance and dignity, and d) Becoming effective educators of future physicians. The larger system(s) that support individuals with disabilities and their families benefit from the expansion of expertise and knowledge on providing medical care to individuals with intellectual/developmental disabilities and the increased access to quality services in this area.

D. How was the accomplishment achieved?
OCDD partnered with the LSU medical centers to implement this program. Families in the geographical area surrounding these training centers volunteered to participant as

family educators. OCDD completed a reorganization of its Resource Center to assure that adequate resources were available for the partnership.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. Components are aligned with goals III and IV of OCDD's Strategic Plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. The program is based on a demonstrated effective medical professional education model using collaborative relationships with families and individuals with disabilities. Supporting individuals with complex needs in community-based settings is consistent with national best practices.

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: 1) To provide a Developmental Disabilities Services System that affords people access to information about what services and supports are available and how to access the services; 2) To provide a person-centered system that supports person-centered thinking and planning approaches such that supports identified via needs-based assessments are provided in a manner that focuses on the person's goals and desires and addresses quality of life; 3) To increase the capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings; 4) To increase the capacity of the Developmental Disabilities Services System to support people with complex behavioral, mental health, and/or medical needs in all service settings; 5) To implement an integrated, full-scale data-driven quality enhancement system; and 6) To rebalance the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs. These initiatives also support OCDD's priorities which relate to system transformation, as well as effective and efficient service delivery. Effective utilization of available funding enabled Office accomplishments in FY 2018-2019. Progress on objectives remained steady, and current strategies were effective. The Office 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 2018-2019 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 services to supporting individuals with the most complex behavioral needs and currently acts as a service of last resort. Presentation of behavioral health needs and/or legal involvement represent the primary reason(s) for high cost institutionalization within the OCDD system. A performance indicator (#24259) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative. This year the efforts of the OCDD Resource Center Behavioral Health staff to support individuals referred with complex behavioral health needs resulted in maintenance of community living for 99% of the individuals supported. These results represent significant positive outcomes for these individuals and speak to the success and importance of this OCDD effort.

1. To what do you attribute this success?

    The OCDD Resource Center employs clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral/ medical support needs and utilizes a multi-disciplinary approach to providing consultation, training, and services that improves the ability of caregivers and providers to achieve positive outcomes for persons with complex needs.

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

    Progress is expected to continue. With implementation of triage initiatives,

Resource Center staff can provide services to a greater number of individuals and provider agencies. With implementation of crisis/diversion initiatives, Resource Center professionals, in collaboration with the Local Governing Entities, can initiate a consultation prior to escalation of a crisis such that one's community connection is maintained, or within a timeframe that increases the likelihood of diversion to the most integrated setting.

Enhanced Training for Community Professionals and Providers to Improve Capacity to Support Individuals with Complex Needs

The OCDD Resource Center utilizes the professional expertise of staff to develop and conduct training and technical assistance activities with community providers and professionals to enhance the ability of these providers and professionals to support individuals with complex medical and behavioral support needs. These activities are offered at the initiation of both the Office and actual provider/professional request. A performance indicator (#24696) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative. This fiscal year's efforts resulted in 99% satisfaction from the providers and professionals. Additionally, this fiscal year OCDD continued the joint Transformation Transfer Initiative (TTI) grant with the Office of Behavioral Health (OBH) to develop expertise among behavioral health professionals to provide treatment for persons with co-occurring developmental disabilities and mental health needs. The TTI grant has engaged behavioral health provider agencies across the levels of care in the behavioral health system. One Local Governing Entity (LGE) has successfully completed the grant activities. A multi-location Psychiatric Residential Treatment Facility (PRTF) and two LGEs remain in process of completing grant activities, and an initial training series for independent clinicians has been completed. In FY 2018-2019, OCDD's Resource Center clinicians offered seven multi-disciplinary professional Continuing Education presentations in addition to participating as part of the Louisiana American Association on Intellectual and Developmental Disabilities (AAIDD) annual conference. In the area of nursing outreach and training, the OCDD Resource Center nursing staff enhanced its activities with a specific emphasis on provider agency nursing consultants. OCDD employees a Resource Center registered nurse in each local area of the state, and these nurses collectively completed 437 outreach training events in FY 2018-2019. With regard to dental needs, OCDD began more formal outreach and coordination with Medicaid health plans and stakeholder groups and completed 29 outreach training events in this area in FY 2018-2019.

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 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 at its current pace. 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. Outcomes of the TTI grant will be used to develop joint proposals from OCDD and OBH regarding continued training and certification for community professionals. Professional continuing education and discipline-specific outreach events will continue with planning done each fiscal year.

Development of Electronic Assessment and Electronic Support Plan to Improve Person-Centered Practices and Efficiencies

OCDD's planning values are consistent with person-centered thinking, and the Office has been recognized nationally as an example of best practice in terms of its published *Guidelines for Support Planning*. Louisiana OCDD's ability to implement a person-centered approach to planning inclusive of resource allocation was a major factor in the Office's invitation to the National Home and Community-Based Services conference in 2015. OCDD developed the *Guidelines for Support Planning* in conjunction with Resource Allocation to ensure that person-centered values drove planning for individuals rather than simple cost. Person-centered planning determines the individual's vision and goals and sets how he/she spends his/her time and the people and places important to the individual. Resource Allocation assists in determining and planning for the amount and type of support the individual needs to see the important people, do the important things, go the important places, and move closer to his/her vision and goals. OCDD previously identified challenges in implementation of person-centered thinking and planning approaches and a drift from the *Guidelines for Support Planning* requirements in its Systems Transformation initiative which begin in 2012. This effort was shortly afterwards merged with the exploration of Managed Long-Term Supports and Services (MLTSS). OCDD did not undertake any outside efforts to address support coordination or person-centered issues due to the changes that would occur in these areas in any implementation of MLTSS (i.e., It was not prudent to invest resources to correct a problem in a system that at the time was targeted for a major reformation.). With the decision to halt and re-evaluate MLTSS, OCDD had previously engaged stakeholders across LGEs, providers, support coordination, advocacy groups, and participants/families to evaluate the current implementation of its person-centered approaches and to develop actions to address any needed changes, training/competency building, and accountability. OCDD completed and implemented a modified planning format, and automation of the format had also been completed. During this fiscal year, OCDD evaluated the Information Technology (IT) requirements to roll out this eISP (electronic Individual Support Plan) and an associated electronic assessment and completed internal testing of the product. Actions necessary related to development, internal testing, and IT support have been vetted and OCDD is now ready to complete a formal pilot of the eISP and electronic assessment.

1. To what do you attribute this success?

   OCDD formed a formal Person-Centered Workgroup composed of stakeholders including advocates, providers, LGE staff, and support coordination staff. Family informational sessions and input also occurred. The workgroup used information including data about program outcomes and challenges, participant and family input, and new federal requirements to develop the following: 1) an improved

needs-based assessment process, 2) a more person-driven planning process and document, and 3) a training, certification and mentoring process to infuse the Developmental Disabilities Services System with person-centered thinking skills and tools. Louisiana has received national recognition for its *Guidelines for Support Planning* in the New Opportunities Waiver which sets a good foundation for improvements in this arena. The new initiative and workgroup provided additional resources and focus to ensure ongoing quality improvements as well as improved implementation and sustainability of person-centered practices. OCDD devoted internal resources to testing and completion of the eISP and electronic assessment and collaborated with information technology (IT) related to resources needed to deploy these.

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 pilot of the eISP and electronic assessment will be completed in FY 2020 with implementation roll out to follow.

State-Wide Employment Initiative - Grant with Governor's Office of Disability Affairs (GODA)

Louisiana was selected to receive Training and Technical Assistance (T/TA) as both a Vision Quest State and a Core State for FY 2019 under the United States Department of Labor's (USDOL), Office of Disability Employment Policy (ODEP) Employment First State Leadership Mentoring Program (EFSLMP) Provider Visionary Opportunities to Increase Competitive Employment (VOICE). Core States were eligible to receive up to 200 hours of technical assistance and guidance to support the state in achieving its goals as an EFSLMP state. Our thematic areas were in Provider Transformation and Regional Capacity Building. In our state, we chose to work with two regions (Region 3 and 4) and within each region, two provider agencies agreed to work with the Subject Matter Expert (SME). Each provider who received technical assistance was required to review and sign a Provider Commitment Form and agreed to complete a provider self-assessment, participate in an onsite visit with the SME, submit information and documents pertinent to the provider transformation, participate in phone calls and webinars, and submit quarterly data on specific points of interest. After each onsite visit, the SME provided a report and an analysis of the agency along with recommendations to each agency. From this agreed upon report, the agency worked to identify goals that they agreed to focus on to bring them closer to transforming from a sheltered workshop into a community employment provider. Providers will continue to receive the benefit of having worked with an expert in this area. Also, in both Region 3 and Region 4, a SME facilitated an in-person regional meeting that brought together all stakeholders including individuals, families, provider agencies, state and local government agencies, support coordination agencies among other agencies to discuss how as a region they can improve employment outcomes for individuals with disabilities. A report was provided along with follow-up phone conferences for the group, and each of those groups formulated a plan for their region. The EFSLMP Core Grant ends August 30, 2019. Louisiana plans to apply for the grant again if it is offered.

1. To what do you attribute this success?

   The EFSLMP grant has been very beneficial to those who participated in the provider transformation piece as well as the regional capacity building. The four providers have plans of how they will continue to move forward in the area of providing individual community employment services to those they support. This progress is due to the subject matter expert technical guidance and assistance. OCDD has received technical guidance and assistance from the SME as well which is helping to guide efforts in the redesign of the vocational services. Without this grant, OCDD would not have been able to provide this type of guidance. OCDD will work with other providers to assist them in their continued transformation efforts. The Regional Capacity Building efforts will be taken to other regions to assist them in getting groups started in their areas. This effort has been a joint success among provider agencies, the subject matter experts, the Governor's Office of Disability Affairs, and all the regional stakeholders.

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

   The results from this EFSLMP grant is a one-time opportunity unless it is offered again for the upcoming year and Louisiana is accepted to receive the grant. The efforts from this opportunity however will continue to provide results. With this effort in combination with other initiatives in the Department and State, we expect progress to continue in the area of community employment. Also, we expect the regional teams to continue to grow and expand in support of improving individual community employment. This effort is in full support of the CMS Settings Rule intent which is to ensure that individuals have full access to the benefits of community living and are able to receive services in the most integrated setting and also in support of the Department's goals.

Development of a Value-Based Payment Model for Intellectual/Developmental Disability Long-Term Supports and Services

A Value-Based Payment (VBP) Model offers providers financial incentives for meeting certain performance measures. OCDD has seen significant progress in the areas of stakeholder engagement and performance measure development as they relate to the Value-Based Payment (VBP) Model. So much so the Office is gearing up to implement a pilot of the latest VBP model. In the Fall of 2018, OCDD conducted a state-wide tour to solicit feedback on the performance measures to be utilized in the model. Based on this feedback, significant modifications were made to the indicators and benchmarks that will be used to determine which providers receive incentive payments. OCDD will conduct a follow-up state-wide tour with a target audience of individuals with developmental disabilities, families, providers, advocacy groups, and local interest groups to describe the measures that will be used in the pilot and to lay the groundwork for expectations for quality performance for the future.

1. To what do you attribute this success?

   OCDD working closely with and soliciting input/feedback from stakeholders, i.e.,

individuals with developmental disabilities, families, providers, advocacy groups, and local interest groups, contributed greatly to the success of this initiative.

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

   Progress is expected to continue at an accelerated pace. OCDD envisions that the VBP metrics will be updated on a regular basis, as more sophisticated technology is put into place (such as the eISP) and as the system continues to shift.

- **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 quality process

1. To what do you attribute this lack of progress?
   The Office for Citizens with Developmental Disabilities has designs on creating a full-scale data-driven quality process loop. However, several issues that have yet to be resolved have hampered progress in this effort. First is the lack of a singular data system; such a system where all the information required in developing quality metrics and tracking program does not currently exist. Second, we have not implemented our electronic Individual Support Plan (eISP). Both of these systems would require improvements and/or changes in the current OCDD Information Technology (IT) infrastructure. Finally, we just started using the new Statewide Information Management System (SIMS) Incident Management System, which tracks critical incidents for our program participants and is critical to any Quality Improvement Model.

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 these issues is due to a lack of resources, both in terms of funding to create the singular data system and infrastructure (re: concerns for server

space, web-based capabilities) and adequate personnel to develop and administer the system.

- **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's Strategic Plan was updated for FY 2020 through 2025. 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. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

  Within OCDD, objectives are assigned to specific staff members who are responsible for management and oversight of the accomplishment of each objective and related performance indicators. Additionally, a variety of management tools (i.e., databases, project charters, etc.) and task/initiative specific workgroups/committees are utilized to track, review, and provide feedback for utilization in decision making and resource allocation. Progress or lack of progress (along with support/resources needed to achieve assigned objective) is reported to OCDD Executive Management. Performance data is also reported in Louisiana Performance Accountability System (LaPAS) and available for both management and stakeholder review.

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

("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
   - 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.

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

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

4. 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?

Information Technology (IT) Upgrades/Modernization Project

A. Problem/Issue Description

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

   OCDD's Information Technology (IT) software and equipment are out-of-date and 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?

   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?

   While to varying degrees, this problem affects all units within the Office. IT upgrades and modernization would improve the efficiency of all work units within

the Office.

4. Who else is affected by the problem?

   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?

Yes.

4. Are corrective actions underway?

   Funding has been requested in the FY 2019-2020 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, salary for another full-time programmer and funding for equipment upgrades and system modernization are required. This cannot be managed with current TO and budget.

Ongoing cost associated with facilities that have been closed, vacated or privatized

A. Problem/Issue Description

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

   Over the last thirteen 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. However, OCDD continues to bear responsibility for the ongoing costs associated with six of these eight facilities. These costs generally include: (1) acquisitions and major repairs, the payment of risk management premiums, building and grounds maintenance, utilities, and/or loss prevention/ security, (2) ongoing, or legacy costs, including the employer share of group insurance benefits for retirees, (3) and the supports and services offered through statewide Resource Center operations that formerly ran from each facility. There have been no additional State General Fund (Direct) appropriations until FY 2020 to offset these mandated expenditures absorbed by Pinecrest Supports and Services Center (PSSC). Act 10 of the 2019 Regular Session partially funded the agency's State General Fund (Direct) request to meet costs for these expenditures. Each year the general appropriation act appropriates pooled Interagency Transfers-Revenues derived from the operations at the Pinecrest facility for these expenditures. In addition, OCDD continues to maintain responsibility for the maintenance of the grounds at the former North Lake Supports and Services Center facility.

2. Is the problem or issue affecting the progress of your strategic plan?

   Yes. Although indirectly, this issue is affecting OCDD's progress in implementing its Strategic Plan in that the fiscal resources required to maintain the vacated properties could be better utilized to further OCDD's progress toward one or more of its Strategic Plan goals.

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

   OCDD is managing the problem by continuing to allocate necessary resources to the costs associated with maintaining the properties and fulfilling both Office of Risk Management (ORM) and other state requirements.

4. Who else is affected by the problem?

   To an extent, the PSSC budget is affected by this problem. The mandated expenditures made through this appropriation from Pinecrest pooled revenues may impact the cash flow at the facility. There are also additional indirect impacts of these required expenditures on participants/families in that resources are diverted away from service delivery.

5. How long has the problem or issue existed?

   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 by the operation of the PSSC revenue stream. Though vacated or operating with significantly reduced occupancy, the properties require appropriate effort to keep the physical plant in good condition and prevent theft or destruction of property. A retirement benefit 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. The issue contributed to a shortfall in the reporting year. These expenditures may continue to cause 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 the FY 2009-2010 submittal.

4. Are corrective actions underway?

   Yes. Corrective actions are underway.

   a. Closed Facilities. With respect to ongoing facility maintenance and upkeep at closed facilities, the Office is working to identify potential alternate uses for all properties not occupied or those planning to be vacated due to ongoing downsizing efforts.

      i. During the fiscal year, action was taken on two closed facilities:

         a) Leesville. OCDD began 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.

         b) 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 will be maintained by ELMHS for evacuation destination for its patients should the need occur. An inquiry has been made to ORM regarding the transfer of ORM costs from Pinecrest to ELHMS.

      ii. Updates on previously reported efforts to find a proposed best use for former facilities:

         a) 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.

         b) Northwest. Act 350 of the 2017 Regular Session of the Legislature authorized the transfer of certain parcels of the former Northwest Supports and Services Center in Bossier Parish. The annual Risk Management premium allocations have been actuarially reduced through the normal underwriting cycle for these facilities. To date, this property remains under OCDD as no sale has taken place.

   b. Legacy Costs. Regarding ongoing legacy costs associated with mandated

group insurance premiums for employees who retired from now closed institutions, Act 10 of 2019 appropriated State General Fund in FY 2020 to alleviate the burden placed on the revenue stream at Pinecrest. The appropriated amount represented the gap between the estimated ability of Pinecrest to meet these obligations from its own revenue stream and the mandated expenditure obligation. To the extent necessary, OCDD intends to make a similar request for FY 2021.

c. Resource Center. With respect to the operational costs associated with statewide Resource Center operations, Act 10 of 2019 appropriated State General Fund support in FY20 to alleviate the burden placed on the revenue stream at Pinecrest. The amount appropriated represents the estimated gap between the ability of Pinecrest to fund these obligations under its existing revenue stream and the anticipated expenditure obligation. Since the consolidation of the appropriation of Resource Center operations under one budget, OCDD has taken significant measures to reduce expenditures and preserve the delivery of critical services. Specifically, OCDD eliminated vacant positions, eliminated some contractual services, eliminated lease expenditures by consolidating four hubs to two hubs prior to implementing a telework policy, and restructured positions within a new statewide service delivery model.

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. However, as mentioned above, failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings/facilities.

☐ 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?

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

A. Problem/Issue Description

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

   There continues to be a lack of adequately trained professionals and direct support staff to deliver needed behavioral and medical/nursing services to individuals with complex needs in community settings, including a lack of qualified professionals to deliver applied behavior analytic therapies to persons with autism. There is a shortage of trained staff to provide services and supports for individuals with significant medical needs, including skilled nursing services, and the 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 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.

   While specific departmental and OCDD initiatives have been implemented in this fiscal year to continue addressing this barrier and improvements have occurred in some areas, a general problem continues to exist. It is believed that a multi-faceted and multi-year approach is required to resolve the problem.

2. Is the problem or issue affecting the progress of your strategic plan?

   Yes. Lack of professional supports in community settings has continued to be the primary contributor to admissions to the supports and service center and other more restrictive settings, with requests for admissions resulting when community providers are unable to meet behavioral and psychiatric needs of people whom they are serving in community settings and in smaller numbers those with complex medical needs. Lack of trained autism professionals negatively impacts the ability to develop new autism services, which can prevent more severe negative developmental outcomes. The inability to teach functional behavioral skills adequately detracts from community participation objectives (i.e., that individuals

with disabilities are participating fully in communities). Continued movement from 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 this problem for many years. The Office of Behavioral Health (OBH) and Medicaid are also experiencing some impact due to this problem.

4. Who else is affected by the problem?

   Individuals supported and their families, support coordinators, and private providers who serve persons with intellectual/developmental disabilities in community homes, family homes, and supported independent living settings are impacted by this problem. Hospitals are impacted when individuals with co-occurring needs present at the emergency room due to difficulty accessing other needed services. Behavioral health professionals and agencies are impacted as they are now receiving referrals for individuals with co-occurring needs for whom they may not feel adequately trained to deliver treatment. Managed care entities 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 conduct and are required to conduct very little training with direct support staff on positive behavior supports and medical/nursing needs.

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

   Consequences include: 1) a significant number of people with intellectual/ developmental disabilities having unmet needs, 2) a continued need for costly institutional admissions to the higher treatment cost supports and service center, 3) continued high utilization of high-cost acute services, and 4) 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:

   - Implement Complex Care Supplemental Payment Option for individuals with complex needs via the OCDD waiver options now that CMS approval and legislative funding have been secured.
   - Evaluate benefits of inclusion of behavioral and medical therapeutic respite options via the OCDD consolidated waiver and research development of specialized shared living waiver models for individuals with complex medical and behavioral needs.
   - Continue implementation of opportunities for partnering with university programs that provide training as well as individual clinicians resulting in additional needed professionals, growing the service provider pool.
   - Continue OCDD developed and sponsored professional continuing education opportunities.
   - Complete Transformation Transfer Initiative grant in partnership with OBH and develop proposed recommendations for professional and network development to enhance access to needed behavioral health services for individuals with co-occurring mental health and developmental disability needs.
   - Develop statewide guidelines for meeting complex health, behavioral health and allied health needs for individuals with intellectual/developmental disabilities.
   - Evaluate other state's practices in areas like START 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.
- Collaborate with OBH on development of crisis framework and services.

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, while others remain, 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:

   - Implementation planning is underway for the Complex Care Supplemental Payment Option.
   - OCDD's has evaluated and modified its previous statewide Positive Behavioral Supports (PBS) curriculum for direct support staff to broaden the focus to wellness, trauma and understanding behavioral health needs and will be working to pilot new training efforts with providers.
   - OCDD continues its statewide offering of Medical/Nursing Direct Service Worker (DSW) training via Money-Follows-the-Person (MFP) Rebalancing Demonstration.
   - OCDD continues to offer Board Certified Behavior Analysts (BCBA) continuing education opportunities as well as other behavioral and psychological continuing education options.
   - OCDD has expanded its focus on professional continuing education to cut across allied health and nursing communities.
   - OCDD continues to provide consultation and technical assistance via the OCDD Resource Center.
   - OCDD has expanded its focus and outreach to full time, part time, and contract nurses 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.
   - Joint Transformation Transfer Initiative with OBH continues to build capacity of behavioral health professionals to support/treat individuals with co-occurring mental health and developmental disability needs.

5. Do corrective actions carry a cost?

   ☒ No. If not, please explain.

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

   Most of these actions do not carry a cost. Implementation of training and capacity building efforts approved in the MFP Rebalancing Demonstration (My Place Louisiana) Operational Protocol are funded with federal demonstration dollars through FY 2020. 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 and enhanced waiver services. However, costs are likely offset by costs associated with failure to implement corrective actions as: 1) failure to intervene at the community level can result in extensive additional institutional treatment costs, and 2) failure to intervene with persons with autism at an early age does result in extensive lifelong service costs that are estimated at over one million dollars per person and incurred by families and the taxpayer. The Transformation Transfer Initiative is funded via grant dollars from the National Association of State Mental Health Directors and Substance Abuse and Mental Health Services Administration (SAMHSA).

◆ 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:

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. <u>National Core Indicators Project</u>

Since FY 2008-2009, the Louisiana Office for Citizens with Developmental Disabilities (OCDD) has participated in the National Core Indicators (NCI) Project, which is co-sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services

Research Institute (HSRI). Forty-eight states and the District of Columbia contribute survey data on individualized cycles for each NCI annual survey period. 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. In 2019, OCDD mailed Family surveys to all of the families of individuals with developmental disabilities participating in Medicaid wavier developmental disability programs as well as families participating in the EarlySteps program. The number of surveys that were mailed was calculated to achieve a return rate that provided a minimum of 400 completed surveys for targeted group. The final number of completed surveys OCDD received was 492 Adult Family Surveys, 409 Child Family Surveys, and 184 Family Guardian Surveys for a total of 1,085 surveys. OCDD did not conduct the In-Person Survey that directly interviews adults with a developmental disability participating in services through OCDD managed programs. NCI has fully implemented a web-based survey response site that offers families who were chosen to participate in the adult family, child family and family guardian mail surveys the opportunity to respond to the survey via direct entry of their responses. OCDD has experienced a diminishing rate of return of surveys, which has resulted in this Office pulling larger samples and mailing more survey packets in order to achieve the target of a minimum of 400 completed Family Surveys. In the 2019 survey cycle, OCDD decided to focus on sending the Family Mail Surveys. This decision was the result of OCDD's need to re-establish procedures after significant changes in Resource Center management, as well as the need to more thoroughly analyze the data and develop improvement strategies before the beginning of another survey cycle. Final reports from NCI on the aggregated data will be available in January 2020.

Reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services and delivered to OCDD in 2019:

- *National Core Indicators In-Person Survey 2018 Final Report*: This report provides an aggregated summary of the results of interviews with adults receiving any developmental disability services in any setting and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Child Family Survey 2018 Final Report:* This report provides an aggregated summary of the results of the survey which was mailed to families of children living and receiving developmental disability services in the family home and provides comparisons between Louisiana and the national average of other participating states.

OCDD participated in the NCI Staff Stability Survey (NCI-SSS) for the first time in the FY 2018-2019 survey period. The NCI-SSS is an on-line survey sent out to licensed service providers 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. The survey was voluntary on the part of the statewide sample who were invited to participate. OCDD concluded the survey on June 30, 2019 with a return rate of approximately 20%.

2. Date completed: Surveys and interviews were completed between January and June 2019. Final reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services will be published in January 2020.
3. Subject or purpose and reason for initiation of the analysis or evaluation: 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.
4. Methodology used for analysis or evaluation: The primary tools used for this evaluation were Family Surveys. Analyses reported both the number and percentage of responses to each question. Comparisons were reported among the participating states.
5. Cost (allocation of in-house resources or purchase price): The three family-mail-out surveys were printed by State Printing for $13,005 and mailed by Office of State Mail Operations for $8,668. All other activities were performed using OCDD material resources and Central Office and Resource Center personnel. Approximately 220 hours of staff time were used to obtain the random sample and verify contact information for families for the mail-out surveys and participant interviews. Entering family survey data and consumer interview data into the NCI database took approximately 360 hours of staff time. Postage cost for a Business Reply Permit and return postage cost were approximately $2,139.
6. Major Findings and Conclusions: Final analysis of the reports produced by NCI has not been completed by OCDD. Preliminary review suggests feedback from family members of service participants remains consistent with previous years. OCDD Performance Review Committee will continue to analyze the data to establish potential focus points for Office initiatives.
7. Major Recommendations: OCDD should tie participant feedback to Office initiatives designed to strengthen the system in order to demonstrate to participants/families that feedback is used constructively and does impact state and federal decisions regarding the direction of services. 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.
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 Early Steps 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): Available in electronic file on the National Core Indicators website:

   www.nationalcoreindicators.org

10. Contact person for more information, including:

    Name: Dolores Sarna
    Title: Program Manager 2
    Agency & Program: Office for Citizens with Developmental Disabilities, Quality Management Section
    Telephone: 225-342-5714
    E-mail: Dolores.Sarna@LA.GOV

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

Department: **Louisiana Department of Health (LDH)**
09-375 Imperial Calcasieu Human Services Authority

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

Undersecretary: **Cindy Rives**

Executive Director: **Tanya M. 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?

<u>Accomplishment #1: Opening of Sulphur Behavioral Health Clinic</u>

A. What was achieved?

On April 1, 2019, Imperial Calcasieu Human Services Authority (ImCal) opened the Sulphur Behavioral Health Clinic (SBHC) in Sulphur, LA. The SBHC provides outpatient mental health, substance abuse, and co-occurring treatment to adults, ages 18 and older, and adolescents, ages 5-17. Historically, residents of the West Calcasieu/Cameron Area had to travel to receive services in Lake Charles. With the recent industry expansion in SWLA, the West Cal/Cam

catchment area has seen a boom in population growth. In addition to the population growth, the I-210 bridge which serves as one of the main thoroughfares between Sulphur and Lake Charles, has been undergoing major renovations. These two factors have resulted in travel burdens for those in the West Cal/Cam Area to get to Lake Charles for services.

B. Why is this success significant?

Integrated mental health and substance abuse treatment services are now provided in the West Cal/Cam Area five days a week; historically the closest services were provided in Lake Charles. Currently, the SBHC is staffed with a licensed clinical social worker, a licensed addiction counselor, a licensed practical nurse, an advanced practice psychiatric nurse practitioner, and a child psychiatric provider (via telemed).

C. Who benefits and how?

Prior to the opening of Sulphur BHC, client data revealed that over 500 clients receiving services at Lake Charles BHC were from the West Calcasieu/Cameron Area. Residents of the West Cal-cam area now have access to mental health and substance abuse treatment within their local community. These services improve their daily functioning and enhance their quality of life.

D. How was the accomplishment achieved?

ImCal was able to secure a lease for a building in the Sulphur area in early December 2018. The owner of the building made all modifications needed at no cost to the district. With some available Mental Health and Substance Abuse block grant funding and a few available vacant positions, ImCal was able to hire three full time employees and a part time employee to staff the clinic. In addition, ImCal was able to expand on an existing professional services contract for psychiatric prescribers.

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: Increased awareness, education and access to Medication Assisted Treatment (MAT) for Opioid Use Disorders

A. What was achieved?

Under the State Targeted Response Grant (STR) for Opioid Use Disorders (OUD), a number of enhancements in the area of prevention of and treatment of OUD have occurred this fiscal year. Within the arena of prevention, ImCal HSA partnered with Acadiana Area Human Services District and implemented a local media campaign to increase awareness and educate the public about OUD. This campaign included radio PSAs, bill boards and social media blasts. In addition, NARCAN kits were distributed community-wide to local law enforcement agencies, fire departments, food banks, homeless shelters and man camps. Medication lock bags were also distributed. Under the STR grant, a peer specialist was hired whose work is focused on engaging OUD clients at the point of assessment and engaging them into MAT services with the local Methadone Clinic, BHG. Treatment access was also enhanced through a contract with a local suboxone provider. Under this contract, ImCal was able to fund MAT clinical services for individuals with OUD.

B. Why is this success significant?

The prevention work under the STR grant enhanced public awareness and education regarding

OUD and also increased access to MAT services which were not available previously to individuals who have Medicaid or who are indigent. Prior to the implementation of this grant, methadone treatment was not a covered service under Louisiana Medicaid nor was clinical treatment services for suboxone. This success was significant because it opened the door for individuals with OUD who could not afford MAT services to access those services.

C. Who benefits and how?

The implementation of the STR grant benefitted individuals who suffer from Opioid Use Disorders in the ImCal catchment area by increasing their access to treatment services.

D. How was the accomplishment achieved?

Prevention efforts were achieved through the ImCal Prevention Unit under the direction of our Community Services Director who also serves as our Opioid Use Disorder Specialist. Prevention staff completed community wide outreach to distribute NARCAN and medication lock. The STR media campaign was accomplished through a partnership with Acadiana Area HSD. ImCal was able to hire a peer specialist under a part time WAE position which was funded under the STR grant. The increased access to suboxone clinical services as accomplished through a contract with a local provider.

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

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

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

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

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

ImCal HSA is on time and on target to meet the goals and objectives set within our five 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. To increase public awareness and to provide access to care for individuals and their families who are in need of behavioral health and developmental disabilities services.

II. To ensure that services provided are responsive to client needs, based on evidence-based best practices, and that programs afford the client a continuum of care taking into consideration cultural diversity and abiding by 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 two accomplishments described in Section I. above, while ImCal has not significantly exceeded any stated objectives and strategies, we have made steady and efficient progress in all objectives and strategies as indicated in our five year plan which gets more and more difficult to accomplish with continuous budget cuts every fiscal year.

- **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?

ImCal has made steady and efficient progress in all objectives and strategies as indicated in our five year plan despite budget cuts.

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

ImCal Executive Management Team utilizes the Five-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 Five-year Strategic Plan is collected quarterly and shared with the Executive Management Team. Performance measures are adjusted as needed.

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

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

Complete Sections A and B (below) for each problem or issue. Use as much space as

needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

*Recruitment and retention of professional and qualified staff under a Civil Service System and limited budgetary resources

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   ImCal HSA struggles with recruitment and retention of licensed professional staff and limited access to funds to compete with the private sector. Under a behavioral health Managed Care environment, ImCal HSA is expected to operate similar to the private sector in order to generate revenue to support the budget. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) **not at this time**
2. What organizational unit in the department is experiencing the problem or issue? **The Behavioral Health Division within ImCal HSA**
3. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) **The individuals served by ImCal are affected by waiting lists to access services.**
4. How long has the problem or issue existed? **Since ImCal's inception.**
5. What are the causes of the problem or issue? How do you know? **The cause of the problem appears to be recruitment and retention of licensed professional staff and limited access to funds to compete with the private sector.**
6. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? **Will continue to struggle in filling vacancies and providing needed services to the community.**

B. Corrective Actions

7. 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.

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

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

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

4. 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**
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effectiveness of internal controls over accounting, operational and administrative functions.

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☐ Policy, research, planning, and/or quality assurance functions in-house
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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 management 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 Acadiana Area Human Services District.

☒ **Accreditation review**
During this fiscal year, ImCal participated in its three-year accreditation review by the Commission on Accreditation for Rehabilitative Facilities (CARF). Report detailed below.

☒ **Customer/stakeholder feedback**
ImCal HSA participates in the C'est Bon program through LDH's Office of Behavioral Health and 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 LDH 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* program 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:

Louisiana State Civil Service Audit

1. Title of Report or Program Evaluation
   Louisiana State Civil Service Drop-in Review
2. Date completed
   September 25, 2018
3. Subject or purpose and reason for initiation of the analysis or evaluation
   The mandated Civil Service Audit occurs every two years, and the Drop in Review is conducted within the alternating year within that two year cycle.
4. Methodology used for analysis or evaluation
   Review of personnel records, human resource policies and HR staff interviews.
5. Cost (allocation of in-house resources or purchase price) There was **no cost to ImCal.**
6. Major Findings and Conclusions

No major findings were reported.

7. Major Recommendations

There were no major recommendations.

8. Action taken in response to the report or evaluation
   No action was necessary.
9. Availability (hard copy, electronic file, website) The **electronic file is available upon request.**
10. Contact person for more information,
    Name: Sheryl Meek
    Title: Corporate Compliance Officer
    Agency & Program: ImCal HSA
    Telephone: 337.475.3100
    E-mail: sheryl.meek@la.gov

Louisiana Legislative Audit

1. Title of Report or Program Evaluation
   Louisiana State Legislative Audit
2. Date completed
   March- August 2019
3. Subject or purpose and reason for initiation of the analysis or evaluation
   Legislative Auditors conducted procedures at the Imperial Calcasieu Human Services Authority (ImCal) to evaluate certain internal controls ImCal uses to ensure accurate financial reporting and transparency, to comply with applicable laws and regulations, and to provide overall accountability for public funds.
4. Methodology used for analysis or evaluation
   The Auditors evaluated ImCal's operations and system of internal controls through inquiry, observation, and review of its policies and procedures, including a review of the laws and regulations applicable to ImCal. Based on the documentation of ImCal's controls and our understanding of related laws and regulations, we performed

procedures on selected controls and transactions focusing on ImCal's participation in the Louisiana Behavioral Health Partnership (LBHP).

5. Cost (allocation of in-house resources or purchase price) **$33,794**
6. Major Findings and Conclusions

3 Major Findings

1) **Imperial Calcasieu Human Services Authority (ImCal) did not bill Medicare, Medicaid, private insurance companies, or the patients in a timely manner and did not perform timely collection procedures. In addition, ImCal lacks adequate written policies over its billing and collection process. Failure to bill and collect outstanding debt timely increases the risk that accounts will become uncollectible and may impair the authority's funding of ongoing operations.**
2) **Imperial Calcasieu Human Services Authority (ImCal) does not have adequate procedures in place to accurately report outstanding account receivable balances. Failure to maintain adequate controls over account receivable balances increases the risk of inaccurate fiscal reporting and decision makers using inaccurate information.**
3) **Imperial Calcasieu Human Services Authority (ImCal) disbursed federal funds to contractors without properly determining whether each contractor qualified as a sub-recipient and failed to clearly identify federal award information to them at the time of the contract award, as required by federal regulations. Failure to notify contractors of sub-recipient status and all federal award information could cause the sub-recipient to be in noncompliance with the award and federal regulations.**

7. Major Recommendations

Management should strengthen its controls over accounts receivable and establish written policies that ensure billings, outstanding debt collection notices, and submission of delinquent accounts to the Office of Debt Recovery (ODR) are performed timely. In addition, management should ensure all reports per the ODR contract are received and used to monitor and adjust patient accounts.

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

- **Action for Finding #1**

Management should develop policies and procedures to accurately report outstanding account receivable balances and maintain supporting documentation for the balances reported. ImCal management should provide its personnel with detailed training to appropriately determine whether a contractor is a sub-recipient and strengthen its policies and procedures to ensure that awarding documents include all required federal award information.

In March of 2019, ImCal HSA hired a new Chief Financial Officer (CFO), who worked diligently with the auditors and ImCal fiscal staff to obtain an accurate outstanding account receivable balance. Once this balance was achieved she was able to provide accurate accounts receivable reports to LDH. ImCal HSA Chief Financial Officer will continue to oversee the reporting of all outstanding account receivable by running timely quarterly reports and verifying the accuracy of outstanding receivable balances reported to LDH, including but not limited to Medicaid, Medicare, private insurance companies, and self-pay.

- **Action to finding #2**

  ImCal 's Chief Financial Officer will strengthen controls over billing by running monthly billing reports to identify unbilled charges to insurance and patients. This will ensure that insurance companies and patients are billed within 30 days. ImCal 's Chief Financial Officer will strengthen controls over outstanding receivables by running monthly reports to identify aged receivables so the billing unit can take necessary actions to collect from insurance or patient in a timely manner. This includes but not limited to identifying patient responsibility after insurance, error corrections, transferring to collection, and correcting denials.

- **Action for finding #3**

  ImCal Administration will follow Federal regulation 2 CFR §200.330 in determining the classification of non-Federal entity contractors as a sub-recipient and identify as such on the first page of contract under #7. ImCal Administration will follow Federal regulation 2 CFR §200.331 to ensure all contracts identified as a sub-recipient include the required information as stated in the regulation and all requirements are imposed on the sub-recipient so that the Federal award is used in accordance with Federal statues, regulations and the terms and conditions of the Federal award in order for ImCal to meet its own responsibility as a pass-through entity.

9. Availability http://www.lla.la.gov/ (hard copy, electronic file, website)
   electronic file available upon request.
10. Contact person for more information,
    Name: Sheryl Meek
    Title: Corporate Compliance Officer
    Agency & Program: ImCal HSA
    Telephone: 337.475.3100; E-mail: sheryl.meek@la.gov

*CARF Accreditation

1. Title of Report or Program Evaluation

Commission on Accreditation for Rehabilitative Facilities (CARF) Survey

2. Date completed

June 3-5, 2019

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

Accreditation for ImCal HSA Behavioral Health Clinics

4. Methodology used for analysis or evaluation

Review of ImCal administrative and behavioral health program policies and procedures, chart reviews, staff interviews, stakeholder interviews, client interviews, and facility walk through.

5. Cost (allocation of in-house resources or purchase price) **$9,540.00**
6. Major Findings and Conclusions

ImCal HSA was awarded a three-year Accreditation

7. Major Recommendations

It was recommended that ImCal's assessment process also gather and record information about the person's physical health history, culture, spiritual beliefs, relationships, history of trauma and literacy levels. It was suggested that ImCal identify what specific actions, behaviors, or symptoms trigger the development of a formal safety crisis plan to provide staff with objective indicators to ensure that a plan is completed with the persons served when appropriate. It was recommended that the written transition plan also include information on the continuity of the person's medication, referral information, and communication of information on options and resources which are available and what to do if symptoms recur. It was recommended that since medication samples are kept on site that written procedures be implemented that address medication inventory

8. Action taken in response to the report or evaluation

ImCal Executive Management Team developed and submitted to CARF a Quality Improvement Plan (QIP) to address major recommendations in the survey.

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

electronic file available upon request.

10. Contact person for more information:

Sheryl Meek, Title: Corporate Compliance Officer
Agency & Program: ImCal HSA
Telephone: 337.475.3100; E-mail: sheryl.meek@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2018-2019

Department:	**Louisiana Department of Health (LDH)** 09-376 Central Louisiana Human Services District
Department Head:	**Rebekah E. Gee, MD, MPH** LDH Secretary
Undersecretary:	**Cindy Rives**
Executive Director:	**Michael R. DeCaire, Ph.D.**

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

For each accomplishment, please discuss and explain 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: Behavioral Health Accreditation by the Commission on the Accreditation of Rehabilitation Facilities (CARF)

A. What was achieved?

Central Louisiana Human Services District (CLHSD) was accredited by CARF for its second consecutive 3-year period.

B. Why is this success significant?

CARF Accreditation lets consumers and the public at-large know that CLHSD meets the rigorous performance standards established by CARF and that the care CLHSD provides is of a high quality. In addition, accreditation is required by health plans in order to bill for services rendered, which allows CLHSD to achieve its self-generated revenue requirement. Lastly, accreditation is required for licensing as a behavioral health clinic.

C. Who benefits and how?

All of the consumers and potential consumers in CLHSD's 8 parish human services district benefit from our CARF accreditation. Demonstrating that your organization meets or exceeds the quality standards established by an independent third party is paramount when attempting to establish and maintain a trusting therapeutic relationship with potential and current consumers. CARF accreditation lets people know that we are competent and provide high quality services.

D. How was the accomplishment achieved?

CLHSD, through Administrative oversight and its Corporate Compliance Department, monitors the delivery of behavioral health services and assesses them for congruence and compliance with the CARF behavioral health standards. CLHSD then uses these assessments to implement continuous quality improvement.

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

Yes. Accreditation supports CLHSD's ability to attract a wide array of consumers, which enables us to meet the needs of the community while generating revenue.

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

Accreditation by CARF or another accrediting organization is considered a best management practice for behavioral health organizations and has already been shared with the LGE's.

<u>Accomplishment #2: Integration of Service Delivery</u>

A. What was achieved?

CLHSD was able to secure a new location, which will accommodate all three divisions: Administration, Behavioral Health, Developmental Disabilities.

B. Why is this success significant?

Previously, the three divisions operated out of three separate locations. This fragmented

disconnected model hindered management and communication, made service delivery inefficient, and prevented CLHSD from establishing its identity in the community. On a greater scale, the integration of service delivery is exactly what was intended, when the human services districts/authorities were created, so CLHSD's integration is the realization of that intention. Furthermore, the new location is in an area of Alexandria that is experiencing tremendous growth and development and places CLHSD in the best possible location now and for years to come. Lastly, the new location is on a main thoroughfare, which is a part of the bus route and allows for much greater and more convenient access for current and potential consumers.

C. Who benefits and how?

All of the consumers and potential consumers in CLHSD's 8 parish human services district benefit from our integration and the new location. The new location was designed with our three divisions in mind, so it is extremely efficient and meets our needs for service delivery perfectly. Being new imparts a value to our consumers that our previous locations failed to do. It also allows for increased efficiency of service delivery, increased effectiveness of management and communication for CLHSD's staff. Further, it allows CLHSD to have one culture with one collective morale, which benefits management and the staff equally.

D. How was the accomplishment achieved?

CLHSD received notification of eviction from Central Louisiana State Hospital (CLSH), which necessitated relocation of CLHSD's Administrative office and its Caring Choices clinic. In tandem with the eviction notice, Central Louisiana Technical Community College (CLTCC) relocated to downtown Alexandria and the parking for CLTCC was to be provided by the razing of the building that CLHSD's Developmental Disabilities (DD) office was located, thereby necessitating the relocation of CLHSD's DD office. CLHSD found a location suitable to house all three divisions and leased that space.

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.

<u>Accomplishment #3: Applied Suicide Intervention Skills Training (ASIST)</u>

A. What was achieved?

CLHSD has trained 586 individuals through its staff and contracted provider.

B. Why is this success significant?

Avoyelles Parish has the second highest suicide rate in the state and it is one of the eight parishes served by CLHSD. It is also significant because of the increased likelihood of a trainee interacting with an individual who may be contemplating suicide, intervening and successfully mitigating further ideation, planning, and/or attempt.

C. How was the accomplishment achieved?

CLHSD selected two of its staff and two community partners to receive the ASIST Train the Trainer training provided by LDH. Subsequently, CLHSD contracted with the two community partners to provide the ASIST training throughout the eight parishes comprising the District.

D. Who benefits and how?

The entire population of the eight parishes CLHSD serves.

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?

  CLHSD's implementation of its strategic plan has been successful in terms of overall progress and with regard to timelines (there have been some delays, but the goals were

accomplished). The strategies employed have allowed us to accomplish exactly what was intended. The expected returns on investment have been realized and are expected to increase during the ensuing fiscal years.

- **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.

        Overall, CLHSD has achieved significant progress. Much of this progress is simply a result of having effective leadership and competent staff to execute the vision. CLHSD gained the most ground by aligning staff strengths with job duties and/or promotion, reorganizing and establishing needed/missing departments, acquiring staff whose motivation and attitude drive them to succeed individually and collectively, and acquiring much needed technology. It is definitely a team effort.

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

        CLHSD's progress is attributable to a culture established by its leadership and carried out by its staff, which is expected to continue to grow for the foreseeable future.

- **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?

  Yes. CLHSD's strategic plan continues to be revised to address what has been accomplished, what remains to be accomplished, and what new items have been added.

  ☐ No. If not, why not?

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

  CLHSD leadership employs an Executive Management Team model, whereby strategic plan initiatives are shared and discussed each month. Each department reports on their current accomplishments, new or upcoming projects/objectives, and the progress being made. The CLHSD Board of Directors provides input and feedback regarding the strategic plan several times each year.

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 contracted provider for adolescent and adult residential addictive disorders treatment withdrew from the state resulting in a loss of service.

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

   No.

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

   Behavioral Health- residential addiction treatment services.

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

   The problem affects staff, contracted employees, consumers and potential consumers, as well as stakeholders, all of whom depend on CLHSD for residential addiction treatment services.

5. How long has the problem or issue existed?

   Since June 30, 2019.

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

   The contracted provider no longer provides services in the state of Louisiana. They were a Missouri based organization.

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

   The consequence and/or impact on performance is a reduction of 16 adolescent beds and 37 adult beds for residential addiction treatment in the state. CLHSD has secured a new provider and services are expected to be restored by the end of August 2019.

B. Corrective Actions

- 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.

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

   None. CLHSD currently is working with a new provider to restore residential addiction treatment services by the end of August 2019.

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

3. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
      - How much progress has been made and how much additional progress is needed?

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

   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.

CLHSD Compliance Department conducts regular monitoring and identifies/reviews areas of concern. The findings are communicated to the management team and a corrective action plan is established for problem areas.

☒ **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.

Licensing reviews are conducted annual by the DHH Health Standards staff to certify providers abide by established guidelines.

CLHSD Board's reviews: The Board in conjunction with the Executive Director reviews the District operations and endorses Business and Strategic Plans.

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

Policy, research, planning, and/or quality assurance functions in house: Performance Improvement and Critical Incident Review Committees, Continuous Quality Assurance (CQI) process is implemented by providers and reviewed by monitors, on an ongoing basis.

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

☒ Program evaluation by in-house staff

Program evaluation by in-house staff: CLHSD Division of Corporate Compliance conducts quarterly assessments of District and Contract Programs.

☐ 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 CLHSD. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made meetings directly to the agency's Executive Director 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 meetings directly to the agency's Executive Director if modifications or additions are needed. In addition, at the close of a fiscal year, CLHSD reviews and evaluates its 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 CLHSD. Recommendations are compared to benchmarks from

leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's Executive Director or designee if modifications or additions are needed.

☒ **Performance-based contracting (including contract monitoring)**
CLHSD contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

☒ Peer review

☒ Accreditation review

Accreditation review: CARF Quality standards form the cornerstone of CARF accreditation. Conformance to quality standards is a way to identify areas for improvement and growth and help the service provider focus on improved service outcomes, satisfaction of the persons served, and quality service delivery. Accreditation was granted in July 2022, for a period of three (3) years.

☒ Customer/stakeholder feedback

Persons served by the CLHSD programs are asked to participate in satisfaction surveys utilizing the C'est Bon and LaFete survey tool developed by LDH. The survey results are provided to LDH and are used to inform the development of the CLHSD District Strategic Plan. Results of the survey can be used to compare performance to other Districts and Authorities within the state of Louisiana.

☐ 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 2018-2019

Department: **Louisiana Department of Health (LDH)**
09-377 Northwest Louisiana Human Services District

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

Undersecretary: **Cindy Rives**

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?

<u>Accomplishment #1: Expanded Family Support Services for the Developmentally Disabled:</u>

A. What was achieved?
One-time funds received from the Developmental Disabilities Council were used to provide additional family support services in our service area.

B. Why is this success significant?
The funds allowed us to fulfill an additional 146 requests, a 39% increase in individuals served when compared to the previous fiscal year.

C. Who benefits and how?
146 individuals and their families benefited from receiving a variety of supports and services that included: communication devices to enhance interactive skills, stander lifts that improved home mobility, vehicle modifications that allowed for community mobility and other personal services like dental restoration, additional personal care assistant coverage, and respite care. This expansion of the Family Supports Program greatly enhanced our existing program efforts.

D. How was the accomplishment achieved?
The Developmental Disability Council raised awareness as to the inequity of per-capita state funding among the local governing entities (LGEs). When legislators were unable to allocate additional funds for this fiscal year to the lower-funded LGEs, the Developmental Disabilities Council identified funding under their control that could be used to assist the two lowest funded LGEs, one of which was our district. We accepted the funds and used using existing district resources to identify and meet additional needs through our Family Supports Program.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. It expanded the volume of our existing Family Supports Program.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No. This is not a replicable event since one-time funding was used.

<u>Accomplishment #2: Expanded Access to Evidence-Based Treatment:</u>

A. What was achieved?
24 community Licensed Mental Health Professionals received Trauma Affect Regulation: Guide for Education and Treatment (TARGET) training. 16 were from our district, eight were from the community.

B. Why is this success significant?
There is a high prevalence of trauma in the severely mentally ill populations. TARGET is a strengths-based, person-centered approach to teaching self-regulation skills to people who have experienced chronic stress, adversity, or trauma. This training greatly enhances the clinical skills of attendees and clinical services to clients.

C. Who benefits and how? Evidence-Based Practices are proven to have better outcomes for clients, so all clients treated by clinicians trained in TARGET will benefit. Clinicians also benefit from having additional tools to help their clients manage reactions to stressors effectively.

D. How was the accomplishment achieved?
District staff training was funded through Mental Health Block Grant funds. Community clinicians that participated in the training were funded through support from the Caddo

Juvenile Court and the Grayson Foundation.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. It supports core behavioral health services 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?
Yes. It is a good example of collaborative training activity for other LGEs and the communities they serve.

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?

  Progress was made in recovering some of the behavioral health service volumes lost due to past fiscal year deficit cuts and significant expansion was realized in developmental disability family support services due to one-time funding being allocated from the Developmental Disability Council. This year we moved into a "recovery and growth" strategy. This transition was effective in re-aligning staff goals and expectations and positioning our district to meet our five-year strategic plan accomplishments. We believe anticipated returns on investment were realized.

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

  Significant progress was made in providing services to the disabled due to the infusion of additional funds from the Developmental Disabilities Council.

  1. To what do you attribute this success?
     - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
       Progress is due to external factors (one-time funding from the Developmental Disability Council) and could not have been generated without their efforts.
     - 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?)

Progress is directly related to the acceptance of additional funds and using existing district resources to identify needs and effectively use the additional funds to meet those needs. No new technologies, methodologies, or resources were used to achieve this progress.

- 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?

  Progress is related to the combined efforts of the Developmental Disabilities Council, the Louisiana Department of Health, and our district. Key to our success was the developmental disability staff accepting the challenge of a significant increase in workload without an increase in staff or resources.
- 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?

   This significant progress was initially the result of a one-time gain from one-time funding and was not expected to be replicated going forward. This changed when additional state general funds were allocated to our district for the next fiscal year. We plan on using some of this additional funding to maintain the progress that was made.

- **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?** Use as much space as needed to explain fully.

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.)

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

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

- 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.

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

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

4. Do corrective actions carry a cost?

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

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

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

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

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

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

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

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

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

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

☐ Program evaluation by contract

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

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

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

☒ **Performance-based contracting (including contract monitoring)**
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

☐ Peer review

☒ **Accreditation review**
Northwest Louisiana Human Services District (NLHSD) currently operates under a Three-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: