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 Cindy Rives

RE: Annual Management and Program Analysis Report (AMPAR)

DATE: December 5, 2018

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 2018 fiscal year. These reports summarize the activities of each agency as it relates to management and program analysis, outstanding accomplishments, areas where we are making significant progress and any specific management or operational issues that may exist.

If there are questions regarding these reports, you may contact Elizabeth Davis at 225-342-5608 (liz.davis@la.gov).

Louisiana Department of Health

09-300	—	Jefferson Parish Human Services Authority
09-301	—	Florida Parishes Human Services Authority
09-302	—	Capital Area Human Services District
09-303	—	Louisiana Developmental Disabilities Council
09-304	—	Metropolitan Human Services District
09-305 & 306	—	Medical Vendor Administration & Medical Vendor Payments
09-307	—	Office of the Secretary
09-309	—	South Central Louisiana Human Services Authority
09-310	—	Northeast Delta Human Services District
09-320	—	Office of Aging and Adult Services (OAAS)
09-324	—	Louisiana Emergency Response Network Board (LERN)
09-325	—	Acadiana Area Human Services District
09-326	—	Office of Public Health (OPH)
09-330	—	Office of Behavioral Health (OBH)
09-340	—	Office for Citizens with Developmental Disabilities (OCDD)
09-375	—	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 2017-2018

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:

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: Patient Centered Medical Home Recognition Level III

A. What was achieved?
Jefferson Parish Human Services Authority (JPHSA), through its JeffCare program, achieved Level III Patient Centered Medical Home (PCMH) Recognition through the National Committee for Quality Assurance (NCQA). The achievement of obtaining NCQA's highest level of recognition reflects JPHSA's dedication to improving the satisfaction and health outcomes of service recipients, as it requires the implementation of best practices focused on improving quality.

B. Why is this success significant?
This success is significant because it recognizes JPHSA's commitment to a culture of Performance and Quality Improvement in primary care services. This recognition program is the most widely adopted and recognized PCMH evaluation program in the country (per the NCQA website). It is recognized by providers, health plans, and physician groups across the country as being demonstrative of a commitment to improving the experience between the individual and his/her provider; improving efficiencies in the work place; and, ensuring the latest best practices are implemented so individuals receive the right amount of care at the right time.

C. Who benefits and how?
Research supports that fragmented or unintegrated care negatively affects the health outcomes of service recipients. Individuals who receive services from JPHSA benefit from more open and timely communications with their providers, reduced duplication of services, and overall improved satisfaction with services. Staff members also benefit from more open and timely communications with those they serve, as well as from streamlined workflows leading to increased job satisfaction. Health Plans benefit from the knowledge that JPHSA providers are committed to providing quality services in an efficient manner, and participating in ongoing Performance and Quality Improvement processes to maintain these expectations.

D. How was the accomplishment achieved?
JPHSA achieved this recognition through the development of a PCMH Implementation Work Group. This workgroup completed a rigorous year of capturing and reviewing data, identifying workflows and processes in need of improvement, implementing changes, training staff, and updating procedures. Documentation of monitoring for fidelity to implemented changes occurred. JPHSA submitted all of the data, workflows, procedures, and monitoring results to NCQA through the PCMH application process, which resulted in the award of Level III Recognition.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
This accomplishment supports all three goals of JPHSA's strategic plan. Realizing the efficiencies of a PCMH within an integrated practice supports the first goal by helping to preserve limited resources. Improving the satisfaction of service recipients through refined provider communication processes supports the second goal of achieving universal design. Lastly, improving staff satisfaction supports the final goal by ensuring employment longevity of committed staff members.

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

Yes. All providers who integrate primary care, behavioral health, and developmental disabilities services should implement the best practices required to achieve PCMH Recognition. If these best practices were to be adopted by the other LGEs, it could help improve the quality and efficiency of services provided to individuals across the State.

Accomplishment #2: Enhancement of Full Compliance Program

A. What was achieved?
JPHSA, through its Compliance & Performance Support (CPS) division, enhanced its commitment to a culture of continuous compliance and Performance and Quality Improvement (PQI) through the development and implementation of a full Compliance Program based on the "seven components of an effective compliance program" as published by the U.S. Department of Health and Human Services' Office of Inspector General (OIG). The Compliance Program clearly outlines the roles of all staff members in maintaining a culture of compliance, as well as the framework through which routine monitoring and auditing occur across all divisions and programs of JPHSA. The role of the Compliance Officer was enhanced to serve as the staff member primarily responsible for promotion of the program to all staff members, as well as enforcement of the Program's requirements. Reporting lines for staff members to reach the Compliance Officer were created and publicized to encourage proactive communication and broad accountability for compliance activities.

B. Why is this success significant?
As a public entity and a provider of services billable under federal programs, JPHSA has numerous legal and regulatory obligations it must meet in order to continue to operate and provide needed behavioral health, developmental disabilities, and primary care services to the residents of Jefferson Parish. The Compliance Program provides a systematic approach to evaluating JPHSA operations and activities in order to assess compliance and the opportunity for improvement, thereby helping to ensure long-term security and sustainability. It also demonstrates JPHSA's commitment to fighting fraud, waste, and abuse of healthcare resources.

C. Who benefits and how?
Staff members benefit from the full Compliance Program significantly, as it provides necessary guidelines to inform them of the practical implications of the laws and regulations governing their particular job duties. This is of particular importance to staff members providing billable services, as there are many laws and regulations that apply to individual providers personally, as well as to JPHSA. As discussed above, the Program also provides staff members with clear reporting lines to ensure they know how to appropriately handle a potential compliance concern, thus providing further protections.

Service recipients also benefit from the full Compliance Program because it helps to ensure the security of JPHSA, as well as the long-term sustainability of its operations and services. Moreover, the larger public benefits, as the Program serves to protect JPHSA's public resources, and also helps to fight fraud, waste, and abuse of federal and state public healthcare resources.

D. How was the accomplishment achieved?
The JPHSA Compliance Officer and CPS Division Director conducted extensive

research into the topic of compliance programs, and utilized training provided by the American Health Lawyers' Association to ensure the final program contained all necessary legal and regulatory components, while being tailored to fit JPHSA's needs and scope of services. The Program was publicized to all staff members, and training was planned for the first quarter of FY19. The Compliance Officer maintains an internal auditing/monitoring calendar to ensure the Program is carried out effectively.

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

Yes. As discussed, the Compliance Program is directly tied to ensuring JPHSA is able to continue to exist and provide quality services on a long-term basis, in furtherance of its Mission, goals, and priorities.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. Any agency that provides billable services should implement a full Compliance Program and appoint a Compliance Officer to oversee it to ensure the protection of its resources and compliance with federal and state legal and regulatory requirements.

<u>Accomplishment #3: Revamp of First Thirty-Day Orientation Process for New Staff Members as part of Broader Staff Engagement Initiative</u>

A. What was achieved?
In FY17, JPHSA conducted a voluntary survey of staff members, which asked questions related to their engagement at work. Based on the results of the survey, the JPHSA Executive Management Team (EMT) identified several areas as opportunities for improvement, and honed in on the need to revamp the staff member orientation and reorientation processes as a high priority. Specifically, the EMT identified the need for these processes to become more engaging, meaningful, and Mission-focused, in order to ensure staff members have an understanding of JPHSA's culture, structure, and array of services across all service delivery areas.

This initiative was split into three phases: Phase 1, focusing on division-specific orientation conducted within a new staff member's first thirty days; Phase 2, focusing on reorientation; and, Phase 3, focusing on first-day general orientation. The Phase 1 Staff Engagement Work Group was formed in FY18, and began working on reimagining the first thirty-day orientation process, incorporating input from staff members from all areas and levels of the organization. As a result, JPHSA implemented a new procedure and orientation packet, which taken together, serve as a framework for supervisors to deliver orientation in an engaging, meaningful, and uniform manner, and which allows the EMT to have additional oversight to ensure the orientation is provided to all staff members uniformly.

B. Why is this success significant?
JPHSA's staff members are its most valuable resource, both monetarily and in terms of necessity for carrying out activities in support of its Mission. Staff member engagement at work is crucial, as it helps to ensure productivity and longevity of employment. By providing tools to individual supervisors aimed at engaging employees from the start of their employment, turnover may be reduced, and productivity increased.

C. Who benefits and how?
Staff members benefit from receiving a robust and meaningful orientation, which helps equip them with the tools needed to succeed at their jobs. Supervisors benefit from having clearly defined guidelines for how staff member training should be carried out, as well as documentation. Service recipients benefit from an engaged workforce dedicated to providing high quality services. The public at large benefits from the preservation of public resources due to reduced turnover and re-training costs.

D. How was the accomplishment achieved?
As discussed under Section A above, the Phase 1 Staff Engagement Work Group was responsible for completing this initiative, incorporating input from staff members from all areas and levels of the organization. The Work Group met on a regular basis throughout the fiscal year.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. In particular, this accomplishment contributes to goal number 3, which is to "attract and retain a qualified workforce committed to Mission and Vision." The ultimate purpose of the staff engagement initiative is to accomplish this goal. As discussed above, staff engagement and dedication to Mission is crucial to ensuring a productive and long-term workforce.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. Every Executive Branch agency should be taking steps to ensure all staff members receive an orientation to the agency's Mission and/or purpose in a manner that is engaging, interactive, and meaningful. While the tools created by the Phase 1 Staff Engagement Work Group are specific to JPHSA, the model and format of the orientation could certainly be replicated by other LGEs and agencies 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?

Jefferson Parish Human Services Authority (JPHSA) implemented an updated Strategic Plan in FY18 to better reflect JPHSA's state of strategic management versus implementation planning. Throughout FY18, 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."

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 FY18. Specifically, JPHSA maintained its resources in a manner that allowed for the preservation and expansion of services.

Please note in particular:

- JPHSA maintained its Centralized Care Coordination program throughout FY18, and continued to receive grant funding in order to streamline referrals, improve feedback with community stakeholders, and ultimately, improve upon the services and supports provided to individuals in Jefferson Parish. The grant funding also allowed JPHSA to receive technical assistance during the fiscal year to further improve the program.

- JPHSA's Developmental Disabilities Community Services division received 9% of JPHSA's appropriated State General Fund for FY18 as mandated by ACT 73 of the 2017 Louisiana Regular Legislative Session. These funds were used to provide an additional 69 slots in the Flexible Family Fund Program, as well as to assist 317 individuals and/or families with one-time financial support. Some of the one-time financial support was able to fund adaptive bikes, iPads, and other technology 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 FY18. Specifically, JPHSA made progress toward achieving Universal Design in its physical environment (i.e. facilities), in which individuals receive services and supports.

Please note in particular:

- During FY18, JPHSA made improvements to its physical environment by moving Developmental Disabilities Community Services (DDCS) staff members from

cubicles to larger offices designed to comfortably accommodate individuals with physical disabilities and their families, thus affording these individuals the comfort and privacy they deserve.

- During FY18, JPHSA allocated a greater number of designated handicap parking spaces at the facility housing the DDCS and Behavioral Health Community Services (BHCS) Divisions, in order to provide improved accessibility to the diverse population of individuals and families supported by JPHSA.
- During FY18, JPHSA updated its Access Control policy to ensure the maintenance of a safe environment at JPHSA facilities, and to provide added security for JPHSA staff members working in the community. JPHSA further conducted an audit of active swipe cards to ensure all individuals had appropriate access assigned to their swipe cards based on their positions and/or status with JPHSA.
- During FY18, JPHSA achieved Level 6 on the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) integration scale (the highest level), which signifies its status as fully integrated across all service areas.
- During FY18, 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 the need for mental health, substance use, primary care or developmental disabilities services and supports. To support staff members in facilitating effective screening and disposition of individuals, care coordinators completed a ten (10) week online course focused on engagement of individuals and families into services. The modules focused on effective communication with individuals and families; team-based approaches to care within an inter-disciplinary care delivery model; and, utilizing mentoring and team-based problem solving to enhance the relationships between care coordination staff members and individuals, families, and referral providers. 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.
- During FY18, JPHSA provided telephone etiquette training to administrative support staff members to ensure JPHSA provides individuals, families, and stakeholders seeking information or services with excellent customer service across all service areas on a consistent basis.
- During FY18, JPHSA made improvements to its website, which increased its accessibility to individuals with certain visual impairments or slower processing

times, senior citizens, and those with limited literacy skills. Specifically, the following improvements were made:

- Font size was increased;
- Simple, sans serif fonts without unnecessary flourishes were used, in order to eliminate interference with readability;
- Sufficient leading/line height was maintained to maximize readability, preventing users with limited literacy skills from losing their place in the text;
- A simple design with liberal use of white space was utilized in order to minimize clutter that reduces readability; and,
- Phone numbers on the website were changed to click-to-call links in order to save mobile users the extra step of writing them down or cutting and pasting.

- During FY18, JPHSA expanded supports for individuals with developmental disabilities by collaborating with a Louisiana non-profit to provide children with developmental disabilities custom-made adaptive bicycles. JPHSA worked directly with the support team, the parents, and physical therapist of each child to ensure each bike fit the needs of the child. Parents of bike recipients noted the bikes increased their children's coordination strength, and confidence, as well as their social skills and sleep routines. The increased interaction with peers in a natural environment promotes inclusion throughout the community.
- During FY18, JPHSA expanded opportunities for individuals with serious mental illnesses (SMI) to engage with their peers, by increasing the number of activities taking place in the community and the number of individuals receiving the calendar of events. This focus led to an increased number of individuals with SMI participating in the events in their communities, with 80% of individuals served by this program reporting they engaged in these activities on their own. Community involvement is beneficial for individuals with SMI as it allows them to feel a connection to their community, gain independence, and give them an identity beyond their 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 the agency's 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;
- A commitment to continuous Performance and Quality Improvement; and,

- A culture that is not afraid of taking calculated risks.

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 have become 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 FY18. 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 FY18, JPHSA engaged in brand management as a recruitment tool through engagement with stakeholders and other members of the community.

- Throughout FY18, 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.

- During FY18, JPHSA worked with the Department of State Civil Service to revise its Special Entrance Rates policy to allow for increased salaries for certain positions that are particularly difficult to fill due to local competition.

- As discussed in detail above, the revamp of the first thirty-day orientation process as developed by the Phase 1 Staff Engagement Workgroup in FY18 is expected to have a positive impact on staff member turnover and engagement.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

  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?

FY18 was the first year that JPHSA implemented its revised Strategic Plan, which is planned to be in effect through FY22. The new 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 Carver Policy Governance Model. The Board of Directors establishes the Mission and Priorities, and selects an Executive Director to provide ongoing leadership and operational management of the Authority. The Executive Director presents the members of the Board with regular monitoring reports as required by Board policy and with activity updates at each Board meeting. She prepares an Ends Policy Monitoring Report detailing progress toward achieving Strategic Plan Goals and Objectives on an annual basis.

  JPHSA monitors, reports, and implements corrective action and/or Performance and Quality Improvement (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 develops, adopts, and implements annual cross-divisional PQI Initiatives to further support Mission, Priorities, and achievement of the Strategic Plan. Quarterly progress reports are delivered during committee meetings and reported in the employee electronic newsletter. The Full PQI Committee incorporates input from all levels and areas of the organization through its diverse membership.

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

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

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

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

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

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

There is no significant management or operational problem to report.

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

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

B. Corrective Actions

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

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

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

5. Do corrective actions carry a cost?

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

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

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

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

☒ **Internal audit**
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 Authority performance using benchmarks set forth in Council on Accreditation standards. Improvement and/or corrective action plans are developed and executed as needed. The Division monitors progress on plan implementation as well.

Each JPHSA Division establishes an annual business plan containing measurable outcomes in support of the Authority's Strategic Plan. Outcomes are tracked and reported on a quarterly basis with Performance and Quality Improvement and/or corrective action initiated as needed. JPHSA's Fiscal Services department provides ongoing monitoring of Authority 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 FY17 audit produced **no** findings or any recommendations (e.g. management letter), i.e. the audit was clean. The FY18 audit is scheduled for August 2018. 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 FY18

on-site audit occurred on March 22, 2018. The OCDD audit produced no findings and required no corrective action. The OBH audit included recommendations for improvement; JPHSA is currently in the process of developing corrective action, which is due to OBH in mid-August. The peer review was done with Florida Parishes Human Services Authority with no findings or recommendations.

☒ Policy, research, planning, and/or quality assurance functions in-house
JPHSA's Compliance & Performance Support (CPS) Division has overall accountability for policy development and management, as well as for JPHSA's quality assurance functions. With regard to policy development and update, the CPS Division Director, who is also JPHSA's General Counsel, in conjunction with the Compliance Officer, has overall responsibility for ensuring legal and regulatory compliance. The Executive Management Team, under the direction of the Executive Director, is responsible for short- and long-term planning. The Executive Director informs and seeks consultation from the JPHSA Board of Directors as appropriate and according to Board policy and the Carver 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 Division Director, is responsible for the review and update of JPHSA's Performance and Quality Improvement (PQI) Plan and for the collaborative development and ongoing monitoring of annual 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 FY18, 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. During FY18, Phase 3 of the Health and Wellness Integration Work Group conducted training to implement and support meaningful conversations about health and wellness among staff members throughout all divisions and levels of the organization.

The Executive Director, Executive Management Team, Supervisory Staff, and the Compliance & Performance Support (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 FY18, 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 Performance and Quality Improvement (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 will begin its next accreditation cycle with the Council on Accreditation in August 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 chaired by JPHSA's Medical Director. Further, the Executive Director meets one-on-one with each member of the Executive Management Team on a quarterly basis for reporting on annual plan progress and any need for Performance and Quality Improvement and/or corrective action. 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 FY18, 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 FY18, with Florida Parishes Human Services Authority, focused on administrative 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, JPHSA maintained accreditation and compliance with Council on

Accreditation Standards. As JPHSA was awarded four-year full organization accreditation in FY16, the next review cycle will occur in August 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. Employees have access to comment boxes in all break rooms, and may also provide the employee-led committee, Esprit de Corps, with suggestions for improvement. The Esprit de Corps Chairperson has direct access to the Executive Director and Executive Management Team. The members of the Board of Directors, per the Policy Governance Model, actively engage in "community linkages" and report the outcomes of these community stakeholder interactions during each Board meeting. Additional feedback is obtained through active participation in the monthly Jefferson Parish Behavioral Health Task Force meetings and in the quarterly Regional Advisory Committee meetings for Behavioral Health and Developmental Disabilities. JPHSA also participates on the Child and Youth Planning Board and Jefferson Parish Alliance for Concerned Citizens. The Executive Director and the Chief Administrative Assistant make regular calls on local and state elected officials as well as community partners.

☒ Other (please specify):

JPHSA monitors and evaluates its operations and programs on an ongoing basis, as described throughout this report. The Authority 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.

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

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

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

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

Name: 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 2017-2018

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?

<u>Accomplishment #1: Continued to Increase Collections for Behavioral Health Services:</u>

A. What was achieved?
Continued to increase collections for behavioral health services. Florida Parishes Human Services Authority (FPHSA) was able to continue to increase self-generated revenue collections for behavioral health services.

B. Why is this success significant?
This allows the agency to provide more services to an underserved population without additional need for state general funds.

C. Who benefits and how?
Those receiving services from the agency due to increased services as well as taxpayers due to less need for state funds.

D. How was the accomplishment achieved?
Medicaid expansion is responsible for a portion of the increase while improvements in services delivery and billing procedures has made a significant impact on receivables and denials.

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

Accomplishment #2: Expanded Hours in Livingston Parish at Denham Springs Clinic:

A. What was achieved?
The outreach site in Denham Springs was expanded with additional staff and prescribers added as we grow it further into a full time clinic.

B. Why is this success significant?
The Livingston Parish area has a population as big as Tangipahoa (also in our catchment area) but did not have a permanent clinic. Following the floods of 2016 services available in the area decreased while the need for services continues to increase.

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 repurposing some existing positions and using additional funding available due to increased collections.

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

Accomplishment #3: New Website and Social Media Presence:

A. What was achieved?
A new FPHSA website and social media accounts including Constant Contact, Facebook, and Twitter were established.

B. Why is this success significant?
These efforts allow for increased access to the services of FPHSA allowing for greater visibility and reach to those in need of behavioral health care.

C. Who benefits and how?
The community living in the five Florida Parishes by having greater access to services as well as information and updates about how to access them.

D. How was the accomplishment achieved?
Existing staff and resources were assigned responsibilities for these projects.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes in that it contributes to the agency being better able to provide services to those that are in need of them.

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

Accomplishment #4: Community Involvement:

A. What was achieved?
Florida Parishes Human Services Authority (FPHSA) has continued to partner with other local agencies in the region to advance the availability of behavioral health and developmental disabilities services. Notable examples include participation in the Safe Haven project in St. Tammany, treating clients in the specialty courts of the 22nd judicial district, and working with first responders and other public agencies to provide suicide and mental health trainings.

B. Why is this success significant?
It is important to coordinate with other entities to maximize the use of public resources. FPHSA are the public agency in the area providing for behavioral health and developmental disabilities services and it is appropriate for our agency to lead efforts to improve the continuum of services in these areas.

C. Who benefits and how?

Residents of the Florida Parishes benefit by having increased access to services and a better trained workforce to respond to these needs.

D. How was the accomplishment achieved?
This was achieved by establishing relationships with other local agencies and making staff available to assist where appropriate.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
This contributes to the agency's accomplishment of strategic plan goals in making services available to those who need to access them.

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: Participated in Multiple Grants:

A. What was achieved?
The agency participated in several new grant funded activities to leverage federal and other non-state dollars including the State Targeted Response plan for the opioid epidemic.

B. Why is this success significant?
This allowed the agency to access additional funding to address particular problem areas within the region.

C. Who benefits and how?
Residents across the region have benefitted by having increased scope and scale of services to address behavioral health and developmental disabilities services without requiring additional state dollars.

D. How was the accomplishment achieved?
This was accomplished by partnering with LDH to apply for appropriate grants.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, as it helps assure comprehensive services, improve quality, and promotes healthy lifestyles.

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: Expended 99% of Developmental Disabilities Individual and Family Support Funding:

A. What was achieved?
99% of funding allocated for individual and family support was utilized for appropriate services to individuals in the Florida Parishes.

B. Why is this success significant?
In the past there was occasionally dollars left over at the end of the fiscal year due to some participants with funding approved not invoicing for services. By better monitoring and following up on existing contracts money that would have gone unused was recouped and instead spent on requests that would have otherwise gone unfunded.

C. Who benefits and how?
Individuals and their families with behavioral health needs in the region. The agency was able to fulfill a greater number of requests by redirecting left over funds timely.

D. How was the accomplishment achieved?
This was accomplished through improved monitoring and follow up by the DD staff.

G. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, as it helps assure comprehensive services, improve quality, and promotes healthy lifestyles.

E. 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?

  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."

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

  Goal 2: To improve the quality and effectiveness of services and/or treatment through the implementation of best practices and the use of data-based decision making. There has been tremendous progress on both of these closely linked goals. The agency has continued to transform the way that services are provided in order to use evidence based and best practice methodologies while redesigning workflows and processes to use resources more efficiently and effectively to deliver more of the appropriate type of services to those with the greatest need and to ensure the most favorable outcomes that result in improved health and community participation.

  Improved availability of resources through increased self generated revenue and grant funding, increase community involvement, support of the governing board, and most importantly an engaged and innovative management team are responsible for this progress.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

  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?

  Progress on strategic plan is going well and the goals are still appropriate as written.

  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?

  Florida Parishes Human Services Authority has monthly meetings with its Board of Directors and conducts routine Executive Management Team meetings. The managers of each service area hold regular meetings with their staff at which information related to the agency's overall plan and strategies are discussed. Community input is obtained

through surveys and regular Regional Advisory Council meetings.

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**: <u>Staff Recruiting and Retention</u>**

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 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?
   This is a long-standing issue that has been a problem at the agency for many years recent uncertainty over the budget with all substance use services and many mental

health services proposed for elimination made attracting candidates more difficult.

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. Recent uncertainty over the budget with all substance use services and many mental health services proposed for elimination made attracting candidates more difficult.

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
   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**
HR Time Administration; Quality Enhancement**;**
Florida Parishes Human Services Authority Human Resources department periodically conducts reviews and audits of time administration handled in each clinic/facility.

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)**
Office of the Legislative Auditor; Office of Risk Management; Louisiana Department of Civil Service; LDH; DOA; Healthy Louisiana Plans

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

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

variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

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

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

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

☒ **Peer review**
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:
   Office of Risk Management Compliance Review

2. Date completed:
   March 1, 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation
   FPHSA Risk Management Policy and Procedure (ORM Requirement)

4. Methodology used for analysis or evaluation:
   Audit completed by Sedgwick for ORM

5. Cost (allocation of in-house resources or purchase price) :
   Not calculated

6. Major Findings and Conclusions:
   Agency scored a 96.08% and was considered compliant with 6 findings/recommendations: (1) Slidell Clinic-Finding: The elevator does not have the Inspection Certificate, or a sign indicating where Certificate is located, posted in a conspicuous location. (2) FPHSA Denham Springs Clinic-Finding: The agency had a fire extinguisher that was under-charged. (3) Mandeville Clinic: Finding-Patient TOMS Computer Station: an extension cord is run from the adjacent office, through the ceiling, and is being used in a permanent capacity to power this workstation.(4) Alcohol & Drug Unit: Finding- Several breaker panels are secured with padlocks for which the agency contacts do not have keys.

7. Major Recommendations:
   (1) Slidell: Agency should post elevator Inspection certification in a conspicuous

location inside each elevator, or post a sign indicating where each Certificate is located. (2) FPHSA Denham Springs: The fire extinguisher should be serviced and inspected. (3) Mandeville: Agency should remove the extension cord from use. (4) Alcohol & Drug Unit: Agency should have building landlord (St. Tammany Parish) provide copies of the keys for the breaker panels.

8. Action taken in response to the report or evaluation:
   Corrections made as needed

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

10. Contact person for more information:
    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:
   Louisiana Department of Civil Service

2. Date completed:
   May 9, 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Compliance to State Civil Service requirements

4. Methodology used for analysis or evaluation:
   Civil Service policies and rules

5. Cost (allocation of in-house resources or purchase price) :
   Not calculated

6. Major Findings and Conclusions:
   FPHSA was found to have no rule violations; however, a few documentation and PES violations were noted.

7. Major Recommendations:
   1.) Agency is required to maintain a signed Statement of Agreement and Understanding-Employment in a Non-Permanent Appointment in accordance with Civil Service directives; Agency must properly document and make hire authorizations in a timely manner as described by Civil Service; 3.) Agency must ensure that the evaluating supervisor signs and dates the performance planning and evaluation form to document the planning session; 4.) Agency

must ensure planning sessions are conducted during the first three calendar months following the appointment of a new employee, the permanent movement of an employee in a position having a different position number with significantly different duties, and the beginning of the new performance evaluation year (no later than 9/30).

8. Action taken in response to the report or evaluation:
   Audit results are discussed at management team meetings and troubleshooting is done.

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

10. Contact person for more information:

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:
   Louisiana Performance Accountability System (LaPAS)

2. Date completed:
   October 2017

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Compliance to LaPAS requirement

4. Methodology used for analysis or evaluation:
   DOA-required methodology; performance indicators developed by FPHSA and approved by DOA

5. Cost (allocation of in-house resources or purchase price) :
   Not calculated

6. Major Findings and Conclusions:
   Final reporting not received at this time.

7. Major Recommendations:
   Final numbers haven't been reported

8. Action taken in response to the report or evaluation:
   Final numbers not yet reported

9. Availability (hard copy, electronic file, website):
   www.doa.louisiana.gov/opb/lapas.htm

10. Contact person for more information:

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-The Human Services Accountability and Implementation Plan (AIP) Annual On-site Monitoring Final Report

2. Date completed:
   March 8, 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Compliance with MOU with LDH

4. Methodology used for analysis or evaluation:
   Accountability and Implementation Plan (AIP)

5. Cost (allocation of in-house resources or purchase price):
   Not calculated

6. Major Findings and Conclusions:
   LDH Findings for AIP (OBH):
   1.) Clarification is needed in FPHSA's policy on what happens if a client would object to one of its clinics and/or sub-contractors' religious character. FPHSA needs to include in policy they will report to LDH/OBH when a client is referred to an alternative provider when such client objects to its religious character of one of its clinics and/or sub-contractors; 2.) FPHSA's policy needs to include it will notify HQ within seven (7) days of reaching 90% of the program's treatment capacity for intravenous drug abusers; 3.) At this time, FPHSA does not have a scientifically sound outreach model or an approach, which reasonably can be expected to be an effective outreach method to encourage individuals in need of treatment services for IVDU; 4.) Add any other non-merit factor to FPHSA's policy; 5.) Lack of capacity policy fails to include the component where each individual who requests and is in need of treatment for intravenous drug abuse is admitted within 120 days of the request if the program has no capacity to admit the individual, the program makes interim services available within 48 hours, and the program offers the interim services until the individual is admitted to a substance abuse treatment program; 6.) Policy/procedures fails to identify that each client will be offered a TB test and pre- and post-test TB counseling; 7.)

Documentation was missing from charts reviewed to show adherence to agency policy/procedure in relation to pre-test and post-test counseling for HIV screening, and the establishment of therapeutic measures for preventing and treatment the deterioration of the immune system; 8.) There was no documentation found to determine if ADU provided or arranged for child care while the mother was receiving services, ADU does not admit/include children into this program; There was no documentation found to determine if ADU provided or arranged pediatric care, including immunizations for the woman's children: (when applicable); There was no documentation found to determine if ADU provided or arranged sufficient case management and transportation services to ensure women and their children have access to medical care, prenatal care, & therapeutic intervention for the children: (when applicable), ADU does not admit/include children into this program. 9.) ADU does not admit children into their program, women and their dependent children are not treated as a family unit.

7. Major Recommendations:
   All included above under Major Findings

8. Action taken in response to the report or evaluation:
   Actions taken for AIP (OBH): 1.) Agency updated procedures, admission criteria, etc. to address findings and educated staff as needed; 2.) Agency is developing option for treating the family as a unit for persons who are admitted to our residential program; priority populations.

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

10. Contact person for more information:
    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:
   Louisiana Property Assistance Agency Property Audit

2. Date completed:
   March 9, 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Compliance with Statewide Property policies and procedures

4. Methodology used for analysis or evaluation:
   Statewide Property policy

5. Cost (allocation of in-house resources or purchase price):
   Not calculated

6. Major Findings and Conclusions:
   1.) Two assets were not entered into AMP (property system) within 60 days of receipt as required; 2.) Of the agency's assets, eighteen assets appear to be missing serial numbers which are required information in AMP; 3.) The license plate on two vehicles did not match the plate number in AMP; 4.) Two assets did not have property tags or need replacement tags; 5.)One asset had an incorrect location code in AMP.

7. Major Recommendations:
   1.) In the future, the agency must ensure that pertinent information for all assets is entered into AMP (property system) within 60 days of receipt of property; 2.) The agency must ensure that pertinent information for all assets is entered into AMP within 60 days of receipt of the property; 3.) Agency must ensure acquisitions are tagged within 60 days of receipt with commissioner approved property tags. As tag become unreadable, the property manager must replace them; 4.) Agency must ensure all locations codes are correct and changed in AMP when property is moved to a new location.

8. Action taken in response to the report or evaluation:
   Agency will ensure items are tagged appropriately and documented in the property system (APM) within 60 days of receipt.

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

10. Contact person for more information:
    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 – Office of Aging and Adult Services PSH Program Monitoring

2. Date completed:
   June 7, 2018

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

LDH Permanent Supportive Housing Program contract requirements

4. Methodology used for analysis or evaluation:
   Monitoring by LDH PSH Program Project Coordinator

5. Cost (allocation of in-house resources or purchase price) :
   Not calculated

6. Major Findings and Conclusions:
   Some client files reviewed contained current crisis and/or disaster plans but did not contain historical assessments/plans.

7. Major Recommendations:
   None

8. Action taken in response to the report or evaluation:
   A response has not been sent yet and is due August 23, 2018.

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

10. Contact person for more information:
    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:
   Healthy Louisiana Treatment Record Reviews (Amerigroup; Optum)

2. Date completed:
   November 2017; January 2018

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

4. Methodology used for analysis or evaluation:
   Review completed by Amerigroup and Optum 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:

1.) Amerigroup/Healthy Blue: Mandeville Clinic received an overall cumulative score of 91.33% with no significant findings noted; 2.) Optum: Program received a Facility Site Audit Review score of 100% and a Treatment Record Review score of 93% with no significant findings noted.+

7. Major Recommendations:
   1.) Amerigroup/Healthy Blue: a) A letter of notification should be sent to a member's PCP when he/she consents to receive treatment from the agency. The member's PCP should also be informed if medication is prescribed for the member and when the member is discharged from treatment; b) All of the clinicians' progress notes should include strengths and limitations as it pertains to the member achieving the designated goals; c) Each member's record should contain a current up to date treatment plan which includes all of the goals, interventions, member responses, as the clinician's continued plan; d) When an anti-psychotic medication is prescribed, for a member he/she should receive education about why the medication is being prescribed , as well as any possible side effects and then the member should sign a consent if he/she agrees to receive the medication; e) For any member 12 and above smoking habits and a history of alcohol and substance abuse should be addressed and documented in the psychiatric evaluation and/or the psychosocial assessment; f) The Prescription Monitoring Program (PMP) should be reviewed by the prescribing provider at the time that the initial prescription is being written and also annually. A copy of the query should be printed and placed in the member's record. 2.) Optum: a) Facility is to provide a written course of action for implementing policies and procedures related to risk assessment, including appropriate referrals for those assessed with substance use concerns. This plan will include a training of all clinical unit staff; b) Facility is to provide a written course of action to formalize a process for interdisciplinary communication regarding treatment of high risk patients, including issues related to medication management; c) Facility is to provide a written course of action to refer ensure adequate safety planning for patients at risk of suicide; d) Facility is to develop process for making appropriate referrals for those patients needing treatment for substance abuse; e) Facility is to provide a written course of action to refer patients to peer support as appropriate; f) Facility is to develop standardized treatment planning that is consistent with diagnosis and has objective and measurable short and long term goals; g) Facility is to ensure the treatment plan includes a safety plan when active risk issues are identified. Facility will ensure all clinical staff is trained on how to identify high risk members and to implement an ICPP plan; h) Facility is to ensure the safety plan is reviewed and updated with high risk the patient/family at regular intervals.

8. Action taken in response to the report or evaluation:
   Audit results are discussed at management team meetings and troubleshooting is done.

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

10. Contact person for more information:
    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:
   HR/Time and Attendance

2. Date completed:
   August 2017 (Hammond location); October 2017 (Bogalusa location); November 2017 (Administration); December 2017 (Mandeville location)

3. Subject or purpose and reason for initiation of the analysis or evaluation
   FPHSA Procedure 540.1 Time Administration

4. Methodology used for analysis or evaluation
   FPHSA Procedure 540.1 Time Administration

5. Cost (allocation of in-house resources or purchase price)
   Not calculated

6. Major Findings and Conclusions
   Minor documentation findings were noted.

7. Major Recommendations
   Timekeepers should ensure following policy and procedure. Employees should be reminder they are responsible for correctly reporting time and attendance biweekly and that by singing and initialing the timesheet they are attesting that the timesheet is true and correct.
8. Action taken in response to the report or evaluation
   Audit results are discussed at management team meetings and troubleshooting is done.

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

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:
   HR/Payroll

2. Date completed:
   June (Slidell location)

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   FPHSA Procedure 540.1 Time Administration

4. Methodology used for analysis or evaluation:
   FPHSA Procedure 540.1 Time Administration

5. Cost (allocation of in-house resources or purchase price) :
   Not calculated

6. Major Findings and Conclusions:
   Minor documentation findings were noted

7. Major Recommendations:
   Timekeepers should ensure following policy and procedure. Employees should be reminder they are responsible for correctly reporting time and attendance biweekly and that by signing and initialing the timesheet they are attesting that the timesheet is true and correct.

8. Action taken in response to the report or evaluation:
   Audit results are discussed at management team meetings and troubleshooting is done.

9. Availability (hard copy, electronic file, website) :
   Electronic files

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:
   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:
    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:
   Annual Financial Reports

2. Date completed:
   October 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Compliance to State requirement

4. Methodology used for analysis or evaluation:
   Policies and practices established by DOA or in accordance with Generally Accepted Accounting Principles as prescribed in the Governmental Accounting

Standards Board

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) :
   Electronic files

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

Annual Management and Program Analysis Report

Fiscal Year 2017-2018

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?

<u>Accomplishment #1: On the Red Carpet with CAHS; Area Youth Star in Substance Use Prevention Videos</u>

A. What was achieved?
Capital Area Human Services District (CAHS) hosted a special "Red Carpet" event featuring local students in video public service announcements as part of a new media campaign focused on reducing the risks of substance use and opioid misuse among youth.

B. Why is this success significant?
The videos, which are being shared on various social media, contain messages that support responsible, healthy life choices among youth. After the videos were shown, there was a facilitated discussion about related topics.

C. Who benefits and how?
The video media campaign for adolescents uses the #MeByDesign brand promoting healthy living and the Active Parenting of Teens program participant testimonials emphasizing the importance of parent-child communication about substance use. With funding by CAHS, Ascension Public Schools produced the "One Bad Decision" video PSA on drinking and driving prevention to promote a safe prom season.

D. How was the accomplishment achieved?
The videos highlighted the valuable prevention activities implemented by Mirror of Grace Outreach, Ascension Public Schools, and the Fahrenheit Creative Group in collaboration with CAHS. Other highlights of the program included acknowledgement of the valuable work of all CAHS prevention partners, a presentation by representatives of the McKinley High and Scotlandville High TeamSpirit prevention project, and awarding student certificates of recognition.

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: Gambling: "It's Not Just an Adult Problem" CAHS Wages Campaign to Deter Youth Gambling:</u>

A. What was achieved?
The public awareness campaign features a radio commercial and a video that is being shared via CAHS' Facebook page and other social media. The video was written and produced by CAHS Peers and actors included a 10th grader and an 11th grade student

B. Why is this success significant?
A recent survey of adolescents found that more than 80% of those between the ages of 12 and 17 say they have gambled in the last 12 months, and more than 35% say they gamble at least once a week.

C. Who benefits and how?
These and other alarming statistics have prompted CAHS' Center for Gambling Treatment to develop a special campaign aimed to raise awareness about problem gambling among youth.

D. How was the accomplishment achieved?
The youth campaign followed a multi-media campaign about problem gambling among adults. That campaign included public service announcements on popular music and sports talk radio stations and ads in movie theaters, in the newspaper, and on Facebook.

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: Governor Edwards Signs CAHS Led AOT Bill into Law:

A. What was achieved?
Governor John Bel Edwards recently signed Senate Bill 306 into law, updating Louisiana's law that providing for court-ordered Assisted Outpatient Treatment (AOT) for persons with severe mental illness

B. Why is this success significant?
AOT has been shown to reduce hospitalization rates, homelessness, arrests, and incarceration.

C. Who benefits and how?
CAHS leadership met with community partners to revise the old law, clarify language, establish roles, and develop a process for implementation.

D. How was the accomplishment achieved?
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, will have more defined roles in helping participants adhere to their treatment plans.

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: Behavioral Health Collaborative Developing the Framework for Community-wide Response to the Opioid Epidemic:

A. What was achieved?

The Behavioral Health Collaborative led by CAHS leadership completed its 18-month series of professional and public seminars on issues pertinent to the opioid epidemic -- this time, dealing with recovery and treatment services in the region.

B. Why is this success significant?
The Collaborative is continuing its fight against opioids in the region by employing a CAHS-developed community-wide framework that will involve key agencies that are on the front lines of the battle and who will participate in response plan development.

C. Who benefits and how?
Mayor-president, Broome, through a proclamation, called on CAHS to utilize its extensive network of stakeholders to develop and implement a coordinated community-wide response plan to address the opioid epidemic. The proclamation notes that a comprehensive public health, medical, law enforcement, addiction prevention, and treatment response offers the best chance to make a regional impact on opioid addiction and overdose.

D. How was the accomplishment achieved?
CAHS leadership has begun preparing a draft plan, and the collaborative attendees will have opportunities at upcoming meetings to provide feedback and recommendations in nine key areas. The plan should be ready in September 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 #5: CAHS Conducts 18th CIT Training for Law Enforcement:</u>

A. What was achieved?
Capital Area Human Services District (CAHS) conducted its 18th Crisis Intervention Team (CIT) training, providing a 40-hour institute to help law enforcement officers better respond to behavioral health crises in their communities

B. Why is this success significant?
Law officers from five agencies completed the crisis de-escalation course.

C. Who benefits and how?
Since 2008, 639 law enforcement officers and cadets have completed CAHS' CIT Training.

D. How was the accomplishment achieved?
The April 2018 training included presentations from several local agencies about their

services and resources: the East Baton Rouge Parish Coroner's Office, the East Feliciana Parish Coroner's Office, the Crisis Intervention Center, Alzheimer's Services of the Capital Area, Southeast Louisiana Veterans Health Care System, the Society of St. Vincent De Paul, the National Alliance for Mental Illness (NAMI), and Janssen Pharmaceuticals.

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: CAHS Officials Detail JI-IOP Program at Conference:

A. What was achieved?
CAHS's Executive Director, and a CAHS Licensed Clinical Social Worker spoke at the annual Reentry Alliance for Louisiana (REAL) conference, detailing CAHS' services for judicially involved persons who are identified as having a mental health disorder, a substance abuse disorder, or both.

B. Why is this success significant?
Research shows that between 50% and 80% people in jail who test positive for a behavioral health need also have co-occurring substance use/misuse disorders.

C. Who benefits and how?
They gave details about CAHS' Justice-Involved Intensive Outpatient Program (JI-IOP), which began in 2016 and helps participants avoid returning to jail by providing the necessary tools to maintain emotional stability and sobriety during their recovery process. CAHS was awarded a Wilson Family Foundation grant for their Prison Reentry Initiative, for the Behavioral Health Reentry Program at East Baton Rouge Parish Prison in 2017 and 2018. The grant provides funding for a Co-occurring Disorders Specialist to identify and assess individuals with mental illness or a co-occurring disorder, and a Peer Support Specialist who assists in treatment planning.

D. How was the accomplishment achieved?

The JI-IOP provides risk screening, a mental health or substance abuse assessment, education about anger management and domestic abuse, substance use prevention, diagnosis and treatment of behavioral health and substance use issues, and access to 12-step treatment programs (Alcoholics and Narcotics Anonymous). They detailed several barriers to successful reentry, including lack of: access to phones or computers to receive appointment reminders; state-issued photo identification or driver's license for admission to programs; reliable transportation; stable housing; employment or income; medical and pharmacy coverage; intensive case management

services.

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

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

Accomplishment #7: Campaign Launched to Help Women and Girls Avoid Opioids:

A. What was achieved?
Capital Area Human Services District (CAHS) is one of only 16 organizations nationally to receive a three-year, $300,000 competitive grant, awarded by the U.S. Department of Health and Human Services' Office on Women's Health, to prevent opioid misuse among women and girls. The grant calls for the use of evidence-based practices to increase awareness, knowledge, and skills to address the opioid epidemic in the Greater Baton Rouge region. Strategies will include a media campaign, programs in schools and communities, and consumer and provider educational materials. At a spring Behavioral Health Collaborative meeting, CAHS launched the new media campaign that focuses on reducing the risk for opioid misuse and abuse by women and adolescent girls in the Greater Baton Rouge region.

B. Why is this success significant?
Nationally, there has been an alarming increase in overdose deaths among women, stemming from prescription painkillers and nonprescription opioids.

C. Who benefits and how?
Education and prevention are essential to this collaborative effort to combat the opioid epidemic, and this campaign will help raise awareness in the community and will help people make more responsible decisions about using prescription pain pills. CAHS is also working with community organizations to conduct education in schools and parenting groups as well as distributing printed information through events and other community activities. Community partners for the project are Ascension Public Schools, BREC Recreation Centers, the Big Buddy Program, Evaluation Insights, Fahrenheit Creative Group, the LA-SBIRT Project, the I CARE Program of EBR, the Louisiana Department of Health Office of Behavioral Health, and Mirror of Grace Outreach.

D. How was the accomplishment achieved?
At a spring Behavioral Health Collaborative meeting, CAHS launched the new media campaign that focuses on reducing the risk for opioid misuse and abuse by women and adolescent girls in the Greater Baton Rouge region. CAHS' new prevention campaign for women, "Recognize the Risk: Understanding Starts With You," uses print materials

and social media posts (illustrated right) to emphasize the power women have to create healthy futures for themselves, free of opioid addiction. The campaign for adolescent girls promotes positive lifestyle choices through the overarching CAHS #MeByDesign theme with specific taglines, 'Irresistibly Genuine," and "Ideas and Goals." Girls will be reached through video, digital media, such as Instagram, and through print materials.

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: Parents, Schools Rate School Based Program A+:

A. What was achieved?
CAHS School Based (SB) Therapy Program has completed another successful year, serving 44 schools throughout the region.

B. Why is this success significant?
A satisfaction survey reflects top scores for the program. When parents of elementary and middle-school students were surveyed, 100% said they would recommend the SB services to friends or family, and 96% would continue to choose the SB program over others. 100% of high school clients who were surveyed said they would continue to choose SB services over others.

C. Who benefits and how?
The SB Therapy Program is unique in its commitment in 44 area schools to educate parents, teachers, and school leaders about the students' mental health issues to help keep them in school. In many cases the SB Therapy Program offers the only mental health care services for students in their communities.

D. How was the accomplishment achieved?
According to latest information, the SB Therapy Program last year: Served 884 students and their families; Conducted 350 family-help sessions; Discharged 32 students who met their treatment goals; Assessed and helped 86 students who were in life-changing crises; Reached 2,704 individuals through various workshops; Provided 1,594 hours of physician time with students.

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: Facing Addiction Advocates Participate In Training:

A. What was achieved?
Community advocates from various professional fields gathered at CAHS' campus to participate in a special grassroots training, conducted by the Facing Addiction organization. The four-hour training was part of a technical assistance grant CAHS received -- one of only 15 nationally -- to build grassroots advocacy about the issues of substance use and abuse. The training focused on 1) community organizing, 2) message training, 3) policy matters, and 4) social media.

B. Why is this success significant?
The ongoing grassroots effort is being waged in three stages: 1) building an advocacy base, 2) training advocates, and 3) launching the community-wide campaign in January.

C. Who benefits and how?
The advocacy teams will be trained to conduct activities such as: Working with media to inform citizens; urging local officials to give more attention and funding to the issues of addiction; hosting various events throughout the year to draw attention to the issues; and participating in trainings to become more effective advocates.

D. How was the accomplishment achieved?
The Director of Outreach and Engagement of Facing Addiction conducted the training, noting that every four minutes, someone in the United States dies from drug or alcohol addiction. He led the participants in an examination of effective leadership, including characteristics and skills that include leading by example, being creative to set goals, demonstrating a strong work ethic, and being tenacious when met with challenges.

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

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

Accomplishment #10: CAHS Provides Suicide Prevention Toolkit to Schools:

A. What was achieved?
The CAHS #MeByDesign campaign, launched last year to promote healthy choices and positive behaviors among middle and high school youth, is reaching out this month to provide a suicide prevention toolkit for schools throughout the region.

B. Why is this success significant?
This will provide needed materials to educate students, administrators, faculty, and staff on the ways to prevent Suicide in schools and school aged children.

C. Who benefits and how?
The suicide prevention toolkit includes: Scripts of morning announcements; Social media posts and infographics; Writing prompts; 8.5" x 11" posters; Model school policy on suicide prevention; and Presentations for staff or students, conducted by licensed CAHS clinical specialists related to suicide prevention or the aftermath of a suicide or trauma (upon request).

D. How was the accomplishment achieved?
The resources will be distributed to the schools, at no charge, for administrators, faculty, staff, and students to use to support healthy campus cultures.

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?

  Capital Area Human Services District (CAHS) operates under two separate plans, a strategic plan with the State, and an 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. CAHS is on target with the expected accomplishments set forth in this plan.

  Our 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 CAHS

Board.

- **Where are you making significant progress?** If you are making no significant progress, state "None."

  LDH Plan: Over the past several years, the CAHS 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.

  Capital Area Human Services District (CAHS) 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."

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

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

  The 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.

  Capital Area Human Services District's 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.

No significant management or operational problems exist.

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

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

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

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

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   4. Are corrective actions underway?
      a. If so:

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

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

5. Do corrective actions carry a cost?

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

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

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

☒ **Internal audit**
Capital Area Human Services District ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within the Louisiana Department of Health (LDH) appraises activities within the Department to safeguard the Department against fraud, waste & abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that

operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

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

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

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

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

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

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

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

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

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

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 2017-2018

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?

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

A. What was achieved?
The Developmental Disabilities Council (herein referred to as "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 include the use of funding from the New Opportunities Waiver Fund to provide for 650 mixed waiver opportunities to people with the most urgent needs on the waiting list, to increase the night rate for Individual and Family Support in the NOW, and a high-needs rate to serve people with complex and challenging behavioral and/or medical needs. The Council also succeeded in advocating to retain the NOW Fund and the Community and Family Support System (CFSS) Fund when they were reviewed by the Legislature. The statute governing the use of monies in the NOW Fund was also changed allowing the fund to be used for mixed waiver slots and to improve the capacity of the DD home and community based system.

The Council was instrumental in advocating for and in the planning and development of the new tiered-waiver system. This was a multi-year project that came to fruition this year, ending the decades old first come, first served waiting list.

B. Why is this success significant?
The changes to policies and practices will mean people with the most urgent and emergent needs will not have to wait for waiver services they need now. In addition, people will receive the most appropriate waiver to meet their needs which will be less costly to the state. Ultimately, it is hoped this will further increase the success rate of people living in their own homes or with family members, increase the quality of life, independence and inclusion of people with developmental disabilities. This shift should also decrease the financial burden to the state for lower quality of life outcomes when people enter segregated, institutional settings to receive the supports and services they need.

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.

The Council's contribution to the tiered-waiver system was accomplished through multiple meetings over several years with OCDD and LDH leadership and other stakeholders.

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

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

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

A. What was achieved?
The Council provided support to a number of capacity building initiatives. One initiative involves training and technical assistance for Direct Support Professionals and their organizations to improve practices related to serving people with significant medical and behavioral needs. Another training increased the capacity of individuals with disabilities and family members of people with disabilities to more effectively serve on boards of organizations and provided information related to the self-direction option for waiver services. A series of training events, including a Conference, 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. A competency-based mentoring program in supported employment is building the capacity of Employment Support Professionals and employment provider agencies in two areas of the state. 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 improve the quality of services delivered and results in better outcomes. For example, direct support workers utilizing best practices to support individuals with significant medical and behavioral needs reduce further medical intervention, such as visits to the emergency room, reduces staff turnover and ultimately improves the outcomes for persons with developmental disabilities with significant needs. Skills learned through the training series on customized employment will result in more individuals with significant disabilities discovering employment opportunities which 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?

The Developmental Disabilities 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."

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."

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 third 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 Councils 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.

No significant management or operational problems exist.

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

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

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

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

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

- How much progress has been made and how much additional progress is needed?

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

5. Do corrective actions carry a cost?

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

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

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

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

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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
Council staff review and evaluate planning procedures and policies on an annual basis to determine needed changes to processes for achieving each Council plan activity and related managerial function.

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

☒ Program evaluation by in-house staff
Each Council program/activity is reviewed on a monthly basis with quarterly progress notes provided to the Council. Ultimately the Council directs any change in action to specific 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 all LDH agencies. Explanatory Notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

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wide.

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

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

☐ Peer review

☐ Accreditation review

☒ Customer/stakeholder feedback
Federal grant requires specific feedback related to each initiative. Additional stakeholder feedback is gathered to shape Council Advocacy agendas and target capacity building initiatives.

☐ 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:
   Program Performance Report (PPR). 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 December 2017 on its performance in compliance with the federal Developmental Disabilities Assistance and Bill of Rights Act.

2. Date completed:
   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 2018.

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

4. Methodology used for analysis or evaluation:
   None

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

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

10. Contact person for more information:
    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 2017-2018

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, MD**

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 Dashboard:

A. What was achieved?

Metropolitan Human Services District (MHSD) strives to create and maintain a data driven environment. Data driven decision-making involves making decisions that are backed by data rather than making decisions that are subjective. The development of a monthly data dashboard allows MHSD to track and monitor the provision of services. The dashboard is comprised of data tables and charts related to person served demographics, service utilization, access to services and service outcomes.

B. Why is this success significant?
The dashboard is a tool 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 monthly 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 programs, allows the MHSD Division of Quality and Data Management to produce the monthly 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

<u>Accomplishment #2: (Care Management/Administration) MHSD Resource Coordination Unit:</u>

A. What was achieved?
The continued development and establishment of the Resource Coordination Unit (RCU) within MHSD. The purpose of the RCU is to serve people in need of referral and linkage to non-core MHSD provided services. The unit has continued to build and serve as a resource to the MHSD incoming persons served, Care Center, clinician and peer staff, existing persons served and their families as well as external partners to the agency.

B. Why is this success significant?
The continued evolvement of the RCU is significant because it serves as the equivalent of a "wrap around" unit, purposed for linkage, supportive in nature, and consisting of a variety of referrals and resources to enhance service delivery for person with mental illness, addictive disorders and that are intellectually/developmentally disabled in Orleans, St. Bernard and Plaquemines parish.

Over the course of FY18, RCU has continued to maintain an electronic database of resources found in the MHSD tri-parish area. The RCU continues to validate its

referrals by working directly with internal and external programs to ensure the most accurate and current information/resources/materials is shared. It also has continued ongoing maintenance/monitoring of appropriate documentation on referrals to promote team awareness and ensure person served safety.

C. Who benefits and how?
Persons served and their families, clinic managers and staff, treatment teams at the clinics and the MHSD Care Center. All can rely on current and informed knowledge of non-MHSD specialized services and external supports that enhance the holistic care of persons served.

D. How was the accomplishment achieved?
Under the leadership of MHSD Executive Management the RUC was established. RCU is a unit committed to "wrapping" persons served in a holistic framework of care and assisting them in navigating the behavioral and non-behavioral healthcare systems.

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) MHSD Reengagement Program</u>

A. What was achieved?
In FY18 Metropolitan Human Services District (MHSD) developed a partnership program with the Orleans Parish Sheriff's Office (OPSO) to support the reengagement, specifically behavioral health, of recently released offenders to their community.

MHSD and OPSO have taken steps to address the mental health and substance use issues of these individuals prior to their release. The two agencies have developed a "Warm Hand Off" process that provides a seamless transition for those returning to the community.

B. Why is this success significant?
The Louisiana Department of Public Safety and Corrections reports that nearly a quarter of the state's offenders have serious mental health issues and 75 percent have substance use disorders. In New Orleans, the Orleans Justice Center has an average of 1,550 inmates in its custody, and one in three take prescribed medicines to treat addiction and mental illness.

MHSD recognizes that individuals released for incarceration suffering from mental illness and/or addiction problems require immediate and ongoing medical services. Services include medication, medication management, therapy groups and referrals, but

also include referral and assistance in accessing services like housing, employment and transportation.

The MHSD reentry program was cited by SAMHSA in their FY18 site visit as a promising program to be shared with other SAPT Block Grant Recipients.

C. Who benefits and how?
Persons released from incarceration, the families of these incarcerated individuals and the community to which these individuals will be returning. The lack of a coordinated and timely support system for those prisoners returning to the community can seriously jeopardize positive outcomes for these individuals and make for greater burdens on the community to which they return.

D. How was the accomplishment achieved?
Recognizing that many individuals facing mental health and/or substance use challenges require intensive support in order to navigate life outside of prison, MHSD Executive Management extended the use of its service provision system to OPSO in order to create a process that would provide a seamless transition for those returning to the community.

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) Faith Partners Initiative</u>

A. What was achieved?
The Faith Partners Initiative marries faith and science by equipping MHSD 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 will have more awareness and knowledge of referral options for substance use disorders, other addictions and mental illness, with long-term outcomes to create fully mature congregational ministry teams. MHSD serves as the convener, technical advisor and behavioral health consultant, with the ultimate goal of collaborative care that maximizes overall health.

B. Why is this success significant?
Through a facilitated process, the faith community is equipped to address substance use disorders, other addictions and mental illness, with long-term outcomes to create fully mature congregational ministry teams.

C. Who benefits and how?
Persons served and the public benefits

D. How was the accomplishment achieved?
Under the leadership of MHSD Executive Management these initiatives were provided administrative support, staffing and funding as part of the evolvement of an integrated system of care and service delivery.

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: (Care Management/Administration) ROSC

A. What was achieved?
In FY18, Metropolitan Human Services District (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.

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.

Why is this success significant?
The implementation process of a ROSC is lengthy and in its initial phase MHSD has secured federal technical assistance to serve as the lead for inter and intra agency change.

B. 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.

C. How was the accomplishment achieved?
By design, a ROSC provides individuals and families with more options with which to make informed decisions regarding their care. Services are designed to be accessible, welcoming, and easy to navigate.

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

E. 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: (Adult Behavioral health Services) State Targeted Response (STR) Grant

A. What was achieved?
The State Targeted Response (STR) Grant is a SAMSHA funded grant, intended to address the epidemic use of Opioids, which has resulted in record numbers of deaths in the state. Targeted groups include 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.

B. Why is this success significant?
The grant funds prevention, intervention and referral for services for Opioid Users at risk.

C. Who benefits and how?
Persons served and the public benefits

D. How was the accomplishment achieved?
Under the leadership of MHSD Executive Management, these initiatives were provided administrative support and staffing as part of the evolvement of an integrated system of care and service delivery.

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

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

Accomplishment #7: (Child and Adolescent Behavioral Health Services) Child and Youth Services Expansion

A. What was achieved?
The MHSD Child and Youth Program increased partnerships and enhanced prevention programming as part of the integrated system of care and service delivery. The agency specifically expanded family support, youth support and prevention programming.

B. Why is this success significant?
› The Family Support program reinstituted the Interagency Service Coordination (ISC) process for children and youth served in the MHSD catchment area. ISC is a planning and service coordination process that provides multi-agency planning for youth who are receiving services from two or more child-serving agencies. The goal of this service is to keep referred youth in Orleans, Plaquemines and St. Bernard parishes in the most family-like setting appropriate to their needs and to reduce the use of out-of-home placement.

› The Youth Support program expanded its services to include an alternative high school and two therapeutic day programs in Orleans Parish while maintaining ongoing services at two alternative high schools in Orleans parish and two alternative schools in in Plaquemines and St. Bernard parishes. These services are designed to address behaviorally challenged youth with enrichment programming in the visual arts, career exploration, and soft skills development for the workforce. This accomplishment required program design for the new school and two programs, new agreements with the teams of teachers, and MOUs with three charter management organizations.

› The MHSD Prevention program continued implementation of the Louisiana's High Needs Communities (HNC) Prevention grant in Plaquemines Parish, which led to the development of a strategic prevention framework action plan and budget for the newly formed anti-drug coalition. The coalition's objectives are to reduce underage drinking and the misuse of prescription drugs. The formation of the coalition was achieved by the grassroots efforts of individuals in the community with interest in forming a coalition around targeted quality of life issues.

C. Who benefits and how?
Youth with exceptionalities and their families, schools who offer alternative programming for behaviorally challenged youth, inter-agency coordination within the children's system of care, and the community at large. All benefit from efforts at improving quality of life issues in the schools and broader community.

How was the accomplishment achieved?
Under the leadership of MHSD Executive Management these initiatives were provided administrative support, staffing and funding as part of the evolvement of an integrated system of care and service delivery.

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

E. 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?

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

- **Where are you making significant progress?** If you are making no significant progress, state "None."

None. Progress is being made, but progress is within the expected range and is not considered significant.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

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. Adjustments were not needed.

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

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

There are no significant departmental, management, or operational problems/issues identified. Metropolitan Human Services District continues to work toward its goal of providing quality behavioral health care.

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

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
5. How long has the problem or issue existed?
6. What are the causes of the problem or issue? How do you know?
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

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

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

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

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

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

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

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

☐ Program evaluation by contract

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

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

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

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

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

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

☒ Yes. Proceed to Section C below.

☐ No Skip Section C below.

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

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

1. Title of Report: **AIP/Accountability & Implementation Plan**
2. Date Complete: 1/31/2018
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: AIP is available in hardcopy and electronic file; report file will be available in same format.
10. Contact person for more information:
    Name: Rochelle Head-Dunham, M.D.
    Title: Executive Director/Medical Director
    Agency & Program: 09-304 Metropolitan Human Services District (MHSD)
    Telephone: 504-535-2909
    E-mail: Rochelle.Dunham2@la.gov

1. Title of Report: **Independent Financial Audit**
2. Date Completed: June 30, 2017 (for FY17)

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:

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

1. Title of Report or Program Evaluation: **MHSD Operations Risk Management Audit**
2. Date completed March 20, 2018
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 92.12, status: compliant
7. Major Recommendations: Conduct and document employee awareness/training on the agency's Transitional Return to Work Policy once every 5 years after initial training.
8. Action taken in response to the report or evaluation: Working with HR to document initial training and incorporated the review training in our online training tool RELIAS.
9. Availability (hard copy, electronic file, website): Hard copy, and electronic file.
10. Contact person for more information:

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

Annual Management and Program Analysis Report

Fiscal Year 2017-2018

Department:	**Louisiana Department of Health (LDH)** 09-305 Medical Vendor Administration and 09-306 Medical Vendor Payments
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: Provider Management Solicitation for Proposals Issued

A. What was achieved?
The Louisiana Department of Health (LDH) created and issued a Solicitation for Proposals to accomplish the department's goal of a centralized Medicaid provider enrollment and management system, including a single-source provider registry. This system will also meet requirements of the Affordable Care Act and the 21st Century Cures Act.

B. Why is this success significant?
This success is significant because the Provider Management system will eliminate duplicative credentialing and enrollment processes while also improving provider satisfaction, provider registry integrity, and the State's compliance with federal law.

C. Who benefits and how?
Medicaid providers benefit because they will be able to enroll in fee-for-service Medicaid and the managed care organizations using a single, online application. This will also benefit Medicaid recipients because information entered by providers into the online application will also be used to populate a single-source registry, leading to more accurate information used by recipients to make decisions about their health care.

D. How was the accomplishment achieved?
This accomplishment was achieved by close collaboration with subject matter experts within the department, leading to the creation of an SFP that outlines a foundation for a successful implementation of the system.

E. Does this accomplishment contribute to the success of your strategic plan?
The Provider Management System will provide a more accurate, streamlined process for reviewing provider information and making educated decisions about their enrollment. Therefore, issuing this SFP contributes to the success of the following sections of the department's strategic plan:

1. Activity 4, Objective IV: Through the MMIS Operations activity, maintain effective and efficient enrollment and disenrollment through June 30, 2021.

2. Activity 8, Objective III: Through the Program Integrity activity, prevent, detect and remove from participation providers that do not meet the eligibility criteria through June 20, 2021.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? No

Accomplishment #2: Medicaid Managed Care Organization (MCO) Contract Extension with Quality Health Outcomes and Value Based Payment (VBP) Withhold

Medicaid Managed Care Organization (MCO) Contract Extensions

A. What was achieved?
The Joint Legislative Committee on the Budget (JLCB) approved the extension of the five managed care organization (MCO) contracts until December 31, 2019. The contracts would have expired on January 31, 2018.

B. Why is this success significant?
The two-year extension averted the disruption that would have come from contracts not

being in place on February 1, 2018 and it allows enough time:

1. For the MCOs to invest in change and see results;
2. To provide opportunity for improvement immediately and throughout the re-procurement process; and
3. To drive meaningful change, quality improvement and increased use of value-based payment.

C. Who benefits and how?
The State benefits from the increase in quality and improved outcomes achieved through value-based payment.

D. How was the accomplishment achieved?
LDH staff worked with key legislative staff to respond to inquiries from legislators and provided extensive testimony at JLCB hearings.

E. Does this accomplishment contribute to the success of your strategic plan? Yes
Information provided in Section II below.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No

<u>Accomplishment #3: Introduction of Quality/Health Outcomes and Value-Based Payment (VBP) Withhold of Capitated Payment in MCO Contracts</u>

A. What was achieved?
Through the contract extension approval, BHSF was able to repurpose the current 2% withhold of monthly capitated payments from an incentive for contract compliance to an earn back opportunity based on MCO performance on quality measures and use of VBPs.

- One percent to incentivize quality and health outcomes – LDH updated its Medicaid quality performance measures based on statewide stakeholder input and added stretch goal targets for "money measures," in line with national benchmarks.
- One percent to incentivize the increased use of VBPs – LDH added a withhold earn back opportunity for MCOs to increase the use of VBPs to providers over time and to advance VBP contracts/arrangements with providers per CMS' Health Care Payment Learning and Action Network Alternative Payment Model Framework.

B. Why is this success significant?
The revised withhold puts real money at stake for quality improvement and a shift from volume to value (improved health outcomes) in the way Medicaid pays providers for health care. It also establishes national standards and benchmarks for quality performance measurement.

C. Who benefits and how?
The State benefits because the change focuses MCOs and providers on shared targets for population health improvement using a limited set of stakeholder-recommended quality measures and aligns financial incentives for MCOs and providers. Providers also benefit because the change streamlines the number of incentive-based quality measures across all MCOs, links statewide quality measures to VBP contracts, and requires MCOs to report performance on quality outcomes to providers in a standard format.

D. How was the accomplishment achieved?
LDH staff worked with key legislative staff to respond to inquiries from legislators and provided extensive testimony at JLCB hearings. LDH also worked extensively with MCOs through a Q&A process to gain consensus on the contract changes.

In addition, LDH enlisted the support of external consultants with specific expertise in implementing VBPs in other states to bring a national perspective on best practices to the VBP contract requirements and program design.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, details 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, the consensus building process conducted with the MCOs to "sign off" on these new contract requirements prior to LDH's appearance at JLCB to request approval for the contract extensions helped minimize potential issues/conflicts with the approvals process. In addition, applying national best practices to construct the withhold contract requirements and program design contributed to a defensible contracting strategy.

<u>Accomplishment #4: Applied Behavior Analysis Integration into Managed Care</u>

A. What was achieved?
Applied Behavioral Analysis (ABA) services were only available through the fee-for-service delivery model. The Department established the state and federal authorities, which allowed these services to be integrated into the Managed Care Program.

B. Why is this success significant?
This success is significant because integrating ABA services into managed care ensured continued access to these specialized services through a delivery model, which could provide an adequate network of providers and proper management and prior authorization of the services delivered.

C. Who benefits and how?

Carving ABA into managed care allows the department to verify that individuals are receiving the services authorized in their plans of care and to ensure that an adequate network of providers is in place and ongoing monitoring and measuring of activities is routinely taking place. Recipients of ABA services can benefit as well by having access to a robust provider network, which is assured through the managed care organizations framework.

D. How was the accomplishment achieved?
From a regulatory perspective, the accomplishment was achieved through amendments to the associated administrative rules, 1915(b) waiver, and managed care contracts. From an operational perspective, the accomplishment was made through a vigorous effort to collaborate with, and educate the provider community, managed care organizations, trade organizations, and stakeholders/parents. Weekly meetings and training sessions were held with key stakeholders to ensure that as the Department proceeded with the regulatory infrastructure, it was also building a working knowledge and informing on operational processes under the new managed care environment.

E. Does this accomplishment contribute to the success of your strategic plan?
Yes, this accomplishment contributed to the success of the strategic plan. It ensured that eligible recipients were getting access to the appropriate services and the Department was able to better manage the services.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, this accomplishment does represent a Best Management Practice in that it contributes to the philosophy that involving key stakeholders in the process of change early on and collaborating on what the needs are of those being served is critical to the success of the change.

<u>Accomplishment #5: Successful Change in Reasonable Compatibility Standard</u>

A. What was achieved?
Effective June 1, 2018 the reasonable compatibility standard decreased from 25% to 10%. In addition, the formula for calculating the difference between the self-attested income and income from data sources changed. The Reasonable Compatibility Calculator makes the calculation based on the new formula. Affordable Care Act (ACA) regulations require states to compare electronic data sources to income information provided by the applicant or member to determine if the electronic data and the individual's self-attestation of income are reasonably compatible. LDH used a 25% reasonable compatibility standard in the past (the highest of any other state) and we successfully decreased the compatibility standard to 10% in response to legislative concerns that recipients had incomes higher than they reported on their Medicaid applications.

B. Why is this success significant?
Reasonable compatibility changes may provide cost savings to the State and direct those funds to citizens who are eligible for Medicaid services. It also addresses concerns of the legislature that ineligible individuals received Medicaid because of the 25% reasonable compatibility standard.

C. Who benefits and how?
The change in Reasonable Compatibility Standard could save LDH money by excluding people that are not eligible for Medicaid. The department's budget authority reduced by 20 million dollars state general funds to account for the savings/cost avoidance achieved as a result.

D. How was the accomplishment achieved?
Louisiana Medicaid achieved this accomplishment by House Bill 1 of the 2018 Second Special Legislative Session, where the reasonable compatibility standard decreased from 25% to 10% effective June 1, 2018. In addition, the formula for calculating the difference between the self-attested income and income from data sources changed. The change was implemented throughout our regional offices statewide effective June 1, 2018. This implementation included updating our internal policies and procedures and distributing them to the Eligibility Division. In addition, we created, piloted, and implemented a new tool in late June through early July that provided the regional staff efficient ways to document the cases reviewed, calculate reasonable compatibility, and report this data to the Legislature.

E. Does this accomplishment contribute to the success of your strategic plan?
This accomplishment contributes to the success of our strategic plan by increasing access to Medicaid benefits and maximizing our resources to identify and retain eligible individuals.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
The reasonable compatibility changes represent a Best Management Practice because it restores public confidence in Louisiana government and demonstrates that Louisiana is taking a progressive approach toward improving processes and providing access to care for our residents despite extraordinary challenges.

<u>Accomplishment #6: 1115 SUD Waiver</u>

A. What was achieved?
In effort to combat the opioid crisis, LDH submitted a request to CMS for a Section 1115 demonstration waiver to improve access to and quality of substance use disorder (SUD) treatment which was approved effective February 1, 2018. Following approval of the waiver, the Office of Behavioral Health and Medicaid have worked with CMS to develop and implement the extensive evaluation and reporting requirements outlined in the waiver's special terms and conditions.

B. Why is this success significant?
The SUD demonstration authorizes Louisiana to receive federal financial participation (FFP) for the continuum of services to treat addiction to opioids or other substances, including services provided to Medicaid enrollees with substance use disorder residing in certain residential treatment facilities that meet the definition of an Institution for Mental Disease (IMD).

C. Who benefits and how?
This is part of a comprehensive strategy to combat prescription drug abuse and opioid use disorders, and provide treatment services, including withdrawal management services.

D. How was the accomplishment achieved?
The Office of Behavioral Health and Medicaid worked together to develop the waiver application and secure CMS approval. Approval is conditioned on compliance with a set of special terms and conditions defining the nature, character and extent of anticipated federal involvement in the project. To ensure the terms and conditions of the waiver are met and maintained throughout the demonstration period, Medicaid coordinates all required regulatory and reporting activities and serves as the liaison with CMS.

E. Does this accomplishment contribute to the success of your strategic plan?
Implementation of the Opioid Use Disorder (OUD)/SUD program advances the purposes of the Medicaid program as it is expected to improve health outcomes for Medicaid beneficiaries, by increasing access to high quality OUD/SUD care and by maintaining the OUD/SUD provider networks available to serve Medicaid populations.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
The 1115 SUD Waiver builds on the State's existing efforts to improve models of care focused on supporting individuals in the community and home, outside of institutions and strengthen a continuum of SUD services based on the American Society of Addiction Medicine (ASAM) criteria or other comparable nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines. Additionally, the Office of Behavioral Health and Medicaid were asked to speak at a regional conference on mental health and substance use disorder prevention. Staff shared best practices for developing a successful and sustainable partnership between program offices and were praised for their ability to work together successfully to accomplish goals.

<u>Accomplishment #7: Success of Medicaid Expansion:</u>

A. What was achieved?
As of June 2018, 480,137 individuals were enrolled in the Medicaid expansion program. Three thousand, one hundred and nine (3,109) individuals were pre-enrolled

into expansion through the DOC pre-release program, and approximately 1,700 of those individuals were released and began receiving Medicaid benefits during the year. Medicaid enrollees continued to receive quality healthcare for pre-existing conditions and preventive care that they were not able to afford without this coverage. Colon cancer screenings were provided to 26,133 patients; polyps were removed for 8,355 patients; and there were 362 diagnoses of colon cancer as a result. Similarly, 439 breast cancer diagnoses, identified from 46,675 diagnostic breast imaging screenings, helped to save lives. Hypertension, known often as the silent killer, has been identified in 24,273 individuals who are now being treated for this disease.
With the stabilization of Medicaid expansion, LDH began to analyze the initial effects of the expansion of the Louisiana Medicaid program on state residents, the economy, and the Louisiana health care delivery system. This included the completion of a study to analyze the cost and economic impact of Medicaid expansion; the initiation of an evaluation of the quantitative impacts of Medicaid expansion, such as access to care and health care quality; and the administration of the 2017 Louisiana Health Insurance Survey (LHIS). According to the 2017 Louisiana Health Insurance Survey (LHIS), adult uninsured rates were dramatically reduced following the onset of the expansion program, dropping from 22.7% in 2015 to 11.4% in 2017.

B. Why is this success significant?
Collectively, these continued monitoring and evaluation efforts demonstrate many positive impacts resulting from Medicaid Expansion. Many of the newly insured are able to get quality healthcare for pre-existing conditions and preventive care that they were not able to afford without this coverage. Additionally, the State is able to finance these expenditures through enhanced federal funding through the expansion program rather than through uncompensated care allowances.

A major outcome of the cost and economic impact analysis indicated the state economy was boosted through the infusion of federal funds. This infusion of federal funds is creating or supporting 19,195 jobs across the State of Louisiana.

Additionally, the DOC pre-release enrollment program ensured that the approximately 1,700 individuals who were released from correctional facilities, many of whom are impacted by significant medical and behavioral health issues, could continue to receive needed care and coordinated services immediately upon release. The initial days of re-entry are often fraught with many competing priorities; by providing access to care and medications immediately upon release, the Department is eliminating at least one barrier to successful re-entry.

C. Who benefits and how?
By the end of SFY 2018, 480,137 individuals had access to new or enhanced full-benefit healthcare coverage through Medicaid. As a result, 212,482 individuals received new patient or preventive healthcare services during the year. Improved access to care improves health outcomes and contributes to creating a healthier Louisiana.

Through the DOC pre-release enrollment program, 3,109 individuals were pre-enrolled

into expansion and approximately 1,700 of those individuals were released and began receiving Medicaid benefits during the year. Additionally, as many as 227 individuals were identified as high-needs and began receiving case management and care coordination services prior to release to further assist with reentry.

A study released by the LSU E.J. Ourso College of Business, Public Administration Institute, entitled *Medicaid Expansion and the Louisiana Economy*, indicates that the economic impacts of Medicaid expansion have benefitted the State as a whole as well. The Institute reports that "the federal injection of $1.85 billion created and supported almost 19,200 jobs, state tax receipts of just over $103 million, and local tax receipts of $74.6 million" (http://gov.louisiana.gov/assets/MedicaidExpansion/MedicaidExpansionStudy.pdf).

D. How was the accomplishment achieved?
LDH continued to build on the successes of the first year of expansion. Additionally, through partnerships with its academic partners, LDH was able to increase its capacity to conduct these important studies.

DOC pre-release enrollment accomplishments were expanded to include regional reentry centers throughout the state in addition to state prisons. Assistance through the enrollment program with these new facilities included an abbreviated 1-page Medicaid application and frequent communication with DOC facilities to quickly resolve any issues that arise. LDH has also made a concerted effort to partner with the 19th, 22nd, 24th judicial district reentry courts, and the Orleans Parish Criminal District Court, to ensure that reentry participants who are soon to complete their incarceration and will be transitioning to the next phase of their reentry programming are identified and enrolled prior to release.

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

- MVP – Program A, Activity 1, Objective II: Maximize state general fund savings generated through enhanced federal financing under expanded Medicaid coverage.
- MVP – Program A, Activity 1, Objective III: Streamline eligible offender enrollment in Medicaid prior to release under new adult group and reduce cost and recidivism through case management of offenders with special healthcare needs.
- MVA – Program A, Activity 1, Objective I, Strategy 1.5: Streamline enrollment of justice-involved population.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. The Department's strategies used to implement and track the effects of Medicaid expansion have been used as a model for other states. Additionally, the Department's

close coordination with other agencies, leading to the successes of the DOC pre-release enrollment program, are a best practice that other departments or agencies could use when implementing cross-departmental or agency initiatives.

Accomplishment #8: Fraud, Waste, & Abuse Advancements

A. What was achieved?

Increased Managed Care Collections

The Program Integrity section opened 29 managed care provider cases in Fiscal Year 2017 and 345 cases in Fiscal Year 2018, which was a 1000% increase of opened managed care provider reviews. We also increased dedicated managed care plan oversight resources from one to four, which was a 300% increase in resource oversight.

Implemented Electronic Visit Verification

Medicaid Program Support & Waivers successfully implemented an Electronic Visit Verification (EVV) system across all regions of the state.

Established Recipient Fraud Unit

With the creation of a Recipient Fraud Investigation Unit, the goal of the Medicaid Unit was to centralize all of our fraud investigation activities. Previously, our regional Medicaid offices reviewed fraud complaints submitted through our Fraud.Complaints@LA.GOV email account, health plans, and various case review projects. This process lacked centralized oversight, it did not align with other agencies, and reporting was not available at an aggregate level to determine if the efforts met departmental goals. The new Recipient Fraud Investigation Unit centralizes the agency efforts and pursues fraudulent activity in a cohesive manner.

The unit has reached out to the Office of the Louisiana Attorney General to have standing monthly meetings to review complaints that originate from their office. It also provides a platform for discussion of other cases that we may refer to their office. The unit also has a liaison with LDH Bureau of Legal Services and the Department of Children and Family Services (DCFS). The unit has created a working procedural manual for its staff to follow and has cleared over 50 complaints thus far. The team is also included in an all-state Fraud Eligibility Technical Assistance Group (ETAG) call with Centers for Medicare & Medicaid (CMS) to ensure that we perform procedures according to federal rules and regulations. Upon the request of our Executive Management Team (EMT), we began an investigation of potential repercussions of fraudulent activity by the public involving sanctions, recoupment, and other legal recommendations by LDH.

B. Why is this success significant?

Increased Managed Care Collections

Over 65% of Medicaid, funding and over 80% of Medicaid recipients are in a managed care plan. This significant increase aligns Program Integrity efforts in the

detection, prevention, and recovery of fraud, waste, and abuse overpayments identified in Medicaid. This increase has also resulted in a 17% increase of cost avoidance dollars and an increase in fraud referrals.

It is also significant that LDH added resources to its Managed Care Organization (MCO) plan oversight of fraud, waste, and abuse activities. Increased resources have enhanced fraud, waste, and abuse reports and activities from the MCOs, which resulted in increased fraud referrals and notices as well as overpayments identified by the MCOs.

Implemented Electronic Visit Verification

The department faced substantial challenges in efficiently monitoring and verifying that Home And Community-Based Service (HCBS) providers provided 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.

Established Recipient Fraud Unit

Success is significant because reducing fraud is a benefit to the State of Louisiana and its taxpayers. It reduces waste and ensures we manage public funds in accordance with federal and state regulations. The unit reviews all aspects of fraud complaints, completes Medicaid eligibility actions, and makes referrals to other state departments including law enforcement.

C. Who benefits and how?

Increased Managed Care Collections

Medicaid recipients, Medicaid providers, Louisiana taxpayers, and recipients benefit from the increase in fraud, waste, and abuse reviews of managed care plan providers by having better services performed by compliant providers. Providers benefit by not having to compete against noncompliant providers. Louisiana taxpayers benefit by not having to use their tax dollars for fraud, waste, and abuse.

Medicaid recipients and Louisiana taxpayers benefit from the increase in managed care plan oversight of fraud, waste, and abuse activities because they will receive the best care available. Louisiana taxpayers also benefit by not having fraud, waste, or abuse tax dollars in Medicaid managed care.

Implemented Electronic Visit Verification

The EVV system allows the department to verify that individuals are receiving the services authorized in their plans of care, reduces inappropriate billing/payment, safeguards against fraud, and improves program oversight. The department has realized cost benefits through mechanisms described above in addition to operational benefits. 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. For the first quarter of 2018, payments were $6.5 million less compared to the first quarter of 2017 equating to a 3.8% reduction in total

payments. The EVV system allows LDH employees to access and view all services collected in real time including check in and check out data. Through the department's work with its EVV contractor, we integrated many operational benefits into the EVV system and made it available to providers. Some of these benefits include system ease of use, direct interaction with current procedures and processes, and time-saving and increased efficiency measures. Additional benefits are that it provides greater oversight and validation of services resulting in less audit findings/recoupment, it provides access to free personnel management reports, it greatly reduces the need for manual data entry, and it reduces lag time for reports. LDH has received positive feedback from providers expressing satisfaction with the system.

Established Recipient Fraud Unit

The State of Louisiana benefits when solid fraud monitoring and waste reduction protocols are in place to assure the proper management of tax-funded programs. Reduction of waste ensures sufficient funds to maintain programs for eligible individuals. This in turn ensures that citizens who are eligible for Medicaid will have access to quality healthcare coverage and streamline access to care, which will improve health outcomes and contribute to creating a healthier Louisiana.

D. How was the accomplishment achieved?

Increased Managed Care Collections

Program Integrity accomplished the increase in fraud, waste, and abuse reviews of managed care plan providers by mining strategic data, reallocating resources to focus on managed care providers, and creating a balance of resource allocations between managed care and fee-for-service payments that align with Medicaid funding.

We increased managed care plan oversight resources of fraud, waste, and abuse activities through a strategic budget request for additional personnel and a strategic reallocation of current resources.

Implemented Electronic Visit Verification

As part of a cross-departmental collaboration, 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. Medicaid Program Support & Waivers successfully implemented EVV for HCBS direct care services delivered outside of the home including center-based, vocational and transportation on March 1, 2016. We implemented EVV for personal care service providers across all regions in Fiscal Year 2018.

Established Recipient Fraud Unit

We accomplished our goal by deciding that the Recipient Fraud Investigation Fraud Unit would be associated with the Eligibility Program Operations (EPO) section, which supports the Eligibility Field Operations (EFO) section. We secured funding, posted positions in January 2018, and activated the unit on June 1, 2018. The unit reports to a Program Manager 2 over Post Eligibility Reviews and it has five (5) staff members. The team currently includes a Medicaid Program Manager 1-B, Medicaid Program Manager 1-A and one (1) Medicaid Program Monitor. Over the course of the next month, we will fill two (2) additional Medicaid Program Monitor positions. EFO transferred knowledge and duties from the regional office that managed fraud at the local level to the state office level.

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

Increased Managed Care Collections

Yes, the increase in fraud, waste, and abuse reviews of managed care plan providers and the increase in plan oversight of fraud, waste, and abuse resources and activities contribute to the success of our strategic plan.

Implemented Electronic Visit Verification

Yes. As described in part C, 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.

Established Recipient Fraud Unit

Yes, this accomplishment contributes to the success of our strategic plan. One objective of the strategic plan is to provide Medicaid eligibility determinations and administer the program within federal regulations. The Recipient Fraud Investigation Unit will streamline our business processes to eliminate duplicated efforts and find new and more efficient ways to identify ineligible enrollees.

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

Increased Managed Care Collections

No, the increase in fraud, waste, and abuse reviews of managed care plan providers does not represent a Best Management Practice for other executive branch departments or agencies. The increase in managed care oversight of fraud, waste, and abuse resources and activities does.

Implemented Electronic Visit Verification

Yes. This is an accomplishment and best management practice applicable to Medicaid. House Rule 34, the 21st Century Cures Act, signed into law on December 13, 2016. This law 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.

Established Recipient Fraud Unit

Yes, this accomplishment represents a Best Management Practice for other executive branch departments or agencies. We believe that the Recipient Fraud Investigation Unit will be highly effective in our efforts to streamline services and free up resources for other agencies within the State of Louisiana.

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?

Accomplishment #1: Provider Management Solicitation for Proposals Issued

Issuing this Solicitation for Proposals (SFP) contributes to the success of the following sections of the department's strategic plan:

a. Activity 4, Objective IV: Through the MMIS Operations activity, maintain effective and efficient enrollment and disenrollment through June 30, 2021.

b. Activity 8, Objective III: Through the Program Integrity activity, prevent, detect and remove from participation providers that do not meet the eligibility criteria through June 20, 2021.

Returns on investment have not been realized and may not be fully seen until full implementation.

Accomplishment #2: MCO Contract Extension with Quality Health Outcomes and Value-Based Payment (VBP) Withhold of Capitated Payment

This activity contributes to the agency’s goal of implementing revised payment policies and structures that dis-incentivize the inappropriate use of higher cost, non-medically necessary procedures and further ensures quality of care through performance-based payments.

Through the extension of the MCO contracts and the change to the Withhold, the Medicaid Managed Care Program activity increases budget predictability while providing for a service delivery model of high quality, medically necessary health.

Accomplishment #4: ABA Integration into Managed Care

This accomplishment contributes to the success of the agency's strategic plan by ensuring that eligible recipients are getting access to the appropriate services and the Department is able to better manage the services.

The anticipated outcomes, goals and objectives of integrating ABA into our managed care program are being attained and performance targets are commensurate with what the Department expected. All of the associated policies were released timely and operational milestones were met so the strategies we imposed are working as expected and are effective. The anticipated returns on investments are being realized.

Accomplishment #5: Successful Change in Reasonable Compatibility Standard

This accomplishment contributes to the success of the agency's strategic plan by increasing access to Medicaid benefits and maximizing the agency's resources to identify and retain eligible individuals.

The legislative auditors' data shows that the reasonable compatibility standard will work for Medicaid Eligibility.

Accomplishment #6: Section 1115 SUD Waiver

Implementation of the Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) program advances the purposes of the Medicaid program, as it is expected to improve health outcomes for Medicaid beneficiaries by increasing access to high quality OUD/SUD care, and by maintaining the OUD/SUD provider networks available to serve Medicaid populations.

The agency's goal of increasing access to behavioral health services is advanced through the approval of the Section 1115 demonstration waiver. Medicaid enrollees in need of substance use disorder treatment are able to receive these services in the most appropriate setting for the individual, regardless of length of stay, in a manner conducive to their treatment needs that is cost-effective. Allowing Medicaid enrollees to receive access to services in a setting that is dedicated to treating their specific needs will promote access to high-quality, specialized care, which is both clinical and financially beneficial.

Accomplishment #7: Success of Medicaid Expansion:

This accomplishment contributes to the strategic plan initiatives listed below:

- MVP – Program A, Activity 1, Objective II: Maximize state general fund savings generated through enhanced federal financing under expanded Medicaid coverage.

- MVP – Program A, Activity 1, Objective III: Streamline eligible offender enrollment in Medicaid prior to release under new adult group and reduce cost and recidivism through case management of offenders with special healthcare needs.
- MVA – Program A, Activity 1, Objective I, Strategy 1.5: Streamline enrollment of justice-involved population.

In SFY 2018, the Department built upon the success of the prior fiscal year, in which Medicaid expansion enrollments exceeded the Department's goals. As a result, the Department continued to exceed expansion enrollment expectations, including enrollment of justice-involved populations, which contributed to the overall health and economic growth of the state. The LHIS and *Medicaid Expansion and the Louisiana Economy* reports indicate that the Department is meeting its goals for the expansion program by maximizing state general fund savings with the use of enhanced federal funding.

Accomplishment #8: Fraud, Waste, & Abuse Advancements

The increase in fraud, waste, and abuse reviews of managed care plan providers and the increase in plan oversight of fraud, waste, and abuse resources and activities contribute to the success of our strategic plan.

Implemented Electronic Visit Verification

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.

Our targeted goals of maximizing the use of data and technology to produce efficiencies that facilitate or ensure program integrity are being accomplished with the successful implementation of EVV. By implementing EVV, the Established Recipient Fraud Unit.

This accomplishment contributes to the success of the agency's strategic plan. One objective of the strategic plan is to provide Medicaid eligibility determinations and administer the program within federal regulations. The Recipient Fraud Investigation Unit will streamline business processes to eliminate duplicated efforts and find new and more efficient ways to identify ineligible enrollees.

Additionally, the resources and leadership of these resources are in place to achieve the goals; our strategies are very effective. The return on investment has not been apparent for Program Integrity but now with more resources and leadership, we expect to see a return in the next fiscal year.

- **Where are you making significant progress?** If you are making no significant progress, state "None."

Accomplishment #1: Provider Management Solicitation for Proposals Issued

None

Accomplishment #3: Introduction of Quality/Health Outcomes and Value-Based Payment (VBP) Withhold of Capitated Payment in MCO Contracts

BHSF engaged legislators, providers, MCOs, and other key stakeholders in the development of the new value-based payment approach.

BHSF has invested in staff with experience in quality management and innovations to further the progress. BSHF has also contracted with nationally recognized experts in value-based payment to assist with driving the delivery of services in a way that improves outcomes.

Our progress is expected to continue at a steady pace.

Accomplishment #4: ABA Integration into Managed Care

We are making significant progress toward building a robust provider network across all managed care organizations and improving access to ABA services by streamlining processes where possible.

The success is attributed largely to close collaboration between the Medicaid Program, impacted populations, providers and stakeholders. We involved these individuals early into the process and provided robust training and follow-up throughout the process. The same results would not have been generated had we not utilized a very focused and "hands-on" approach to this initiative. We had a dedicated program manager assigned to the project to ensure an efficient and timely progression of activities associated with the transition from a fee-for-service to a managed care delivery model. The success was a collaborative effort across multiple Sections within the LDH Medicaid program.

Progress is expected to continue in improving and growing the provider network for the delivery of ABA services and we do anticipate utilization of ABA services will progress at an accelerated pace.

Accomplishment #5: Successful Change in Reasonable Compatibility Standard

Efforts associated with the reasonable compatibility changes maximize our revenue opportunities, redirect our resources, strengthen our review processes, and continue to meet state and federal guidelines by providing healthcare to Louisiana citizens

Our success is largely due to management seeing opportunities to improve health outcomes in

Louisiana that they would not have been able to achieve without the specified actions from the Louisiana Legislature.

Medicaid expects progress to continue at an accelerated rate.

Accomplishment #6: 1115 SUD Waiver

None

Accomplishment #7: Success of Medicaid Expansion:

Our success is largely due to management's continued efforts to develop and streamline processes related to the expansion enrollment, including extensive efforts to establish efficient data-sharing with correctional facilities to enable administrative simplification of DOC pre-release enrollment efforts and capitalizing on eligibility simplification authorities to streamline enrollment such as being an Federally Facilitated Marketplace (FFM) determination state and utilizing SNAP assisted enrollment.

Progress related to the continued success of the expansion program is related to departmental actions during the prior fiscal year. These actions include proactively "flipping" individuals who were enrolled in limited-benefit plans to the full-benefit expansion program financed by enhanced federal match and streamlining the Medicaid application process by leveraging the existing resources available through the Federally Facilitated Marketplace and Supplemental Nutrition Assistance Program. Progress related specifically to expansion enrollment of the DOC pre-release population is a result of resources dedicated to proactively streamline processes, especially through technology-driven solutions and daily systems interfaces. The Department has also capitalized on contractual staff augmentation resourcing to assist with the influx of applications to maintain reasonable processing times.

The success of Medicaid expansion is directly attributed to the involvement of the LDH Secretary's office and all sections of the Bureau of Health Services Financing (BHSF). The success of the DOC pre-release enrollment program is attributable to a joint effort by BHSF and DOC.

Expansion population enrollments continued to surge through much of this second year of implementation; however, recent months have shown that the growth is leveling off, especially as the first annual eligibility redeterminations began rendering some individuals ineligible for continued coverage. Progress with the DOC pre-release population, however, is expected to continue as BHSF expands efforts to extend the program to local correctional facilities as technologies allow.

Accomplishment #8: Fraud, Waste, & Abuse Advancements

Implemented Electronic Visit Verification

As described under accomplishments, significant progress has been made 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.

Established Recipient Fraud Unit

The unit created a procedural manual for staff, we exceeded our timeline for achievement by clearing more than 50 complaints and additional reviews are underway in hopes to minimize departmental costs.

Increased Managed Care Collections

Program Integrity is making significant progress in preventing, detecting, and recovering Medicaid provider overpayments by aligning resources with Medicaid funding and then allowing those resources to focus on strategic and targeted data mining, research, and review of claims to increase the recovery of dollars identified and prevent ineligible payments. Focusing on the return on investment drives our desired performance.

Implemented Electronic Visit Verification

Cross-departmental collaboration resulted in 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 approved a sole source request to include EVV for in-home services in the current prior authorization data contract with Statistical Resources, Inc. (SRI).

Increased Managed Care Collections

We attribute our success to a leadership change and additional resources. External factors do not affect our progress and we could not achieve our results without specific department action.

Established Recipient Fraud Unit

Our success is largely due to management seeing opportunities to improve health outcomes in Louisiana that they would not have been able to achieve without the specified actions from the Louisiana Legislature.

Implemented Electronic Visit Verification

After working with the initial EVV contractor, researching best practices, and documenting system issues, the Division of Administration 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. Medicaid Program Support & Waivers successfully implemented EVV for HCBS direct care services delivered outside of the home including center-based, vocational and transportation on 3/1/2016.

Increased Managed Care Collections

Yes, Program Integrity added more resources in managed care plan oversight and reallocated resources to accomplish our goals. We also implemented new technology that will assist in determining ROI (return on investment) on case reviews before allocating resources. Other methodologies that helped improve service delivery included strategic data mining efforts and coordination by planning data runs and working with more internal units.

Established Recipient Fraud Unit

Many departments took actions simultaneously to implement the reasonable compatibility policy changes, establish the new Fraud Unit, and coordinate our efforts to ensure our success. The Secretary and Medicaid Director led these efforts and all sections within the Bureau of Health Services Financing (BHSF) engaged to modify systems, forms, policies, procedures, training, etc. As mentioned above, we developed a new electronic tool to track the processed cases, calculate the reasonable compatibility, and for reporting purposes.

The success of the reasonable compatibility changes and the Fraud Unit implementation were a result of the direct involvement by the LDH Secretary's office and all BHSF Sections.

The benefits to the citizens of Louisiana will not be apparent immediately; however, with streamlined access to care, over time we will see a reduction in ineligible payments, which will decrease the cost of healthcare for Louisiana's citizens.

Implemented Electronic Visit Verification

Medicaid coordinates and leads EVV implementation efforts for the department.

Increased Managed Care Collections

Our success is largely because management saw opportunities to improve health outcomes in Louisiana.

Established Recipient Fraud Unit

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

<u>Accomplishment #1: Provider Management Solicitation for Proposals Issued</u>

The vendor protest, an external issue, impacted the timeline but not overall requirement of the project.

Accomplishment #7: Success of Medicaid Expansion

We are experiencing a lack of progress because we have been unable to continue advancing the DOC program to additional phases of implementation with local facilities due to technology and resourcing constraints.

Resourcing constraints at the Department of Corrections inhibit our ability to collect necessary data and maintain data integrity.

The lack of progress is related to an external issue as dedicated funding needs to be tied to hiring resources to manage Medicaid enrollment. Additionally, a new, more advanced offender tracking system would allow us to operate more efficiently and assist with data integrity issues.

Accomplishment #8: Fraud, Waste, & Abuse Advancements

None

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

Accomplishment #1: Provider Management Solicitation for Proposals Issued

☒ No. If not, why not?
We are in the process of updating and will address in the future.

Accomplishment #3: Introduction of Quality/Health Outcomes and Value-Based Payment (VBP) Withhold of Capitated Payment in MCO Contracts

☒ No. If not, why not?
A change is not needed.

Accomplishment #4: ABA Integration into Managed Care

☒ Yes. If so, what adjustments have been made and how will they address the situation?
Medicaid has increased opportunities to collaborate with those who are directly impacted by agency initiatives (i.e. managed care organizations, providers, recipients and other stakeholders) early into the planning phase and continued that collaboration well after implementation.

Accomplishment #5: Successful Change in Reasonable Compatibility Standard

☒ No. If not, why not?

No adjustments are necessary at this point.

Accomplishment #6: 1115 SUD Waiver

☒ No. If not, why not?
Will update based on the timeframe of when updates can be made.

Accomplishment #7: Success of Medicaid Expansion:

☒ No. If not, why not?
Our strategic plan was revised in 2016 to reflect current Departmental priorities that remain relevant.

Accomplishment #8: Fraud, Waste, & Abuse Advancements

☒ No. If not, why not?
No adjustments necessary at this point.

- **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?
   Under-resourcing due to budget constraints and procedural issues causing delays in progress.

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, MMIS, 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.

   In addition to these recruiting difficulties, we have experienced marked delays in implementation of federal requirements such as implementation of a single provider management system module. This resulted from procedural requirements allowing extended and multiple protests by the entity not selected as awardee on the RFP.

This issue has been particularly detrimental to systems modernization as required by CMS.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Providers are particularly impacted by these issues due to continued administrative complexity (e.g., the state was delayed in implementing a single provider management contract that would have allowed them to credential with one entity instead of six). Our inability to recruit into key vacancies has led to deficits in provider network management and provider relations staff along with encounter/claims oversight. This creates additional burden on providers seeking `redress of payment issues.

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

6. What are the causes of the problem or issue? How do you know?
   One cause is budgetary and political constraints that do not allow for additional state hiring. Additionally, Civil Service requirements do not allow for appropriate flexibility.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   We are unable to comply with federal requirements along with provider abrasion.

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.

   While there is no corrective action that LDH can take solely on its own to correct the issue, the Department has worked with Civil Service on this matter. LDH has met with Civil Service to convey the complexity of the Department and to explain why the current Civil Structure does not meet the needs of LDH. LDH Executive Management will continue working with Civil Service to help to identify the type of positions and organizational structure that will accommodate the complex needs of the Department.

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

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

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

5. Do corrective actions carry a cost?

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

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

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

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

The Internal Audit function, within LDH Office of the Secretary, appraises

activities within the Department to safeguard the Department against fraud, waste 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 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 communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts financial audits, 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 Office of Inspector General and the Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

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

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

☒ **In-house performance accountability system or process**
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the

Office of the Secretary, as well as each LDH agency. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies and programs review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, as well as agency and program management department-wide.

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

Additionally, Medicaid utilizes Healthcare Effectiveness Data and Information Set (HEDIS) along with other CMS and National Committee for Quality Assurance data benchmarks to measure program effectiveness under managed care.

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

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

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:
   Response to HCR 86 of the 2017 Legislative Session (hospital payment study) & Expansion Economic Impact Analysis

2. Date completed:
   March 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   To show to the legislature the impact of Medicaid expansion on hospital costs and reimbursement along with the growing need for hospital payment modernization.

4. Methodology used for analysis or evaluation:
   Outside contractors utilized data direct from hospitals and Medicaid data supplied by LDH to perform statistical analysis on utilization trends and outcomes.

5. Cost (allocation of in-house resources or purchase price):
   $644,943.75

6. Major findings and conclusions:
   There was a 17% shift from uninsured (uncompensated care) in inpatient discharges and 12% shift in outpatient treatment due to expansion. Additionally, cost coverage varies widely across hospitals with most losing money on Medicaid base payments. As the supplemental payment cap approaches, we need to shift funding through Diagnosis Related Groups (DRGs) based into the base reimbursement rate for hospitals.

7. Major recommendations:
   Move to Diagnosis Related Groups to modernize hospital payment reimbursement within base payments as opposed to supplemental payments.

8. Action taken in response to the report or evaluation:
   Medicaid is moving toward DRG implementation in FY 19.

9. Availability (hard copy, electronic file, website):
   http://ldh.la.gov/assets/docs/LegisReports/HCR86RS2017JanRspns.pdf

10. Contact person for more information:
    Name: Jen Katzman
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-5166
    Email: Jennifer.Katzman@LA.gov

1. Title of Report or Program Evaluation:
   Expansion Economic Impact Analysis

2. Date completed:
   April 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   To analyze the impact of Medicaid expansion on the economy including jobs and taxes, etc.

4. Methodology used for analysis or evaluation:
   Outside contractors utilized Medicaid data supplied by LDH to perform statistical analysis on economic and utilization trends and outcomes.

5. Cost (allocation of in-house resources or purchase price):
   $138,880

6. Major findings and conclusions:
   The infusion of $1.8 billion in federal spending on health care through the Medicaid expansion had a $3.5 billion economic impact in Louisiana.

7. Major recommendations:
   Not Applicable

8. Action taken in response to the report or evaluation:
   Not Applicable

9. Availability (hard copy, electronic file, website):
   http://gov.louisiana.gov/assets/MedicaidExpansion/MedicaidExpansionStudy.pdf

10. Contact person for more information:
    Name: Jen Katzman
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    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-5166
    Email: Jennifer.Katzman@LA.gov

1. Title of Report or Program Evaluation:
   Health Homes Report

2. Date completed:
   April 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Response to HCR 116 and SR 188 of the 2017 Regular Legislative Session. Evaluate the feasibility and desirability of implementing a health home program to provide comprehensive care coordination for Medicaid beneficiaries with serious mental illness.
4. Methodology used for analysis or evaluation:
   Medicaid staff conducted a literature review, including analysis of outcomes of other states that implemented health home programs. Studies of early adopters were used to evaluate potential efficacy of the program and other programmatic, administrative, and fiscal impacts to the state, with special attention paid to programs focusing on specialized mental health services, including serious mental illness.

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

6. Major findings and conclusions:
   States face many challenges in designing and implementing health home programs that are fiscally sustainable. As enhanced federal funding expires, several states have transitioned their health home program into a medical home program.

7. Major recommendations:
   In lieu of developing a health home model, LDH recommends pursuit of alternatives within the upcoming Healthy Louisiana procurement.

8. Action taken in response to the report or evaluation:
   Health home alternatives were considered during the development of the next Healthy Louisiana model contract.

9. Availability (hard copy, electronic file, website)
   http://ldh.la.gov/assets/docs/LegisReports/HCR116HealthHomes.PDF

10. Contact person for more information:
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1. Title of Report or Program Evaluation:
   Response to HCR 51 of the 2016 Regular Legislative Session

2. Date completed:
   July 2017

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Legislative requirement: HCR 51 of the 2016 regular legislative session. Provide data related to payment for health care services through the implementation of a health coverage expansion of the Louisiana medical assistance program.

4. Methodology used for analysis or evaluation:
   Rate and Audit Section compiled information provided by the Business Analytics Section and Mercer for this report.

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/assets/docs/LegisReports/HCR51RS201672017.pdf

10. Contact person for more information:
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    Telephone: 225-342-5166
    Email: Jennifer.Katzman@LA.gov

1. Title of Report or Program Evaluation:
   Uncompensated Care Costs Report

2. Date completed:
   July 2017

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://ldh.la.gov/assets/docs/LegisReports/ACT540RS20087272017.pdf

10. Contact person for more information:
    Name: Jen Katzman
    Title: Chief of Staff to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-5166
    Email: Jennifer.Katzman@LA.gov

1. Title of Report or Program Evaluation:
   Year End Financial Report for SFY 2016/17

2. Date completed:
   September 2017

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/assets/medicaid/forecast/FY17_YearEndReport.pdf

10. Contact person for more information:
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    Email: Jennifer.Katzman@LA.gov

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:
   December 2017

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, as defined in the report, for infants born during calendar year 2016 who were born premature at less than 37 weeks gestational age and are in their first six months of life is 4.79 percent. The 2015 re-hospitalization rate, reported in December 2016, was 4.71 percent. This indicates that the re-hospitalization rate in this group of newborns has remained relatively stable over the 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://ldh.la.gov/assets/docs/LegisReports/ACT311RS2013DEC2017.pdf

10. Contact person for more information:
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1. Title of Report or Program Evaluation:
   Response to House Resolution 181 of the 2017 Regular Legislative Session

2. Date completed:
   February 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Legislative requirement: HR 181 of the 2017 Regular Legislative Session. Study the desirability and feasibility of adopting a state policy to provide for the review of prescription drug prices in Medicaid.

4. Methodology used for analysis or evaluation:
   Program staff researched recently enacted policies in the states of New York, Texas, Ohio, and others. Staff also participated in webinars held by these states and consulted with Magellan Medicaid Administration, Louisiana Medicaid's supplemental rebate vendor and subject matter expert on the drug rebate

program.

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

6. Major findings and conclusions:
   States employ diverse approaches in managing Medicaid preferred drug/prior authorization programs, utilization management, and managed care coverage. Although states have taken varied approaches, Federal laws require drug manufacturers nationwide to give Medicaid programs their "best price" — equal to or less than what is paid by private insurers. Most states, including New York and Louisiana, already seek supplemental rebates, often in exchange for priority placement on lists of which drugs can be dispensed.

7. Major recommendations:
   LDH should explore options such as a single preferred drug list (PDL) to maximize supplemental rebates on both the FFS and managed care programs.

8. Action taken in response to the report or evaluation:
   Medicaid began pursuit of a single PDL to maximize supplemental rebates through inclusion of managed care utilization in the PDL program.

9. Availability (hard copy, electronic file, website)
   http://ldh.la.gov/index.cfm/newsroom/detail/4510

10. Contact person for more information:
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    Telephone: 225-342-5166
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1. Title of Report or Program Evaluation:
   Medicaid Forecast Reports SFY 2017/2018

2. Date completed:
   Monthly, Nov 2017 - May 2018

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://ldh.la.gov/index.cfm/newsroom/detail/4470

10. Contact person for more information:
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    Telephone: 225-342-5166
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1. Title of Report or Program Evaluation:
   Response to HCR 119 of the 2017 Regular Legislative Session

2. Date completed:
   April 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Evaluate the possible use of an independent claims review process for dental services provided through the Medicaid managed care program.

4. Methodology used for analysis or evaluation:
   Due to the unique aspects of dental benefits administration, LDH took a multifaceted approach to gathering information and engaging stakeholders for this study. A thorough assessment of the agency's policy and procedures, currently being implemented for MCO independent claims review, was used as a foundation. In addition, because the state of Tennessee has operated a system of independent review for Medicaid dental claims since 2013, online research and contacts made directly to Tennessee's Department of Commerce and Insurance Oversight Division provided information on the inclusion of dental claims in an independent review process.

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

6. Major findings and conclusions:
   A review of current programmatic policies and procedures and stakeholder feedback on the current process found that Louisiana Medicaid's dental benefits management program would benefit from the establishment of an independent review process, as it would give providers an alternative to more costly litigation and arbitration.

7. Major recommendations:
   The study recommends establishment of an independent dental review process. Specific recommendations regarding implementation, policies, and procedures include: exhaustion of internal complaint/appeals processes prior to independent review; exclusion of fraud cases; considerations for maintaining costs at a minimum; members of the selection panel; members of the reviewer pool; eligibility for independent review; aggregation of claims to be reviewed; and the administrative fee for review.

8. Action taken in response to the report or evaluation:
   Legislation was passed in the 2018 Regular Legislative Session requiring the establishment of a dental independent review process. This process was operationalized in the fall of 2018.

9. Availability (hard copy, electronic file, website):
   http://ldh.la.gov/assets/docs/LegisReports/ResponseHCRNo.11903122018.PDF

10. Contact person for more information:
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1. Title of Report or Program Evaluation
   Louisiana Medicaid Diabetes and Obesity Report

2. Date completed:
   April 2018

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:
   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/assets/docs/BayouHealth/ACT210201742018.pdf

10. Contact person for more information:
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    Telephone: 225-342-5166
    Email: Jennifer.Katzman@LA.gov

Annual Management and Program Analysis Report

Fiscal Year 2017-2018

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?

<u>Accomplishment #1: Governor John Bel Edwards Announces Statewide Collaborative Effort to Address Cancer in Louisiana</u>

A. What was achieved?
In May 2018, Governor John Bel Edwards was joined by the Louisiana Department of Health (LDH) Secretary, Dr. Rebekah Gee, the UnitedHealth Group Chief Clinical Officer and board member of United Health Foundation, and other leaders in health care, business and government to announce a statewide collaborative effort to address cancer in Louisiana.

B. Why is this success significant?
This is significant because Louisiana has the fourth-worst cancer outcomes in the United States, with more than 175 people dying from cancer every week. Data also

shows significant racial disparities across populations and regions of the state.

C. Who benefits and how?
The goals of the initiative, Taking Aim at Cancer in Louisiana, include improving early detection, improving patient care and treatment, and ultimately improving patient outcomes. Patients, their families, and for our entire state will benefit from this initiative. Additionally, the initiative places emphasis on the committed action that is needed from statewide partners to better align policies, programs, and practices among all who diagnose and treat cancer.

D. How was the accomplishment achieved?
This effort, led by the LDH, brings together our State's leading cancer experts. In addition, United Health Foundation provided a $500,000 grant to the Louisiana Cancer Research Center to develop a coordinated strategy to improve care, support, and outcomes for the people of Louisiana.

Future meetings are planned which will allow leaders throughout the state to work to improve payment structures, establish agreed upon quality measures, and expand access to cancer care and clinical trials.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. The Louisiana Department of Health's goal is to protect and promote health statewide and to ensure access to medical, preventive and rehabilitative services for all state residents.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. This accomplishment represents a Best Management Practice 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 #2: LDH Response Assets Provided to States and US Territories affected by Hurricanes:</u>

A. What was achieved?
The State of Louisiana sent medical strike teams to Florida, Puerto Rico, and Virgin Islands to assist with response efforts to Hurricanes Harvey, Irma, Maria and Nate in 2017.

B. Why is this success significant?
Louisiana is typically in the posture of requesting Emergency Management Assistance Compact (EMAC) support from other states for the numerous disaster response activities – rather than providing support to other states. The Emergency Management Assistance Compact is a mutual aid agreement among all 50 states, the District of

Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. EMAC enables states to share resources during natural and man-made disasters, including terrorism.

C. Who benefits and how?
Louisiana was able to 'give-back' to other states and US Territories. Louisiana was also validated in-state plans by applying state-developed plans and resources in out-of-state environments. The receiving states and territories (temporarily) gained medical resources for shelters and other medical operations.

D. How was the accomplishment achieved?
This was achieved by EMAC process. LDH had secured medical augmentation staffing support through an RFP process. The awarded contracted through request for proposal (RFP) competitive process provided a mechanism for determining reasonable cost, a prerequisite determinant in successful disaster reimbursement. Discussions with the Department's Legal Section and EMAC Program directors identified the out-of-box consideration of sending an LDH state-contract as an EMAC.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, EMAC complements the national disaster response system.

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

Yes, EMAC is a mutual aid agreement among states and territories of the United States.

<u>Accomplishment #3: Hospital CEO District Meetings on Emergency Response:</u>

A. What was achieved?

LDH Emergency Preparedness participated in the Louisiana Hospital Association's CEO District meetings. The intent was to thank the hospital leadership, gauge their value of Emergency Support Function (ESF) 8 Network, and to request their continued support to the ESF8 Network despite diminishing funds (approximately 34% decrease) of the Hospital Preparedness Program (HPP) grant. ESF8 relates to Public Health and Medical Services which provide the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency.

The ESF8 Network ensures an integrated and scalable response for real events and exercises. Over the past few years, live events have included: Active Shooter events in Lafayette (2015) and Baton Rouge (2016); the Catastrophic Flood of August 2016; Hurricane Harvey (2017), Hurricane Irma (2017), Hurricane Maria (2017) and Hurricane Nate (2017).

B. Why is this success significant?
Despite the decrease in funding levels, the (remaining) funds were directed to priority areas, such as maintaining infrastructure and web-enabled ESF8 Portal. The federal HPP grant is the primary source of funding for emergency preparedness activities for ESF8 Response. The primary intent was to distribute funds directly to facilities. The HPP grant had been cut by 34% over the last several years. Despite the diminishing funds, the value of participating in the ESF8 Regional Network was supported. Namely, that participation in the ESF8 Network ensures that scalable plans for disaster response are inculcated into the routine regional relationships and networks germane to a jurisdictional area. Secondarily, the ESF8 Network is composed of skillsets of individuals that can assist facilities with the newly implemented community preparedness requirements as outlined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards and the 2017 Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness rules.

C. Who benefits and how?
Rather than providing (smaller) HPP checks to participating facilities to purchase items, the 'pitch' was to gain support for using the limited HPP funds to maintain the Designated Response Coordinator (DRC) infrastructure and to continue advancements in technology of the ESF8 Portal.

D. How was the accomplishment achieved?
Sharing the benefits of maintaining the infrastructure with the hospital CEOs was important in gaining their support. Achievements were shared with the CEO's such as: Louisiana being ranked #3 in Disaster Response by the American College of Emergency Physicians (ACEP); Louisiana's ability to standardize and web-enable the JCAHO and CMS requirement for Hazard Vulnerability Assessments (HVA) so that LA can report a 97% compliance report of hospitals completing the HVA in 2016-2017.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. The ESF8 Network ensures an integrated and scalable response for real events and exercises. Live-events over recent years have included: Active Shooter events in Lafayette (2015) and Baton Rouge (2016); the Catastrophic Flood of August 2016; Hurricane Harvey (2017), Hurricane Irma (2017), Hurricane Maria (2017) and Hurricane Nate (2017).

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Perhaps. Other sections of the department are in the regulatory and compliance business; hence, the transfer of this methodology may not be appropriate.

Accomplishment #4: Successful Completion of State Performance Standards and CMS Performance Standards

A. What was achieved?
The LDH Health Standards Section achieved or exceeded established successful thresholds for each performance measure set by the Centers for Medicare & Medicaid Services (CMS).

B. Why is this success significant?
This achievement reflects the successful performance of established processes and adherence to guidelines that ensures consistency with enforcement and the survey process related to licensure and certification for health care providers and facilities.

C. Who benefits and how?
The citizens of Louisiana who receive the care and services provided by the healthcare institutions and other providers as regulated by this section.

D. How was the accomplishment achieved?
This accomplishment was achieved through meticulous adherence to established laws, rules, and processes set forth through the 35 plus program requirements under the auspices of the Health Standards Section.

E. Does this accomplishment contribute to the success of your strategic plan?
Yes. Striving to maintain consistency and fairness in decision making assures licensed health care providers that the licensing and certification section expects compliance with applicable state and Federal requirements which allows this section to achieve the highest standards of care for the citizens and other consumers of health care in Louisiana.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. The methodology primarily involves following processes. Failure to follow process and procedures taints the credibility of the actions and determinations made by members of the Health Standards Section.

Accomplishment #5: 100% Success Rate of All New Health Standards Section Survey Staff Qualified to Perform Inspections:

A. What was achieved?
Assurance of qualifications of LDH Health Standards Section (HSS) staff to perform the regulatory aspects of their positions by training both online and in person and demonstration of competence through oversight by program and field office management.

B. Why is this success significant?
This is significant because it ensures the citizens of this state of the high standards and

qualifications of field staff to ensure the safe delivery of care by healthcare facilities and other providers licensed and/or certified by the HSS.

C. Who benefits and how?
All recipients of health care and services provided by licensed health care entities in Louisiana benefit by receiving services with oversight by regulatory agencies. Also, when a consumer has a complaint related to a service provided by a licensed health care entity, there is a consistent and thorough investigatory process in place to make a determination of regulatory non-compliance and severity of the non-compliance.

D. How was the accomplishment achieved?
This was achieved through the establishment and refinement of the training and/or continuing education protocols established by the LDH Health Standards Section and by State and Federal requirements applicable to surveyors and other survey staff.

E. Does this accomplishment contribute to the success of your strategic plan?
Yes. It is critical that training protocols are updated on a continuous basis, as laws and regulations both on the State and Federal levels evolve requiring training as needed for each provider type surveyed by the HSS staff.

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 HSS strives to be on the forefront of best practices, and as an active partner with the Office for Citizens with Developmental Disabilities, the Office for Aging and Adult Services, and Behavioral Health services to find the most effective and practical solutions for optimal use of resources afforded by the Department.

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.

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 July 2016, provides: (1) a general picture of intended performance across the agency, (2) a general discussion of strategies and resources the agency will use to achieve its goals, and (3) general confidence and reliability that agency performance information will be credible.

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

Our priorities as an agency center on three themes: Building Foundational Change for

Better Health Outcomes, Promoting Independence through Community-Based Care, and Managing Smarter for Better Performance. As we present the next iteration of our planning process, we continue to use these themes to guide our efforts to improve the way we manage our programs and services for a healthier Louisiana.

Within the Health Standards Section (HSS), 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.

- **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?

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. The primary funding source for readiness and response activities is a Federal grant which is subject to fluctuations in annual funding. These fluctuations cause a 'feast or famine' budget climate that precludes funding operational costs for a consistent infrastructure for multiple years.

Given these unknowns, sufficient infrastructure is defined as maintaining access to disaster-responders through one year-renewable contracts (rather than infrastructure based on LDH human capital). The contracts are for Designated Regional Coordinators (DRCs) to be industry-brokers between government and private sector resources to coordinate hospital and EMS response efforts. This infrastructure enables public/private bridging during a response and provides a platform for identifying concerns/needs of the private sector while also coordinating available private resources for good-of-community needs.

- **Where are you making significant progress?** If you are making no significant progress, state "None."

LDH Emergency Preparedness Section

LDH Emergency Preparedness Section has made significant progress in contracting resources, such as staff augmentation for command centers, ambulances, wrap-around services for medical operations, etc. The achievement in contract development is primarily to make up for the growing gap in LDH employees.

Long-term strategic progress is relegated by two driving factors: 1) parameters of a Federal grant which is the primary/sole funding source for ESF8 planning activities; 2) gap(s) driven by one-time events.

Despite this achievement, the progress does not make up for the continued loss in employees attributable to budget constraints and normal attrition. Also, using contractual services do not make up for the loss of historical knowledge gained in working natural disasters.

Health Standards Section

Success and progress is due to the concerted and combined efforts of staff to standardize processes across all programs. The Health Standards Section continues to make progressive movement toward the use of new and updated electronic processes for license renewals; payments of required fees and imposed fines; unlicensed healthcare personnel registries and databases; survey packet submissions and submissions; and the approval of plans of corrections. The HSS has also received approval to engage in sole source testing for certified nursing assistants (CNAs) and to move forward toward integration of automated licensing and payment processes.

Health Standards Section is also make significant progress in the area of Expedited Licensing Process Notice of Intent. Act 324 of the 2018 Regular Session of the Louisiana Legislature enacted R.S. 40:2006.2 which directed the Department to establish an expedited licensing process and fees for healthcare facilities and providers licensed by the Department. In compliance with the requirements of Act 324, the Department proposes to adopt provisions governing an expedited licensing process and fees for healthcare facilities and providers licensed by the Department.

This expedited licensing process statute is a forward thinking step for the HSS in addressing the Department's ability to meet costs incurred for expediting the licensing process for those providers seeking a shortened timeframe in the licensing process. The HSS will avail the use of WAE workers who have retired (or were previous survey staff) and are now seeking employment on an as needed, no benefits basis.

Limited resources in this section has been re-focused to address all available electronic processes to improve efficiencies. This is imperative to achieve given the current fiscal climate and the realization of no additional T.O. The section is seeking all access to affordable technology that will improve access for the public and providers. The established efficiencies from the electronic processes should result in the ability to reallocate human resources to other tasks that cannot be replaced with current technology.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

Emergency Preparedness

The funding source for Emergency Preparedness is the Hospital Preparedness Program (HPP) and PHEP grants. These grants advance federal priorities that are not always the state's priority. Multi-year strategies are heavily driven by grant priorities.

Each event tends to generate a major issue. For instance, during Hurricane Katrina in 2005, the issue was generators; for Hurricane Gustav in 2008, the issue was dialysis; for the Catastrophic Floods of August 2016 the burning issue to be solved was pharmaceuticals in shelters. Hence, multi-year strategic plans and fidelity to addressing long term issues gets side-tracked for the gap(s) identified in a one-time event to be solved within 6 month or less timeframe so as not to be repeated for the next hurricane season.

Health Standards Section

Lack of progress is being made in the establishment of an adverse action database that would benefit multiple sections of the department as well as providers.

Lack of progress is attributed to the many requests for assistance from the Office of Technology Services and the lack of resources to address the many technology needs. Without additional resources, this backlog appears to be likely to continue.

- **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?

Strategic plan revisions occur within each office/section on a continuous basis to efficiently address critical needs and issues within each office; identify and quantify electronic processes to improve efficiencies; address needed rule revisions for consistency with processes and new statutes; and to address resources for improved efficiencies.

☐ No. If not, why not?

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

On a Department-wide level, Performance-Based-Budgeting activities (including, but not limited to, strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the 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 significant department or operational problems exist.

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

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

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

☒ **Internal audit**

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

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

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

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

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

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

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

☒ **In-house performance accountability system or process**
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This

section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies and programs review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, as well as agency and program management department-wide.

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

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

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

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 2017-2018

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 & answer each question below:

A. What was achieved?
The South Central Louisiana Human Services Authority (SCLHSA) was awarded a Three-Year Re-Accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) for the existing programs: Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults, Children and Adolescents) and Outpatient Treatment: Mental Health (Adults, Children and Adolescents); Crisis and Information Call Centers Integrated: AOD/MH (Adults),), Intensive Outpatient Treatment – Alcohol and Other Drugs/Addictions (Adults) and new programs to include Health Home: Comprehensive

Care (Adults) and Services Coordination (DD). The 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 that centers on enhancing the lives of the persons served. 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.

B. Why is this success significant?
This accreditation decision represents the highest level of accreditation that can be awarded to an organization and shows the organization's substantial conformance to the CARF standards. An organization receiving a Three-Year Accreditation has put itself through a rigorous peer review process. It has demonstrated to a team of surveyors during an on-site visit its commitment to offering programs and services that are measurable, accountable, and of the highest quality. Achieving national accreditation was cited as a goal in the SCLHSA's Strategic and Operational Plans. Payer sources such as the Statewide Management Organization (SMO) Health Plans require accreditation; therefore SCLHSA will continue to be able to maximize funding opportunities as a result of this success.

C. Who benefits and how?
The entire SCLHSA organization benefits from the accreditation process. The staff receive validation for the agency's exceptional work product and the quality service delivery provided to our clients on a daily basis. The SCLHSA clients benefit by receiving outpatient services from an organization that has achieved accreditation and focuses on evidence-based and best practices for treatment/services delivery, client satisfaction, and improving performance. Mechanisms are built into the accreditation process to provide continuous opportunities for systems improvement to include: Assurance to persons seeking services that a provider has demonstrated conformance to internationally accepted standards; Improved communication with persons served; person-focused standards that emphasize an integrated and individualized approach to services and outcomes; accountability to funding sources, referral agencies, and the community; management techniques that are efficient, cost-effective, and based on outcomes and consumer satisfaction; evidence to federal, state, provincial, and local governments of commitment to quality of programs and services that receive government funding; and guidance for responsible management and professional growth of personnel. .

D. How was the accomplishment achieved?
Achieving accreditation requires a service provider to commit to quality improvement, focus on the unique needs of each person the provider serves, and monitor the results of services. SCLHSA began its accreditation process with an internal examination of its program and business practices. The examination consisted of the SCLHSA staff conducting an in-depth self-evaluation review of agency policies, procedures and documents. The administrative team conducted numerous site visits and mock surveys at all seven behavioral health clinics, the developmental disabilities office and the

pharmacy of which all complied with CARF standards. Consequently, SCLHSA requested an on-site survey that was conducted by a team of expert practitioners selected by CARF. During the three-day survey, SCLHSA had to demonstrate that it conformed to a series of rigorous and internationally recognized CARF standards. The survey team visited all aspects of the agency to include administration (leadership, fiscal, human resources, information technology, compliance/risk, quality, environmental services, etc.), developmental disabilities, integrated care (health home), pharmacy and all seven behavioral clinic sites under SCLHSA purview. Interviews were conducted with staff, clients, contractors, stakeholders, board members and representatives from LDH. Based on the results of the survey, CARF prepared a written report of the SCLHSA's strengths and areas for improvement. Since SCLHSA demonstrated exemplary conformance to the standards, the agency earned a three year CARF accreditation which is the highest level of accreditation that can be achieved. The SCLHSA was pleased to receive three pages that referenced its areas of strength in relation to services, staff and overall compliance with standards. SCLHSA has also submitted a Quality Improvement Plan (QIP) to CARF to show how it is addressing any areas cited for improvement. Each year during the term of accreditation, the SCLHSA must submit a report to CARF documenting additional improvements it has made to its service array.

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

CARF is committed to providing the greatest value for a provider's accreditation investment. Customers look for CARF accreditation as their assurance that an agency's programs or facilities are of the highest quality. Payers recognize CARF accreditation as a demonstration of superior performance for their clients. As a service provider, SCLHSA now has the advantage of utilizing clearly defined and internationally accepted standards to ensure that our services maintain excellence. Among the many benefits provided by CARF accreditation are: 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 in initiation of services that are aligned nationally with best practices in the fields of behavioral health and developmental disabilities.

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

Payers - whether a third-party funder, referral agency, insurance company, or governmental regulator looks for CARF-accredited service providers to lessen risk and provide greater accountability. Behavioral health payers prefer CARF International as an independent accrediting body of health and human service providers. Accredited providers have proven they have applied a comprehensive set of standards for quality to their business and service delivery practices. Because CARF accreditation signals a provider's demonstrated conformance to internationally accepted standards, it can significantly reduce governmental monitoring and help to streamline regulation processes. The value of CARF Accreditation is more than a certificate hanging on the

wall. CARF Accreditation is evidence that an organization strives to improve efficiency, fiscal health, and service delivery -- creating a foundation for consumer satisfaction. With the addition of the Health Home (Integrated Care/Primary Care Program) and Services Coordination (DD) this year, SCLHSA is now considered a one stop shop for patients with its holistic approach to care. This designation is not only desired by patients, but by health insurance agents as well.

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?

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.

- **Where are you making significant progress?** If you are making no significant progress, state "None."

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.

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.

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

Services Authority strives for continued progress toward achieving Strategic Goals and Objectives in support of its Mission: To increase public awareness of and to provide access for individuals with behavioral health and developmental disabilities to integrated community based services while promoting wellness, recovery and independence through education and the choice of a broad range of programmatic and community resources

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

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?

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

☐ No. If not, why not?

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

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

As an organization that has adopted and actively practices both Accountable Care and

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

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

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

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

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

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

open discussion is encouraged.

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

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

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

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

No significant management or operational problems exist.

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

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

☒ **Internal audit**
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)**
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 and Prevention Services Contract Monitors meet monthly with all contracted services for review of contract objectives and to gather service data information.

The contract agency or individual has the opportunity to share any issues with service provision or funding at that time.

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

☒ **Program evaluation by contract**
The South Central Louisiana Human Services Authority 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. The South Central Louisiana Human Services Authority coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis as well. Explanatory notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the LDH - Division of Planning and Budget if modifications or additions are needed.

☒ **In-house performance accountability system or process**
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. South Central Louisiana Human Services Authority utilizes: the Louisiana Department of Health Accountability and Implementation Plan, the Commission on Accreditation of Rehabilitation Facilities (CARF), Performance Improvement model, Staff Development and Supervision Guidelines in conjunction with the Louisiana Department of Civil Service Performance Planning and Review system; ongoing internal monitoring and auditing mechanisms including corrective action and/or process improvement action plans with assigned accountability.

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

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

☒ **Peer review**
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.

☒ **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, 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 2017-2018

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 A. Sizer**

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

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

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

Accomplishment #1: Developmental Disabilities Services:

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 FY 18, 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 385 individuals with developmental disabilities $1,027,000 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 1,200 Medicaid Waiver participants.

Additionally, the department established Partners in Employment (PIE), 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. A summit was held in June 2018 inclusive of a panel of employees with developmental disabilities who shared information about their employment journey. A nationally known speaker gave facts supported by research and studies about employing people with disabilities and the benefits of utilizing the Customized Employment Model. The summit was well attended by professional agencies, self-advocates, parents, developmental disability provider agencies, and state agencies that support people with developmental disabilities.

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, 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 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 our 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 Services (CMS-Federal Government). Leading the way in spotlighting the significant need for more people to become employed gives individuals 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 #2: Behavioral Health Services:

A. What was achieved?

Northeast Delta Human Services Authority (NEDHSA) has implemented an abundance of initiatives during the past year that stem from our integrative behavioral health and primary care approach. These initiatives bolster this innovative approach and help move the needle toward better recovery outcomes for the individuals served in the NEDHSA area. Some of these initiatives included:

Faith-Based Outreach
NEDHSA engaged faith-based communities as these communities provide hope that further supports traditional mental health services. Along with reaching out to citizens through faith-based approaches, clergy leaders were also engaged to better understand their challenges along with the challenges of their congregations. NEDHSA knows that faith can offset hopelessness, and by coordinating all resources, the NEDHSA area communities will grow and prosper to their full potential.

As part of this initiative, NEDHSA sponsored a public faith-based metal health summit, "Faith Strategies that Build Communities," in partnership with the National Alliance on Mental Illness - Ruston Chapter (NAMI Ruston), on Tuesday, October 3 at the Ruston Civic Center. The Summit featured solution-based topics and discussions, including: the state of mental health and addiction in Louisiana, the expanding role of churches in mental healthcare, faith and integrated mental health and primary care, and advocacy and scholarly perspectives. The summit brought together experts among behavioral health, government, faith-based organizations, community and academia to further catalyze meaningful discussion and action. 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.

The Phoenix Clinic
For decades, citizens with developmental disabilities, their family members and industry throughout the country have been seeking appropriate care and treatment

solutions for people with co-occurring developmental disabilities and behavioral healthcare issues. NEDHSA has recognized this struggle and has put a solution in place locally to help fill this significant service gap. Families and caregivers experience constant frustration trying to care for the people they love most. To help alleviate these serious issues, NEDHSA opened The Phoenix Clinic, a pilot program within the Monroe Behavioral Health Clinic that offers behavioral healthcare services for citizens with co-occurring developmental disabilities and mental health issues.

Louisiana Opioid Summit

Given the growing epidemic of opioid misuse and abuse in the State of Louisiana, NEDHSA hosted the Louisiana Summit, Louisiana's Opioid Crisis: Its Realities and Solutions. This purpose of this 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.

"It Is What It Is" Radio Show

In November of 2017, NEDHSA launched a new radio show entitled, "It Is What It Is." featuring NEDHSA Executive Director, Dr. Monteic A. Sizer. This innovative radio show seeks to give voice and perspective to those battling and seeking to overcome challenges associated with poverty, mental illness, addiction and developmental disability. The show gives listeners valuable information and life strategies on how to navigate broken family and social systems that often restrict individuals from reaching their full potential. Each weekly hour-long segment is moderated by Public Information Director, Tenille Terry on KOUS 96.3 FM (Monroe, Louisiana), online and via phone. Listeners are able to submit questions across NEDHSA's social media platforms and share personal stories and experiences on how they overcame some of life's most difficult challenges. It Is What It Is Radio Show was created out of the need to address conflating societal coping issues within one's present state. Providing a more realistic outlook and introducing different perspectives on one's current position in life. It is the goal of NEDHSA that this new platform will help expand its primary focus by utilizing untraditional governmental agency mediums.

Louisiana Re-entry 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 will also have access to NEDHSA's tobacco cessation, gambling, developmental disability, prevention, workforce training and placement services. Additionally, they may also be referred to one of NEDHSA's many regional primary health care partners for medical, dental and vision care.

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, SOWS has served over 58 individuals, and of those placed into employment 76% remained employed for over 90 days.

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 compliance checks and an EAP program (Employee Assistance Program). Following are a few major initiatives recently rolled out within the NEDHSA Prevention section:

U-ACT Coalition (Union Parish Alliance for Community Transformation)

Stemming from a DHH Louisiana Partnership for Success fund award, NEDHSA recently managed the formation of a collaborative coalition to address underage drinking and prescription pill use in Union Parish. The U-ACT Coalition (Union Parish Alliance for Community Transformation) works to reduce the incidence of underage drinking and other data-driven priorities in Union Parish. This award not only targets

substance abuse, but also aims to have an indirect positive impact on depression, suicide, teen pregnancy, school failure and violence.

Opportunity Zone
The NEDHSA Opportunity Zone is a strategic initiative designed to help transform fragile south Monroe communities. This initiative seeks to increase access to NEDHSA services and promote healthy community behaviors. The NEDHSA Opportunity Zone grew out of the agency's regional faith-based mental health community summits. The Opportunity Zone is one of several NEDHSA-initiated regional coalitions that aim to reduce mental health and addiction prevalence, improve primary healthcare outcomes, reduce crime rates, enhance school and academic performance, equip faith and community leaders, increase job opportunities and establish and support public policies.

RX Take Back Days
NEDHSA has conducted numerous prescriptions take-back days regionally with take-back boxes where citizens can safely turn in unused or expired prescription medication for disposal. At these events, NEDHSA has Prevention staff onsite who specialize in parental engagement, drug and alcohol addiction and violence prevention to assist the general public.

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, then actively puts programs and services in place that meet citizens' needs and fill healthcare gaps.

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

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

NEDHSA's vision, mission and tenets.

Accomplishment #3: Fiscal Operations

A. What was achieved?

- Self-generated revenues increased by 3%
- The largest increase to self-generated revenues can be attributed to ineligible patient fees which increased by 47% from FY 17, largely due to monthly billing of self-pay clients.
- NEDHSA made necessary adjustments to remove inefficiencies associated with claims processing, correcting claim errors, and posting of payments.

B. Why is this success significant?

Each of these successes helps the agency achieve its Three Tenets:

- Greater access to services – By increasing revenues and timely billing, NEDHSA is able to provide clients with greater access to services.
- Excellent customer services – Efficiencies implemented allows the fiscal department to process transactions and respond to requests in a more timely and efficient manner.
- Quality, competent care – Our clients, staff, contractors, and LDH leadership are assured that NEDHSA is a strong steward of public funds.

C. Who benefits and how?

NEDHSA staff, clients, the Northeast Louisiana community, and the State of Louisiana benefit from these accomplishments. The workloads of current staff are reduced as NEDHSA is able to hire additional staff with increased revenues. This also leads to clients gaining greater access to services, which benefits the local community as individuals receive the necessary mental health, developmental disabilities, and addictive disorder care needed to realize their full human potential. And, as our clients are able to receive the care they need, the State of Louisiana benefits from reduced costs and strain on hospital emergency rooms, law enforcement, corrections, emergency housing, etc.

D. How was the accomplishment achieved?

These accomplishments were achieved through teamwork and dedication to NEDHSA mission and its clients. Additionally, the fiscal department spent a large portion of the year diligently working old claims and strategically processing new claims, which lead to the increased revenue, reduction in aged receivables, and the significant decrease in unbilled revenues. Also, the implementation of new policies and procedures for fee setting, LaCarte purchasing card, fuel card, and contracts aided in the favorable legislative audit.

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?

NEDHSA follows standard best practices for claims billing.

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?

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

- **Where are you making significant progress?** If you are making no significant progress, state "None."

NEDHSA 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.

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.

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."

NONE

1. 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?

  NEDHSA is in the 3rd year of implementing its 5-year strategic plan and as the end of the fiscal year reports are being completed, NEDHSA will revisit the 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.

- **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.

  Northeast Delta Human Services Authority's 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. Each department of our agency has quarterly performance improvement committee meetings to discuss the performance indicators and strategies to enhance our delivery of services. As leadership makes data driven decisions about management and funding, we consider the performance indicators to help us determine how to streamline our funds and processes for improved outcomes.

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

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

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. Ancillary

No significant management or operational problems exist.

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

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

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

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

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

   5. Do corrective actions carry a cost?

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

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

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

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

☒ **Internal audit**
Northeast Delta Human Services Authority 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**
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 and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

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

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

Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

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

☒ **Peer review**
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 2017-2018

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: Electronic Visit Verification (EVV):

A. What was achieved?
In March 2018, LDH successfully completed the transition to statewide use of EVV for billing in-home personal care attendant services. All Office of Aging and Adult Services (OAAS) Personal Care Attendant (PCA) providers, as well as center-based Adult Day Health Care (ADHC) providers, have been trained by Statistical Resources Inc. (SRI) and are utilizing the EVV system.

OAAS, along with other LDH departments, are now monitoring the EVV usage, as well as the manual entry portion of the EVV system.

B. Why is this success significant?
Successful statewide implementation allows state agencies to track real-time service delivery at the individual participant and worker level and enables providers to do the same. This real-time oversight aids participant safety, as providers are able to monitor the GPS location of all check-ins and check-outs for a direct service worker. Since statewide implementation, LDH has a new tool to stop payment of overlapping services and locate fraudulent billing. EVV also results in simplified billing and documentation for providers.

C. Who benefits and how?
Because EVV allows for more oversight and better management of direct service workers, participants greatly benefit from the EVV implementation.

Benefits to direct service providers include:

- Ability to better track employee delivery of home and community-based services;
- Ability to better determine if services are provided as scheduled/planned;
- No cost to providers for the system;
- Provides GPS verification of services;
- Allows for electronic access to reports;
- Supervisors have the ability to send messages to staff; and
- Data is exportable.

Benefits to the state include:

- Ability to verify that individuals are receiving services authorized in their Plans of Care;
- Safeguards against fraud and improved programmatic oversight; resulting in a reduction of inappropriate billing and payments; and
- State-level access to data and reporting.

Louisiana taxpayers also benefit from the EVV system as it saves the state money by reducing fraud, abuse and inappropriate billing and payments.

D. How was the accomplishment achieved?
Overall, successful statewide implementation of EVV has been achieved through multi-agency collaboration within LDH and through the willingness of LDH agencies and its contractor to accommodate provider requests in the design of the EVV system.

LDH used a phase-in plan to roll out the EVV system. In March 2016, LDH phased in all center-based service agencies (such as adult day health care and adult day care, vocational services, and transportation services). The initial implementation for in-home service providers was voluntary. This implementation acted as a pilot allowing for providers to test the system, voice their requests, and make recommendations/suggestions for the overall system design. The final implementation was completed using a regional phase-in process across the state. Each provider received in-person training, a testing period and then were given a go live date. By using this

phase-in approach, LDH and its contractor were able to collect practical feedback, which was used to address system and usability issues as they were identified. This phase-in approach assisted in the facilitation of a smooth transition to EVV.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, it contributes to the agency's goal to administer and operate OAAS programs in a cost-effective manner while achieving high quality outcomes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, EVV will be a federal requirement in 2020. By having successful implementation, Louisiana came into compliance well ahead of the federal requirement date with a system that is exemplary due to the system's state-level access to data and reporting. EVV technology could be used to monitor delivery of services by state employees and contractors in other realms besides healthcare.

Accomplishment #2: Disaster Case Management Program

A. What was achieved?
In partnership with the Office of Community Development Disaster Recovery Unit (OCD-DRU), OAAS received a $64,000,000 FEMA grant to provide disaster case management services to the 52 Louisiana parishes that were declared for FEMA Individual Assistance (IA) as a result of the March and August 2016 flood events. This is the first time that LDH, through OAAS, is serving as the management agency for the Disaster Case Management program. The program grant has an initial two-year term with the possibility of a no cost extension. During FY 18, the program was granted 3 month extensions for both disasters.

OAAS implemented a new data collection and reporting system during this fiscal year. The agency identified concerns with the system used in previous disasters and was granted permission to procure a new system. The new system, Service Point, has significantly improved data collection, security, and reporting.

Through the Disaster Case Management program, 51 households with a member who had a disability were referred to the OAAS Permanent Supportive Housing program for a long-term housing solution and 682 households were linked to rapid rehousing, a rental assistance program that was established to prevent disaster related homelessness.

As of June 30, 2018, 1,530 households have been provided with 3,649 services for the August 2016 Flood. For the March 2016 Flood, 6,514 households have been provided with 15,272 services. The dollar value of these services is $11,190,474. In addition, 530 of these households were placed in Manufactured Housing Units (MHU) and 348 have successfully transitioned out. The remaining 182 households continue to receive DCM services and are actively working on their rebuild plan.

B. Why is this success significant?
This program is significant in that it links households, including elders and those with long-term disabilities, to available resources to assist in their overall disaster recovery efforts. These populations tend to have a harder time accessing resources and navigating systems, and disaster case managers provide this much needed service.

C. Who benefits and how?
Any household affected by the two significant flooding events are eligible for these services. There are no income limits; the household must only demonstrate disaster related needs. However, a large portion of those who sign up tend to be low income and often have access and functional needs. Households are linked to services that include but are not limited to rebuild and repair, housing assistance, community resources, and LDH services.

D. How was the accomplishment achieved?
Based on our already established relationship through OAAS's Permanent Supportive Housing program, OCD DRU approached OAAS to partner on the grant submission, implementation and overall daily management of the Disaster Case Management Program.

Through program implementation, OAAS staff has been successful in establishing new partnerships with additional federal, state and non-profit organizations to enhance recovery results for program participants.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, it provides disaster related services to assist the elderly and individuals with disabilities to live with dignity and independence in a safe environment.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
FEMA has indicated that they regard management of DCM through LDH as a best-practice for this grant.

<u>Accomplishment #3: Response to U.S. Department of Justice Findings</u>

A. What was achieved?
In 2016, the U.S. Department of Justice (DOJ) issued a Letter of Findings alleging that Louisiana was violating the civil rights of Medicaid recipients with Serious Mental Illness (SMI) under the Americans with Disabilities Act. The statement contended that the State unnecessarily institutionalizes persons with SMI in nursing homes.

In response to the findings and to assure more appropriate use of high-cost nursing facility services, OAAS has improved procedures for approving long-term nursing

facility stays and has begun identification and transition assessment of nursing facility residents with SMI.

OAAS was also an important participant in LDH's negotiations with the DOJ. Those negotiations resulted in a Settlement Agreement that became effective June 6, 2018.

B. Why is this success significant?
OAAS's actions will help the state come into compliance with the Americans with Disabilities Act and the U.S. Supreme Court's *Olmstead* decision. Individuals with Serious Mental Illness will be helped to live in the least restrictive setting appropriate to their needs and wishes. Better control of nursing facility admissions and length of stay will also help assure that people receive the right amount of services at the right place and at the right time – an important principle in assuring that services are both cost-effective and produce good outcomes.

C. Who benefits and how?
Persons with Serious Mental Illness who are institutionalized or at risk of institutionalization will be the primary beneficiaries. Taxpayers also benefit from greater control over the use of high-cost nursing facility services.

D. How was the accomplishment achieved?
OAAS worked with other LDH agencies to obtain funding in FY 18 to begin activities designed to address the DOJ findings. In order to begin transitioning persons with SMI from nursing facilities, OAAS has hired and trained additional transition coordinators and Medical Certification Specialists to complete assessments, planning, and transitions of persons with SMI who also qualify for OAAS services. OAAS's analytics section developed reports to identify persons with SMI using nursing facility and behavioral health data. OAAS's many years of experience with successfully transitioning nursing facility residents under the federal Money Follows the Person (MFP) demonstration provided expertise and a model for many aspects of the transition activities. OAAS has partnered closely with LDH legal and the Office of Behavioral Health, and OAAS's training unit has provided exceptional support in developing process flows and in training new staff. Expansion of transition efforts has also strengthened coordination between OAAS regional offices and regionally-based transition coordinators.

Improvements to the nursing facility admissions process have been largely attributed to the accomplishments of an expanded OAAS Nursing Facility Admissions (NFA) unit and managers, and OAAS's policy section. Rules and waiver amendments were initiated to eliminate the behavioral health eligibility pathway from OAAS services including nursing facility. Procedural changes were made so that more persons would receive approval for temporary nursing facility stays rather than permanent. This has resulted in temporary approvals increasing from less than 2% of all facility admissions to over 70%.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, it contributes to the agency's goal to administer and operate OAAS programs in a

cost-effective manner while achieving high quality outcomes.

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 Money Follows the Person (MFP) program has previously been identified as a Best Management Practice. Lessons learned from that program are now being used successfully in this initiative in OAAS and LDH's Office of Behavioral Health.

Accomplishment #4: Revamped the Traumatic Head and Spinal Cord Injury Trust Fund Program:

A. What was achieved?
The Office of Aging and Adult Services (OAAS) has streamlined policies, procedures and processes to ensure participants receive services in a more consistent and timely manner. OAAS has also revised the statute to ensure all participants who qualify receive services in a more effective and timely manner.

B. Why is this success significant?
Participant's needs are being met faster and more efficiently.

C. Who benefits and how?
Approximately 650 participants of the program and another 200 on the waiting list for services that will be opened more timely will benefit.

D. How was the accomplishment achieved?
A new manager was hired, policies were rewritten and case managers were trained on policies and procedures to ensure participants are served more timely and efficiently.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, it is in line with our vision, mission, philosophy and goals. Specifically, these changes allow this program to run in a more cost-effective manner while achieving high quality outcomes. Activity 4 is specific to the THSCI Trust Fund and states that we will "continue to revise policies and statues to more effectively serve additional people within available levels of funding". These changes are doing just that.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No, these changes are specific to the THSCI program.

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, the Office of Aging and Adult Services' **(**OAAS**)** strategic plan is on time for accomplishment. OAAS continues to make progress in many areas related to its strategic goals and objectives, specifically Goal 1: "Administer and operate OAAS programs in a cost-effective manner while achieving high quality outcomes."

OAAS made substantial revisions to the 5-year strategic plan in FY 17, and the plan is good through 2022.

- **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?

  OAAS continues to improve the cost-effectiveness of its home and community-based programs compared to nursing facility services. The Office has also implemented effective controls to address fraud, waste and/or abuse.

- **Where are you making significant progress?** If you are making no significant progress, state "None."

  The expansion of EVV in this fiscal year is the most recent accomplishment in addressing fraud, waste, and abuse. Improvements to nursing facility admissions and efforts to identify and transition persons with Mental Illness from nursing facilities contribute to several strategic goals including system rebalancing and improving the cost-effectiveness of services delivery.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

  Budget constraints continue to limit the expansion of community-based waiver services, and program waiting lists remain above 25,000 in FY 2018. Medicaid spending for nursing facility care continues to rise. 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.

- **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 substantial revisions to its strategic plan in FY 17, and the plan is good through 2022. Therefore, it is not necessary to make additional revisions at this time.

- **How does your department ensure that your strategic plan is coordinated**

throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation? 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.

No significant management or operational problems exist.

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

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

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

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

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

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

5. Do corrective actions carry a cost?

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

requests?

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

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

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

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

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

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The Louisiana Department of Health (LDH) has a designated Audit Coordinator for financial audits. The LDH Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved 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 Services (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis

for all LDH agencies. Explanatory Notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary if modifications or additions are needed.

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

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

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

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

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 2017-2018

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: Trauma Program Developed in Region 5 at Lake Charles Memorial Hospital</u>

A. What was achieved?
Lake Charles Memorial Hospital signed a Level II Trauma Program attestation.

B. Why is this success significant?
There is no trauma center in Region 5.

C. Who benefits and how?
The citizens of Region 5 or anyone passing through that may be injured.

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 2 trauma centers – one in Shreveport and one in New Orleans. Now we have 6 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.

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 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: Secured $124,900 in grant funding to support trauma and EMS Registries:</u>

A. What was achieved?
Received two grants impacting the EMS and Trauma Registry. $49,900 to fund a data analyst for the EMS Registry and $25,000 to fund an AIS injury scoring course for the hospitals who submit data to the state trauma registry.

B. Why is this success significant?
Data validity is imperative to any registry. The AIS course taught 25 registrars accurate injury coding. Accurate coding will help target injury prevention efforts in the state. The EMS Data Analyst travels the state and assist EMS providers in efforts to transition from paper charting to an electronic medical record, data validation, data imports and report running.

C. Who benefits and how?
The state and its citizens benefit by having accurate data which is used to target injury prevention efforts or improve performance in a variety of areas.

D. How was the accomplishment achieved?
The agency's executive director is on the HPP Executive Board. Through this board, the executive director became aware of Hospital Preparedness grant funds. The LERN Call Center serves as the 24/7/365 information coordinator for mass casualty events. The phone system utilized to manage communications during an event is on its end of life. Therefore, the grant funds were requested to replace the aging system via the HPP

Grant.

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

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? No

Accomplishment #3: Started Trauma Band Pilot:

A. What was achieved?
Collaborated with Our Lady of the Lake (Level 2 Trauma Center) and Baton Rouge EMS to begin a Trauma Band Pilot.

B. Why is this success significant?
Trauma bands serve a very simple but important purpose, they link the EMS registry to the hospital registry. They also make the data more reliable and clean by eliminating duplicate entries. While each individual facility knows about what condition the patient was in, the care provided, and the time frames they operated in, no one knows that happened to the patient across the entire system of care. Trauma bands are designed to change that. Once a patient is banded, every agency involved in the care of that patient (pre-hospital and hospital), would document the band number on the patient's care record. Once the data is sent to the EMS registry and trauma registry, the records will be linked together using the band numbers on the patient's records.

C. Who benefits and how?
If we are successful with the linkage, those injured in Louisiana will benefit. Linking pre-hospital and hospital data will allow for better data in which to make trauma system decisions.

D. How was the accomplishment achieved?
Our trauma medical director implemented this in Arkansas and proposed the same process to the LERN Board with unanimous approval. We chose region 2 due to the trauma center and because most transports are covered by BR-EMS.

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

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? No

Accomplishment #4: Implemented Stop the Bleed Education in all 9 Regions:

A. What was achieved?

We implemented the ACS course "Stop the Bleed" in all 9 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.

D. How was the accomplishment achieved?
We used our nine LERN Regional Commissions to champion the cause at the regional level. We received a $14,000 grant from the Living Well Foundation. We also received 3 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 were able to begin teaching the program.

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

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes- using local champions helps to promote engagement and establish relationships. The hardest part was getting in the door. Now we have classes scheduled weekly. So far this CY we have conducted 23 classes and 473 students completed the course.

<u>Accomplishment #5: Mandated all Level 3 Stroke Centers Submit Data to LERN and the Board established a process for holding hospitals accountable to data submission and meeting benchmarks:</u>

A. What was achieved?
The LERN Board mandated that all Level 3 stroke centers submit data to LERN and the Board approved a process to hold hospitals accountable.

B. Why is this success significant?
CEO's at all Level 3 hospitals attest to meeting the level 3 requirements. 36 of the 54 hospitals were submitting data to LERN. Some of the 36 were leading the pack, others making improvements with the remainder consistently not meeting benchmarks. We had no idea how the remaining 18 were performing. The LERN Call Center routes stroke patients to level 3 stroke centers and we have a responsibility to ensure they are

meeting the requirements listed in the attestation. Mandating data submission and implementing a process to put hospitals on probation or demote to Level 4 ensures that the LERN Call Center is routing to hospitals that can provide stoke care commiserate with a Level 3 hospital.

C. Who benefits and how?
Anyone experiencing a stroke in Louisiana.

D. How was the accomplishment achieved?
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. An action plan template was developed and provided to the hospitals. 2. To require centers with less than 6 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 Non-stroke center. 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.

We have the authority to implement the state stroke system via legislation.

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?

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

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

- Louisiana has the 11th highest mortality rate in the United States – 75.72 deaths/100,000 population. This is down from 2007 when Louisiana had the 5th highest mortality rate in the United States.
- The staff updates the Build Out plan which was based on the 2009 ACS Consultative visit. LERN conducts annual strategic planning sessions with the Executive Committee.
- We do not have a comprehensive trauma registry. We now have 10 hospitals submitting data to the state trauma registry. This is up from 7 in CY 16.
- We now have 6 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
    - Lakeview Regional Medical Center – Level 3 Trauma Center
- We have three other hospitals working towards trauma center designation
- LERN is leading an effort for the trauma centers to participate in the American College of Surgeons Trauma Quality Improvement Program. We have 5 hospitals signed on to this collaborative and expect our first report in September of this year.

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 2 years, have a 3% secondary transfer rate. Patients not directed by the LCC have a 28% secondary transfer rate. This is the one area where we have not made significant progress. We are not able to attribute a dollar amount to this efficiency. The LERN Budget continues to depend on the state general fund. We continue the Low Income Needy Care Collaborative Agreement (LINCCA) for the Communication Center Staffing contract in order to leverage

state general fund dollars.

- We received to grants to help support the trauma and EMS registries = $124,900
- We received a grant from the Living Well Foundation for $13,865 to implement Stop the Bleed Education in region 8. We also received training kits from the Hospital Preparedness Grant = $17,295
- Anticipated returns on investment are being realized in terms of efficient use of resources.

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 2 in 2011 to 6 in 2018 provides 68.6% 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:
    - Lafayette General Hospital – has ACS verification survey in December 2018 (Level II Trauma Program)
    - Lake Charles Memorial Hospital (Level III Trauma Program – has survey in June of 201consultation visit from ACS in December 2018)
    - St. Tammany Parish Hospital – Had ACS consultation in May 2018. Should have survey for verification in May 2019.(Level III Trauma Program)
- When considering the 6 Verified Trauma Centers and the 3 trauma programs, 88% 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 4 levels of stroke hospitals. These levels are used by the public and EMS to access the appropriate hospital for stroke care. 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 Level I, II, or III stroke center 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 36 hospitals provide 96.6% of the population with access to a STEMI Receiving Center within a 60 minute drive time.
- Also, LERN continued education efforts across the state. For CY 2017, those courses included:
    - Trauma Nurse Core Curriculum (TNCC) = 32 classes, 331 students

- Emergency Nurse Pediatric Course (ENPC) = 6 classes, 56 students
- 12 Lead EKG Course = 12 classes, 327 students
- Rural Trauma Team Development Course = 1 class, 24 students
- Hemorrhage Control Training = 16 classes, 497 law enforcement agents and we provided 456 tourniquets

- EMS Registry continues to be developed. We now have 36 EMS agencies participating in the registry. This is up from 30 as compared to this time last year. 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.

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
- Established curriculum for the Governor's detail focused on: stopping bleeding, choking, CPR and LERN logistics. Will be implemented in August 2018.

- **Where are you making significant progress?** If you are making no significant progress, state "None."

We have been very successful moving systems forward due to leadership from our physician medical director 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 9 LERN Regional Commissions also contribute to our success.

Progress is due to specific department actions and LERN Board decisions. We have initiated two new policies that place tighter controls over the trauma programs and level 3 stroke centers. We promulgated additional rules related to trauma programs that require ACS consultation or survey within a specific timeframe for the attestation date. This will speed up the trauma center verification process. The requirements for stroke data submission, mock codes and action plans have already improved level 3 stroke center performance. These policy changes are resulting in increased accountability and performance.

Specific department actions have directly related to the success of LERN. Examples include: Continued support from the Secretary and Under Secretary as it relates to funding, Bureau of Health Informatics continues to provide stroke data as available and Vital Records provides mortality data related to trauma, stroke and STEMI. Collaboration with LDH Office of Community Preparedness on disaster response has been very helpful.

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."

  We had expected to have an additional level 2 trauma center in 2017. Due to hospital internal physician issues, the ACS survey had to be delayed. Through working with the LERN Trauma Medical Director, those issues are being resolved. The hospital is scheduled for an ACS survey in December 2018. A successful survey will bring the number of ACS verified trauma centers to 7.

  We have made little progress lessening or eliminating LERN's reliance on state general fund dollars. We have received some grant funds, but we have not been successful in identifying larger grants that fit LERN's mission and strategy. 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. LERN does not have the authority to mandate data collection. Hospitals have a hard time collecting data due to competing priorities. It cost money to hire a data entry person. To deal with STEMI data collection, LERN has had success getting hospitals that already use ACTION Registry and to agree to submit their data to a state report. This does not cost them any additional money. For trauma, we are focusing our efforts on those facilities working to become trauma centers.

  The reliance on the state general fund will continue until we are in a position where we can successfully pursue passing legislation to fund the system. Most trauma systems are funded via fees or fines associated with DUI, traffic violations or vehicle registration. 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.

- **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 adjust the action items. In November we will re-work 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?
   The STEMI State Report has been on hold for a year due to the end of the partnership between the American Heart Association and the American College of Cardiology.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   It has affected our ability to compare the state STEMI system to national benchmarks.

3. What organizational unit in the department is experiencing the problem or issue?
   LERN STEMI system (LERN only has one department)

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

We are unaware if anyone else is affected.

5. How long has the problem or issue existed?
   1 year, but just last week we received the new report from the ACC/NCDR so it looks like we have a resolution.

6. What are the causes of the problem or issue? How do you know?
   Partnership ended 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? Problem is resolved.

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

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

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

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

   5. Do corrective actions carry a cost?

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

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

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

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

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

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

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

LERN conducts monthly review and reconciliation of all call center volume/reports.

☒ **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**
QA calls in the LCC on a monthly basis, entry of a case reviews in data base which can now by tracked by issue.

☒ **Policy, research, planning, and/or quality assurance functions by contract**
Review of literature, other best practices, review of other state trauma programs, is performed by LERN staff and consultants, used to guide the implementation and continued development of the LERN Trauma and Time Sensitive Illness Network

☒ **Program evaluation by in-house staff**
Performance Improvement meeting bi-monthly. Led by Dr. Michael Sutherland, LERN Trauma Medical Director. Monthly Stroke PI Call as required, led by Dr. Sheryl Martin-Schild.

☒ **Program evaluation by contract**
Communications Center staffing provided by contract with AMR. Data is input to the Louisiana State owned Image Trend system. This system software provides data on calls, time to definitive care, mechanism of injury and transport time. We also track secondary transfers as a performance indicator for the LERN Call Center. Louisiana Hospital Inpatient Discharge Database (LaHIDD) data and the Level III Stroke data base is used to evaluate the stroke program.

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

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

operational planning, as well as agency and program management department-wide.

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

LERN compares state trauma registry data with NTDB data. STEMI Regional Report is compared to national benchmark. Stroke Registry (Level III) centers are compared to the aggregate and reports are sent to hospitals quarterly. Benchmarks are based on national standards.

☒ **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**
The LERN Communicators are required to perform peer review audits on two calls per shift.

☐ 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
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation

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

1. Title of Report or Program Evaluation
   LERN Annual Report FY16-17

2. Date completed
   March 2018

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)
   None

6. Major Findings and Conclusions
   tPA administration has nearly tripled since 2010

7. Major Recommendations
   None

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

9. Availability (hard copy, electronic file, website)
   Available on the LERN Website http://lern.la.gov/about-lern/annual-report/ -- This can also be provided by hard copy.

10. Contact person for more information:
    Name: Paige Hargrove, RN, BSN
    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 2017-2018

Department: **Louisiana Department of Health (LDH)**
09-325 Acadiana Area Human Services District

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

Undersecretary: **Cindy Rives**

Assistant Secretary: **Brad Farmer**

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

For each accomplishment, please discuss and explain:

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

Accomplishment #1: Partnership with OCDD Regarding New Eligibility Determination:

A. What was achieved?
Partnered with the Office for Citizens with Developmental Disabilities (OCDD) to implement new eligibility determination policies and procedures.

B. Why is this success significant?
It established a clearer definition of who is eligible for developmental disability services and supports. It will help OCDD and ensure the right individuals applying for supports and services are reaching the appropriate agencies.

C. Who benefits and how**?**
Individuals with developmental disabilities and their families. It informs them of possible services available no and gave them information as to who to contact if needs emerge in the future.

D. How was the accomplishment achieved?
Acadiana Area Human Services District (AAHSD) collaborated with OCDD to begin following the new policy and procedures. This began in April of 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 #2: Partnership with OCDD regarding rollout of a new tiered waiver system:</u>

A. What was achieved?
Partnered with the Office for Citizens with Developmental Disabilities (OCDD) for the rollout of a new 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 LDH Local Governing Entities throughout the state to screen all of the individuals on the registry. Once completed, the needs of those individuals were established. Priority was given to those with the highest, most urgent need. Once approval from the Centers for Medicare & Medicaid Services (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 #3: Establishment of direct-care productivity standard:

A. What was achieved?
Establishment of direct-care productivity standard.

B. Why is this success significant?
Improved productivity will allow more clients to receive services and for existing clients to receive services more frequently.

C. Who benefits and how?
Acadiana Area Human Services District (AAHSD) clients benefit from improved response to service demands. AAHSD benefits by increasing self-generated revenue.

D. How was the accomplishment achieved?
Based on consultant recommendation, a baseline productivity threshold of 1,000 hours of direct, billable service time per year for full-time direct service clinicians. Additionally, establishment of real-time productivity reporting feedback for staff and management to monitor productivity.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.) Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, the threshold recommendations are based on nationally-recognized industry productivity norms.

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: Mental Health First Aid Training to First Responders

A. What was achieved?
Acadiana Area Human Services District (AAHSD) sponsored Mental Health First Aid Training to First Responders within the community.

B. Why is this success significant?
Two sessions were conducted and thirty-three (33) first responders completed the training.

C. Who benefits and how?
First responders located in AAHSD catchment area.

D. How was the accomplishment achieved?
Training was accomplished at the Lafayette Parish Sheriff's Office and Lafayette Police 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 #5: Transitioned Pharmacy Services to Genoa Healthcare

A. What was achieved?
Acadiana Area Human Services District (AAHSD) transitioned its pharmacy services to Genoa Healthcare.

B. Why is this success significant?
This transition was planned to be effective April 1, 2018, but was 'fast-tracked' and became effective on November 1, 2017. Genoa is fully licensed and on the panels for all of the Medicaid managed care companies and other private insurances as well.

C. Who benefits and how?
This partnership with Genoa Healthcare has several benefits: it ensures timely access to medications for persons served; it maintains the quality of care/medication services for persons served; and, this is being offered at a lower cost than the District could provide directly (a savings of public-sector funds).

D. How was the accomplishment achieved?
Through several meetings with Genoa Healthcare and AAHSD Executive Director.

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

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

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

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

AAHSD submitted our initial five-year Strategic Plan in June 2013. Thus far, our goals and objectives are being met and the plan is on target for successful completion.

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

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."

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.

Our progress is expected to continue at 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."

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.

No management or operational problems exist.

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

B. Corrective Actions

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

☒ **Internal audit**
Acadiana Area Human Services District ensures ongoing monitoring of programmatic and administrative functions.

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

☐ In-house performance accountability system or process

☐ Benchmarking for Best Management Practices

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

☒ **Peer review**
Medical Doctors and OCDD peer review process.

☒ **Accreditation review**
The Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation—AAHSD received a 3-year accreditation.

☒ Customer/stakeholder feedback

Acadiana Area Human Services District (AAHSD) completes quarterly client satisfaction survey and an annual Stakeholder Survey.

☒ **Other (please specify):**
Human Services Accountability Plan (AP) monitoring visits by OBH and the Office for Citizens with Developmental Disabilities (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:
Acadiana Area Human Services District (AAHSD) Management Report.

2. Date completed:
June 2017.

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 the Commission on Accreditation of Rehabilitation Facilities (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.
- 2017/2018 budget submitted and approved. AAHSD maintained operations within budgetary guidelines.
- AAHSD realized an increase in collections for self-generated revenue. AAHSD has doubled its self-generated collections in the past three years.
- Professional and service contracts maintained and monitored by AAHSD. Monitoring was increased to at least quarterly for all contracts (some monitored monthly). The monitoring process has received positive comments from two separate regulatory reviews.
- Employees completed Civil Service PES as required.
- AAHSD continued its employee training program/schedule and utilized two online training programs – LEO and Relias Learning. Targets and timeframes were met.
- All Senior Managers have maintained a succession plan for their respective areas.
- AAHSD did implement a new pay/performance structure as outlined by State Civil Service.
- AAHSD maintained credentialing by all five MCOs within the State plan.
- AAHSD conducted and/or participated in numerous public events, health fairs, community forums, and other professional forums. This is reflected by the increase in number of stakeholder surveys.
- AAHSD was monitored by: ORM, LDH/OBH and OCDD, LDH/Bureau of Health Standards, State Civil Service, and the Fire Marshal. All reviews were successful.
- AAHSD assumed operation of services, including the provision of crisis services within our designated area.
- Selected staff has completed training in Applied Suicide Intervention Skills Training (ASIST) and have provided training to sixty-three (63) 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:
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    Title: CEO
    Agency & Program: AAHSD
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Annual Management and Program Analysis Report

Fiscal Year 2017-2018

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**

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

For each accomplishment, please discuss and explain:

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

Accomplishment #1: Critical Reproductive Health Services:

A. What was achieved?

The Louisiana Department of Health (LDH) Office of Public Health (OPH) Bureau of Family Health has successfully contributed to the state increasing access to critical reproductive health services by: 1) elevating the quality of reproductive health services in parish health units by implementing new evidence-based clinical protocols, including increasing competencies in contraceptive counseling and insertion of long acting reversible contraceptives; 2) working to improve access to available services by increasing the productivity of the parish health unit clinics through intensive training, technical assistance, and quality improvement activities; 3)

advancing the parish health unit network's ability to monitor and improve clinical performance through the use of sophisticated data reports generated from the Electronic Health Record; 4) elevating the quality and availability of best-practice reproductive health services in primary care settings through a targeted reproductive health integration initiative designed to provide community health clinics with training and technical assistance to become Title X sub-recipient sites, as well as by conducting outreach and training for residency programs, the Louisiana Primary Care Association, and the Louisiana Rural Health Association; 5) partnering with LDH-Medicaid, in part through the Centers for Disease Control (CDC) 6|18 Initiative, to develop policies and implementation plans, as well as conduct data analyses, to increase access to the full range of contraception including long-acting reversible methods such as Intrauterine Devices (IUDs) and implants; 6) actively contributed to state Zika Action Plan and response activities as subject matter experts on unintended pregnancy, contraception, and reproductive health counseling, contributing to strategy development, provider outreach and training, patient and provider messaging, and Medicaid Informational Bulletin development; 7) completed an assessment of reproductive health screening services for women of childbearing ages in the 10 methadone treatment programs across the state and provided information to the Office of Behavioral Health State Opioid Treatment Authority for program planning, and; 8) contributed to the development of a substance abuse toolkit developed for the Center for Medicare and Medicaid Services (CMS) innovator accelerator project on addressing neonatal abstinence.

B. Why is this success significant?

Critical Reproductive Health Services

Maximizing access to high quality reproductive health services in Louisiana is essential to improving the state's health and well-being, particularly by improving birth outcomes, preventing unintended pregnancy, and addressing the high rate of sexually transmitted infections. In addition, efforts to increase the efficiency, quality, and utilization of OPH reproductive health services is essential to ensure that OPH remains a sustainable, viable clinical provider of choice.

C. Who benefits and how?

The citizens of Louisiana will benefit by increased access to high quality reproductive health services. OPH will benefit by ensuring that services are state-of-the-art, efficient, and better supported by self-generated revenue.

D. How was the accomplishment achieved?

The accomplishments achieved to date set the stage for impact on priority reproductive health outcomes. This was achieved through staff who have aggressively sought to understand, prepare for, and respond to the changing healthcare landscape of coverage and quality. Partnerships across the Department, OPH programs, and with external collaborators have been essential to the success of the Reproductive Health Services program. However, the actualization of the intended health outcomes will depend on continued successful implementation of the established work plans.

Injury programming has been re-established through close collaboration with national subject matter experts and a commitment from the BFH to work in this area since it aligns with other investments related to health and safety of families.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. Reproductive Health is one of OPH's current agency "Big Bets."

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
The collaboration between OPH and Medicaid to develop the plans for expanded services has been a productive and valuable model of synergy between programs. In addition, the Bureau of Family Health RHP plan demonstrates the strength of aligning of public health programs with national standards for clinical quality (HEDIS, CHIPRA, and Healthy People 2020). Practice changes in Public Health Units realized through clinical quality improvement should certainly, when fully realized, represent a best management practice.

<u>Accomplishment #2: Re-establishment of Injury Prevention Programming:</u>

A. What was achieved?
The Bureau of Family Health (BFH) has successfully re-established injury prevention programming within the Office of Public Health (OPH) by 1) organizing injury prevention stakeholders, 2) improving injury surveillance capacity, 3) assessing current injury prevention programming across the state, and 4) successfully implementing two major violence and injury prevention federal grant opportunities, the National Violent Death Reporting System (NVDRS) and the Cores State Violence and Injury Prevention Program. The Core VIPP focuses on prevention of child abuse and neglect, motor vehicle crashes, intimate partner violence/sexual assault, traumatic brain injury (TBI), youth violence, and substance use misuse and abuse. The NVDRS helps state and local officials understand when and how violent deaths occur by linking data from medical examiner, coroner, law enforcement, toxicology, and vital statistics records. It is the only data system for homicide and suicide that links law enforcement data with data from non-law enforcement sources. The team successfully completed the 2017 data collection in four pilot parishes and started statewide data collection in January 2018. Using these data, public health practitioners and violence prevention professionals can develop tailored prevention and intervention efforts to reduce violent deaths. The State continued with injury prevention efforts through investment of HRSA Maternal and Child Health Title V Block grant, Preventive Block Grant funds and CDC Rape Prevention Education funds awarded to and managed by the BFH.

B. Why is this success significant?
Given the level of investment and priorities to promote health and safety of Louisiana families, the most strategic positioning of injury work in OPH was squarely within the BFH. Using these data, public health practitioners and violence

prevention professionals can develop tailored prevention and intervention efforts to reduce violent deaths.

C. Who benefits and how?
Unintentional and intentional injury is a leading cause of death and debilitating injuries for Louisiana residents. Funding to improve surveillance capacity and increase collaboration with prevention stakeholders should ensure a more informed and coordinated response to prevention statewide.

D. How was the accomplishment achieved?
Injury programming has been re-established through close collaboration with national subject matter experts and a commitment from the BFH to work in this area since it aligns with other investments related to health and safety of families.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. It aligns with other investments related to health and safety of families.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
The Injury Prevention programming is still relatively new during the past fiscal year, however, the collaborative approach to prevention of multiple forms of injury and violence prevention through a shared risk and protective factors approach is gaining traction.

<u>Accomplishment #3: Decrease in new HIV diagnoses in Louisiana from 2016 to 2017</u>

A. What was achieved?
New HIV diagnoses in Louisiana decreased from 1,122 in 2016 to 1,037 in 2017 (an 8% decrease). The STD/HIV Program (SHP) has focused on providing interventions across the HIV continuum of care, 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.

B. Why is this success significant?
The number of new HIV diagnoses in 2017 is the lowest number in ten years. Decreasing the number of new infections is one of the STD/HIV Program's top priorities.

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.

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 had fallen out of care, and increasing viral suppression. 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 83% in 2017.

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 the STD/HIV Program'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).

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 STD/HIV Program's HIV prevention projects were carried out by a cross-unit collaborative of key staff and 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.

<u>Accomplishment #4: Expanded Continuum of Care Collaborative:</u>

A. What was achieved?

The Sexually Transmitted Disease/Human Immunodeficiency Virus (STD/HIV) Program, called SHP, was awarded funds through two competitive grant applications from the Centers for Disease Control and Prevention (known as PS15-1506 and PS15-1509 nationally or the Expanded Continuum of Care Collaborative or EC3 locally) to expand comprehensive STD/HIV screenings, to increase knowledge and utilization of highly effective biomedical HIV prevention methods such as pre-exposure prophylaxis (PrEP) and post exposure prophylaxis (PEP) among communities most at risk for HIV infection, and to increase engagement in regular HIV care and viral suppression among those living with HIV. The EC3 project also seeks to increase the capacity of staff and the program to address HIV related racial disparities in the aforementioned key outcomes. The project began in October 2015 and significant progress has been achieved to date including over 3,500 high risk individuals receiving comprehensive STD and HIV screenings, over three million exposures to educational materials related to PrEP and PEP, approximately 300 medical providers being educated on PrEP and PEP, and over 150 high risk people being linked to PrEP Providers and receiving PrEP prescriptions. Additionally, the entire SHP staff and the

staff of community based organizations and HIV care clinics contracted to provide services for these projects were extensively trained on understanding and addressing institutional racism, homophobia and transphobia as those structural factors present significant barriers to effective STD/HIV prevention, care and treatment. The EC3 project will continue through September of 2019.

B. Why is this success significant?

Comprehensive STD/HIV screening (which includes syphilis screening and genital, oral and rectal screening for gonorrhea and chlamydia, as well as screening for acute and established HIV infection) is paramount to reducing the burden of those epidemics in Louisiana. Further, PrEP and PEP are over 90% effective at preventing the acquisition of HIV for HIV negative individuals, and achieving and maintaining viral suppression for people living with HIV not only improves their overall health, it also effectively prevents transmission of the virus to others even in the absence of other preventative measures. The combination of efforts of the EC3 project should have favorable long-term impacts on HIV and STD rates in the state.

C. Who benefits and how?

People who are HIV negative but at increased risk of acquiring HIV infection, as well as people already living with HIV and their sex partners have benefited and will continue to benefit from the project.

D. How was the accomplishment achieved?

The EC3 project has been successful due to SHP's highly experienced programmatic staff and the willingness and dedication of highly skilled community partners, as well as the program's strong and mature HIV/STD data systems, which allowed for the use of those data for continuous quality improvement of the project.

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

Yes. These activities are directly related to the program's goals: 1) decrease new STD and HIV infections, 2) increase the proportion of persons living with HIV who are linked to HIV medical care, and who are virally suppressed, and 3) to reduce HIV health disparities based on race/ethnicity, gender identity and sexual orientation.

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

Yes. The management and monitoring of the EC3 project is carried out by a cross-unit collaborative of key staff and this practice could be replicated for addressing other health issues in the state. Making trainings related to understanding and addressing institutional racism, homophobia and transphobia available to staff and requiring their participation is also a management practice that is highly applicable and could be replicated for addressing other health issues in Louisiana.

Accomplishment #5: Louisiana Immunization Network for Kids Statewide (LINKS):

A. What was achieved?

Louisiana Immunization Network for Kids Statewide (LINKS), the state's immunization information system, continues to broaden its capabilities affording benefits to vaccine providers and information for the public. In 2018, Louisiana was awarded CMS HITECH funds through 2020 for immunization information system (IIS) modernization.

LINKS is used to facilitate vaccine delivery, accountability, recommendations and demographic information to positively impact overall healthcare performance by preventing disease. LINKS is key to accurately and efficiently managing vaccine by public health and providers. Information from LINKS is used to provide state, regional and parish level information to inform communities and direct resources.

In the past year, the Louisiana Vaccines For Children (VFC) Program provided over 1,076,990 doses of vaccines valued at $72,166,864.90 from the federal government to children in every community in the State. LINKS is used for VFC vaccine management. LINKS reminder recall functionality is used by both providers and the Immunization Program for calls and postcard vaccination reminders. VFC Providers are informed of urgent information and program updates through LINKS' blast-fax capability.

Information from LINKS was also used by providers for quality improvement. In addition to compliance visits, eligible VFC providers receive an AFIX (Assessment, Feedback, Incentives, and eXchange) visit where vaccine-coverage rates are assessed and a Vaccine Coverage Rate Report Card is presented with results of the assessment. A pilot project in 2018 is underway to provide system level Vaccination Coverage Rate Reports with rankings. Awareness of rates provides incentive for improvement and focuses efforts to meet state performance measures and national targets, such as Healthy People. Feedback has been especially effective for providers and improvement activities of school-based health clinics to increase HPV vaccination rates.

Information from LINKS is proving helpful in determining potential vaccine disparities in the State.

LINKS' school nurse module is used in an annual school assessment of vaccination rates of kindergartners and sixth graders in public and non-public schools in Louisiana. This data is mapped each year by parish (county) and shared with key stakeholders and the public on the Health Informatics webpage. Communities, partners, and stakeholders can then examine health data, set goals, and develop and implement plans to improve rates for better health. Making this de-identified data available accelerates the translation of evidence into action.

B. Why is this success significant?

LINKS benefits individuals and is a valuable source of information for local public

health professionals, vaccine providers, and the public to work together toward reducing vaccine preventable diseases and improving vaccination rates in Louisiana.

C. Who benefits and how?

Children, parents, families, providers, and communities as a whole benefit from this confidential, population-based, computerized database that records all immunization doses administered by participating providers to persons in Louisiana.

- At the point of clinical care, LINKS provides consolidated immunization histories for use by a vaccination provider in determining appropriate and up-to-date patient vaccinations.
- At the population level, LINKS provides aggregate data on vaccinations for use in surveillance and program operations, and in guiding public-health action with the goals of improving vaccination rates and reducing vaccine-preventable diseases, ultimately preventing disability and death in individuals and interrupting disease transmission in Louisiana communities.

D. How was the accomplishment achieved?

The OPH has achieved success with LINKS by spending 22% of federal funding and significant staff time on LINKS activities to securely maintain the systems and continue to make improvements. This included needed system upgrades and a transition to cloud hosting in December 2017. Staff participate on national IIS boards and associations. LINKS remains a priority for the Louisiana Department of Health.

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

Yes. LINKS planning includes capabilities to the Immunization Program's 2018 Goals, including:

- Maintain data quality to remain a trusted source of immunization information
- Provide information to direct programmatic activities and inform the public
- Inform public health outbreak response efforts
- Increase the number of interfaces with providers, including community pharmacies
- Conduct reminder recall on a regular schedule
- LINKS will continue to promote MyIR to securely provide better customer service so current immunization information to individuals is available while complying with confidentiality requirements
- Continue system upgrades to improve performance
- Participate in cutting edge, cross-jurisdictional immunization data exchange through the Public Health Immunization Data Exchange (PHIZ) Pilot Project

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

Yes. LINKS demonstrates commitment of the Louisiana Department of Health (LDH) and the Office of Public Health (OPH) to broaden capabilities benefitting health care

providers and program operations and informing the public. This experience will be beneficial to other executive-branch departments and agencies in the state. LINKS has recently worked to expand IIS participation by demonstrating the value of the IIS. Working in collaboration with many partners such as Louisiana Medicaid, the Louisiana Board of Pharmacy and the Louisiana Chapters of the AAP and AFP, the Immunization Program has not only demonstrated the incredible value of LINKS to the health of Louisiana citizens, but also expanded LINKS participation to include other, non-traditional immunization providers, such as specialty physicians and pharmacists.

Accomplishment #6: Zika Surveillance and Epidemiologic Response:

A. What was achieved?

The state of Louisiana has a long history of endemic arboviral disease transmission, starting with Yellow Fever in the 1800s and continuing to West Nile Virus (WNV) in the present day. Louisiana has been identified as being one of the relatively few states at increased risk for local transmission of Zika. Factors contributing to this designation include: multiyear surveillance of travel-associated Dengue and Chikungunya cases; year-round abundance of *Aedes aegypti* and *Aedes albopictus*; a substantial proportion of the population experiencing poor living conditions; and increased vector breeding sites (such as Port cities, historic underground hibernation sites in aged sewer/water systems, public drainage canals with standing water, above ground cemeteries, and a high number of vacant lots, abandoned/undeveloped properties, and waste tires).

During fiscal year 2017-2018, the Infectious Disease Epidemiology Section (IDEpi) continued to utilize funding awarded through CDC's Epidemiology and Laboratory Capacity for Infectious Diseases Cooperative Agreement (ELC) grant to support activities including epidemiologic surveillance and investigation, participation in the U.S. Zika Pregnancy Registry, strengthening human and ecologic laboratory capacity and also mosquito monitoring and vector control, to protect Louisianans from Zika virus.

IDEpi collected pertinent clinical and epidemiologic information for all suspect Zika cases, issued testing recommendations to healthcare providers, coordinated with the State Office of Public Health laboratory in the shipment of specimens, and provided communication/interpretation of results to the provider and patient. IDEpi monitored all suspect Zika cases to verify they were provided information to monitor for symptoms, take precautions to avoid exposure to local mosquito populations (stay indoors in screened, air-conditioned rooms, use personal repellents, consider mosquito reduction activities around the home) and ensure that all their questions regarding their infection were answered. IDEpi enhanced surveillance for severe clinical manifestations (congenital infection with microcephaly or other birth defects, Guillain-Barre syndrome, other neurologic syndromes, deaths, etc.) and Zika virus infections among children. Weekly summary reports on all surveillance activities were produced for public and private distribution.

B. Why is this success significant?

The Infectious Disease Epidemiology Section (IDEpi) has been consulted and

completed follow-up on over 1,150 patients, coordinated shipment and testing of 965 patients of which only 49 cases laboratory-identified as travel-associated Zika virus infections among returning travelers to Louisiana. IDEpi has maintained a robust Zika surveillance system, including strong communications and collaborations with internal and external partners.

C. Who benefits and how?

Stakeholders for these activities include urgent care clinics, acute care hospitals, birthing hospitals, obstetricians, pediatricians, infectious disease and maternal-child healthcare professionals, and vector control professionals. Stakeholders remain engaged and ready to collaborate with Infectious Disease Epidemiology (IDEpi) to address Zika virus infections, monitor for birth defects and other health outcomes, and plan for services for pregnant women and families and improve prevention. IDEpi provides situational awareness and counseling on guidelines for diagnosis and management of persons with laboratory evidence of Zika. Mosquito abatement districts receive guidance on epidemiologic investigations and tools for surveillance of mosquito pools and/or insecticide resistance monitoring. Without rapid surveillance, testing, institution of preventive measures and vector control, Zika could more likely spread via local transmission in Louisiana mosquitoes. As a result, all Louisiana citizens are considered important beneficiaries of this activity's success.

D. How was the accomplishment achieved?

The Infectious Disease Epidemiology Section (IDEpi) and the State OPH Lab strengthened collaboration and communication by implementing a shared database; training staff in new laboratory and epidemiology protocols to evaluate clinical inquiries for arboviral testing and utilize testing algorithms; and enhancing the state's laboratory diagnostic capacity with purchased equipment, supplies, and the purchase of STARLIMS software. IDEpi also coordinated efforts with the State Medical Entomologist to purchase $117,000 of vector control equipment for use by mosquito abatement districts and control operators statewide.

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 #7: Louisiana's Response to the Severe 2017-2018 Flu Season:</u>

A. What was achieved?

The 2017-2018 influenza (flu) season was the worst season in the United States since public health officials began tracking the virus each season more than 10 years ago. Louisiana was hit particularly hard. Influenza A (H3N2) viruses were the most common

this season. H3N2-predominant seasons are associated with more severe illness especially among people older than 65 years and children. Nursing homes in Louisiana were hit particularly hard, with >30% of them reporting influenza outbreaks. Flu outbreaks in nursing homes accounted for 1,271 cases, 152 hospitalizations, and 31 deaths. Due to the early activity and great number of reported outbreaks, the Infectious Disease Epidemiology Section (IDEpi) created a more formalized response that resulted in more rapid implementation of control measures and the opportunity to confirm the flu subtypes causing outbreaks in nursing homes.

Flu vaccine is the best way to prevent flu illness and serious flu complications, including those that can result in hospitalization. In January 2018, IDEpi worked with other Louisiana Department of Health (LDH) and Office of Public Health (OPH) partners on a three-week, Mardi Gras themed public awareness and flu vaccine campaign in response to this season's extremely high flu activity. On January 31, 2018, 60 parish health units offered no-cost, walk-in appointments for flu vaccination. To promote this campaign, the LDH Bureau of Media and Communications (BMAC) embarked on a media campaign utilizing social media, television, and radio interviews. The campaign created a strong online conversation about vaccines resulting in LDH posting a special blog to distribute correct information about vaccines.

B. Why is this success significant?

In January, more than one in every 10 Louisianans who visited emergency rooms did so because of flu-like illness. CDC and states use baselines as a number to measure the level of flu activity, and Louisiana experienced widespread activity earlier than most other states. The United States did not pass baseline levels until December while Louisiana was above baseline in the beginning of November. Outbreaks of flu at schools and nursing homes in Louisiana hit record levels. During a bad flu season, Louisiana has close to 700 deaths and 8,000 hospitalizations. By early January, we already passed these numbers based on estimates. IDEpi also began systematic tracking of severe influenza infections in all ages early in the season. So far, IDEpi epidemiologists have collected medical information on >350 severe cases. This allows IDEpi to identify risk factors specific to Louisiana residents and categorize those individuals who experience severe infection. In partnership with the Louisiana Office of Vital Records, IDEpi has identified >230 death certificates with influenza listed as the immediate or underlying cause of death. All deaths have been investigated, and if hospitalized, clinical information was obtained so these cases can be described.

The flu vaccine campaign was an enormous success in Louisiana and it likely prevented many infections and hospitalizations/complications. News releases announcing the No Cost Flu Vaccine Day generated approximately 32 media stories in 23 hours. In all, more than 1,000 stories for flu prevention were generated in 3 days. During a three ½-hour period on January 31st, public health units around the state administered 2,800 flu vaccines. Due to the enormous success, the campaign was extended two more weeks leading up to Mardi Gras. A total of >4,000 doses of flu vaccine were given through the public health units.

C. Who benefits and how?

Because the goal of surveillance for any infectious disease is to reduce the disease burden in a population, all citizens of Louisiana benefit from the success of this activity. However, there are several specific groups that benefit in additional ways. Nursing home residents at particular high risk for complications benefit when recommendations for control measures are made in a timely manner to prevent more cases of disease. Physicians and external partners benefit because they can get additional guidance on severely ill individuals and rapid testing turnaround from the state where they may usually have to wait for testing results from a reference lab, which delays prompt antiviral treatment. The Centers for Disease Control (CDC) benefits because they receive additional surveillance data and specimens to compare strains that are circulating.

D. How was the accomplishment achieved?

IDEpi respiratory and healthcare associated infection (HAI) epidemiologists worked together to ensure nursing homes were not only using anti-viral medication correctly but also that proper infection control guidelines were followed (handwashing, gloving, masking). HAI also engaged the Louisiana Nursing Home Association to help distribute information to their members about flu activity and outbreak response efforts. The vaccination campaign was achieved through partnerships with the Immunizations program, BMAC, local public health unit staff and LDH leadership.

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

Yes.

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

No.

<u>Accomplishment #8: Statewide Vital Records Stakeholder Outreach:</u>

A. What was achieved?

The Vital Records Field Services team within the Quality Management Unit conducted a three month long statewide outreach project of over 120 individual on-site meetings with stakeholders in nearly every parish in Louisiana. The purpose of these meetings was to facilitate strong partnerships with our Vital Records stakeholders and to ensure clear communications of Vital Records policies and relevant Louisiana laws on vital record registration. These meetings included 49 birthing facilities, 53 parish clerks of court that issue vital records, 17 regional meetings for funeral homes and Parish Health Unit employees, and select Parish Coroners' offices. For birthing facilities, individual facility reports were shared to highlight specific areas of potential improvement for data quality issues.

B. Why is this success significant?

While Vital Records provides ongoing registration and issuance support to all of its stakeholders, the opportunity to meet face-to-face and include every relevant stakeholder location yielded excellent feedback and had an immediate effect on the volume of support calls received by field staff. By including all areas of the state in one outreach effort, standards were effectively communicated and data quality consistency can be assured. As future birth data quality reports are released by the National Center for Health Statistics (NCHS), we expect to see considerable improvement based on the one-on-one conversations held with each birthing facility.

C. Who benefits and how?

The expected improvement of birth quality data directly benefits the National Center for Health Statistics and Centers for Disease Control and Prevention (CDC) researchers who rely on timely and complete data from state vital records jurisdictions. This research is in turn used to directly improve understanding of health issues concerning birth (e.g., racial disparities among teen pregnancies, risk of birth defects, effectiveness of prenatal care) and used to improve understanding of health issues among healthcare providers, in turn improving birth outcomes.

Individual clerks of court offices who choose to issue vital records benefit from the on-site visits that provided all issuing staff with an opportunity to ask location-specific questions and gain a thorough understanding of vital records requirements, making them more confident partners in their role of offering same-day service for the issuance of vital records statewide.

D. How was the accomplishment achieved?

Vital Records received funding in the form of a federal grant that allowed for extensive travel for Vital Records staff for the purposes of this outreach. Over 120 meetings were scheduled and conducted with various external offices.

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

Yes. A primary goal of Vital Records is to continue to improve the quality and timeliness of vital event data. Furthermore, Vital Records' partnerships with external record registration and issuance partners are critical to its mission of registering vital event data and providing the service of issuing certified copies of vital records to the public.

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

Yes. While Vital Records uses various strategies for supporting external stakeholders, we believe that no communication is more effective than in-person direct communication of expectations and potential areas of improvement. These in-person site visits will be referred to in future conversations with each facility as a

baseline for meeting data quality and service standard expectations.

Accomplishment #9: Hurricane Harvey Response:

A. What was achieved?

Hurricane Harvey was the first major hurricane (Category 3+) to make landfall in the United States since Wilma in 2005. Harvey reached hurricane status on August 23, 2017 and progressed to a Category 4 on August 25, 2017 before making landfall the first time near Rockport, TX. Governor Edwards declared a state of emergency on August 24, 2017 and federal declarations were issued for 12 parishes. LDH/OPH/BCP provided support to two (2) CTNS shelters, including medical support to a MSNS. Transport and re-entry were key activities. Medical volunteers and local governing entities (LGEs) were critical to supplement LDH staffing. LA received ~ 6,531 evacuees during activation. The R6 MSNS received approximately 1388 evacuees during the same time period with ~ 70 of those clients needing transport to local hospitals for further evaluation. Region 5 received ~ 500 rescues from flooded areas. Two shelters were opened in R5 to support evacuations from Southeast Texas (Lake Charles Civic Center and the Burton Coliseum). R7 opened a CTNS site at Jewella. Pharmacy provided 1489 prescriptions from 8/30/17-9/4/17. LA was successful in the repatriation of all evacuees from LA and TX by 9/6/17 with no reported incident-related deaths.

B. Why is this success significant?

Success in this area is significant because it serves as a federal benchmark of the state's planning and ability to respond in public health emergencies. Louisiana's efforts in emergency preparedness are trend setting and are realized once again due to the continued planning and exercising completed in order to continue to be able to respond expediently and effectively during major disasters. Louisiana continues to rank 3rd in the nation in Emergency Preparedness.

C. Who benefits and how?

The citizens of Louisiana benefit by the state's ability to successful respond to a public health emergency. This event showcased the state's ability not only to support its citizens but those citizens from the neighboring state of Texas.

D. How was the accomplishment achieved?

This accomplishment was achieved through the Agency's (ESF-8) planning meetings, reviewing response plans, conducting trainings/workshops and exercising state emergency plans. Also, the agency's work with regional health coalitions that encompasses the ESF-8 network –EMS, Hospitals, Nursing Homes, Home Health, and Public Health helped to accomplish this goal.

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

Yes. Preparedness and response attributes to our five-year strategic plan under the

auspices of Community Preparedness. Success in this area is essential to sustain and maintain grant deliverables and future funding.

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 collaborative response efforts throughout all the LDH agencies have been valuable in maintaining and developing community and emergency preparedness. Our success in these areas is reflected in the expedient response of our federal partners respond during a real or perceived threat to the state.

Accomplishment #10: WebEOC:

A. What was achieved?
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, 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?
For many years, the LDH EOC has used several disparate manual processes to maintain and track a variety of incident data. The processes were labor intensive and struggled to provide timely data in a format useful for analysis and decision making. Additionally, collecting information from other LDH response operations was also a manual process and required frequent direct communication to validate the information being shared.

WebEOC consolidates many of these processes into a single platform with customizable

search and analysis tools for manipulating incident data. This provides greater value to processes already being used, particularly by reducing staff time dedicated to manual processing of resource requests and incident reporting and allowing both high level and detailed views of current response activities. Greater accessibility to information that was already being collected is now much easier to integrate into decision-making in ways that were previously impractical.

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?
Use of WebEOC benefits (directly or indirectly) all LDH staff working in an emergency operation. The most direct benefits are experienced by staff working in the LDH EOC, Regional LDH EOCs, and LDH field operations (medical special needs shelters, transportation triage, points of dispensing). Anyone affected by these operations also benefits from the increased efficiency to many incident response processes (which includes reduced errors in data management, faster fulfillment of resource requests, greater availability of critical incident information, etc.)

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?
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 emergence preparedness staff worked closely with vendors to develop the software to match the specific needs of LDH emergency response activities.

An in-person training was conducted in each of the nine LDH regions to familiarize the regional leadership teams with the new software systems and to prepare them to train their regional response staff in their use.

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

F. Does this accomplishment or its methodology represent a Best management Practice that should be shared with other executive branch departments or agencies?
Yes. The MSNS application was uniquely built to meet the needs of Louisiana based on lessons learned from past events. Once implemented, this data collection tool will be

able to provide a host of information regarding MSNS patients and resource needs.

Accomplishment #11: Project Public Health Ready Re-Recognition for Office of Public Health Region 1 and Region 6:

A. What was achieved?

The Bureau of Community Preparedness worked meticulously with the Office of Public Health (OPH) Region 1 and Region 6 to attain National Association of County and City Health Officials' (NACCHO) Project Public Health Ready (PPHR) Re-Recognition in autumn 2017. OPH Region 1 and Region 2 met NACCHO's stringent criteria that included the most current Federal preparedness initiatives divided into three goals: 1) all-hazards preparedness planning, 2) workforce capacity development, and 3) demonstration of readiness through exercises or real world response. During the 2018 Preparedness Summit in Atlanta, Georgia, NACCHO presented Region 1 and Region 6 with Re-Recognition awards!

B. Why is this success significant?

First, this distinction is significant because it validates the State Health Department's continuous proficiency in successfully meeting a standard of rigorous requirements in all-hazards preparedness planning, workforce capacity development, and readiness demonstration through exercises or real world response. Second, this success symbolizes the State Health Department's commitment to public health and continuous quality improvement. In fact, the Office of Public Health Regions 1 and 6 were previously awarded this status in 2012. Finally, this success enhances Public Health's image as the OPH-Region 1 and Region 6 stand out as examples of excellence in Public Health and Emergency Preparedness.

C. Who benefits and how?

The beneficiaries are the citizens of Region 1 and Region 6, in addition to visitors, businesses, and community partners. This status is also helpful in maintaining and augmenting statewide emergency planning for all state regions. Moreover, the Public Health profession benefits by having examples of exemplary agencies, i.e., Region 1 and Region 6 in emergency management.

D. How was the accomplishment achieved?

The accomplishment occurred through relationships and collaboration with agency officials, community partners, and other stakeholders within the Regions and State. These relationships are critical to leveraging expedient preparedness resources in capacity and capability building.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. This accomplishment is significant as the agency prepares for other accreditation processes inclusive but not limited to Public Health Accreditation Board (PHAB).

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

Yes. Project Public Health Ready is a benchmark that aims to protect the public's health and increase the public health infrastructure by equipping local health departments with sustainable tools to plan, train, and exercise using a continuous improvement model. In fact, the Bureau of Community Preparedness notified the State Health Department's Executive Leadership of Region 1's and Region 6's achievement. Furthermore, the Bureau of Community Preparedness published an article about the achievement in the State Health Department's monthly newsletter (February 2018).

Accomplishment #12: Retail Food Quality Assurance Program

A. What was achieved?

A challenge of a statewide regulatory inspection operation is to ensure accuracy and consistency across inspectors, inspection types and industries. Sanitarian Services developed a Quality Assurance Program in FY18 by creating structure, gathering information on the training needed, strategically developing and delivering training in several face-to-face models, and by changing the style of training to one that is more effective for the material taught. OPH Sanitarian Services, in FY18, created two Quality Assurance (QA) Sanitarian 7 positions dedicated to statewide education, auditing, coaching and compliance. In addition to creating consistency in violation detection during inspections of retail food establishments, the QA Program leaders were able to identify areas where additional training was needed. They developed training "boot camps" which involved non-traditional training methods to better equip the Sanitarian inspectors with the ability to know how to identify violations. The two QA Program Leaders also performed "ride along's" with the Sanitarians to observe, coach, and audit their inspections. To date, they have shadowed 31 Sanitarians and conducted 3 audits, where they compared their inspection findings to the Sanitarians and coached for improvement, in tandem with the field supervision.

Through community partnerships, the training model was one of lecture and lab as opposed to strictly lecture. Sanitarians were trained in actual kitchens where the violations were staged to mimic what they would see in the field. This year 18 trainings were conducted and 1 "boot camp."

In addition, a training was held to retrain Sanitarians on the use of the technology software. Field leaders were identified and trained in person. They returned to train their network of Sanitarian co-workers and to serve as an ongoing technical resource. Another critical role of the QA Sanitarians is that they serve as liaison between industry stakeholders and OPH Sanitarian Services. The QA leaders develop and present formal and information food safety training for both Sanitarian Services, local and state government and industry. They were integral in the launch of the new ACT 66 fee for repeated re-inspections. The proactive collaboration created a positive message and was embraced by industry.

B. Why is this success significant?

This achievement is significant to our goals of reducing the instances of food borne illness, and protecting the public. Quality and consistency in our inspections and communications are a major focus of the program. This model of training, the amount of training delivered, and the availability of technical resources to our field Sanitarians also gives our field staff the required support they need to be excellent regulators, which in turn develops our workforce in the skills needed to be successful. This investment in our greatest resource, our employees, is significant.

C. Who benefits and how?

The 24 million citizens and visitors to the State of Louisiana benefit from prompt correction of violations that could result in food borne illnesses. The industry and stakeholders who consistently receive quality inspections. Our field staff benefit from the being trained and developed to be excellent regulators of a complex Sanitary Code.

D. How was the accomplishment achieved?

The accomplishment was achieved by the investment of two Quality Assurance, Sanitarian 7 positions to create the statewide QA Program. The QA leaders have shadowed 31 sanitarians, conducted 3 audits, and presented or sponsored 18 trainings, and 1 regional boot camp. The agency is working to expand this to a third position to expand the QA Program.

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

Yes, this contributes to the Office of Public Health Strategic Priorities by workforce development. The QA Program features quality training, consistent information to stakeholders and one-on-one training of Sanitarians during shadowing. Quality assurance and training are synonymous with improving communications with operators, thereby increasing the number of violations corrected during inspections and reducing the number of repeat violations.

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

Yes. A statewide Quality Assurance Program can be effective and can generate long term efficiencies by increasing education, decreasing rework (re-inspections) and providing accountabilities at the inspector level. This approach features a few critical elements: (1) Program support at all levels of management (2) High level QA leaders (3) Accountabilities built in for both the QA leaders and the Sanitarians they serve, teach and audit, and (4) Positive approach to the entire process with phased implementation: observation, teaching, and then auditing.

Accomplishment #13: Successful Implementation of ACT 66

A. What was achieved?

September 1, 2018, Louisiana law Act 66, passed to authorize LDH to charge a fee of $150 to any permitted food establishment that fails to correct Louisiana Administrative Code Title 51 code violations cited. The law requires that establishments correct all violations prior to the first re-inspection. Trainings were developed and delivered to Sanitarians statewide to ensure consistent enforcement of the law. Educational materials were developed and distributed to establishments to educate them on the new law. The implementation was a two-step process. Initially only "Critical" (the more serious food safety issues) violations were assessed a fee. Once the industry was given 6 months to acclimate to the program, then the fees were extended to the "non-Critical" violations.

Developed a customized webinar course on ACT 66, to educate Sanitarians and specifically address any questions that might come up in the field. Training was delivered to 235 Sanitarians.

Participated in Louisiana Restaurant Association (LRA) Food Expo to personally dispense educational materials to attendees and sponsors. The Expo afforded the opportunity for outreach and to provide training materials to several hundred people in the retail food industry.

Sanitarian Services partnered with Bureau of Media and Communications (BMAC) to generate notices for establishments. The purpose of the notices was to educate the establishment on ACT 66. An attractive logo was developed and positive message was generated to ensure that retail food establishments were aware of the program prior to any fees being assessed.

B. Why is this success significant?

This success is significant because educating establishments on the new law offered the opportunity for a smooth transition to new regulations. It also afforded Sanitarians the additional support in gaining compliance from facilities willing to correct violations on the spot, in lieu of being charged a re-inspection fee. This created a source of additional motivation for the industry to comply.

C. Who benefits and how?

The 24 million citizens and visitors to the State of Louisiana benefit from prompt correction of violations that could result in food borne illnesses. Re-inspections have always been a challenge to the field Sanitarian, as they represent additional inspection workload that prevents them from more efficiently managing their portfolio of inspections. As the fees lead to a reduced % of re-inspections, the Sanitarians will be able to more easily manage their workload. Likewise, reducing the number of Compliance Orders also reduces the workload on the Sanitarian and allows them to be timelier in their response to complaints, service request for new establishments opening

and more time for outreach and education.

D. How was the accomplishment achieved?

Sanitarian Services collaborated with BMAC team to develop and distribute educational materials in the form of notices for establishments. These materials were supplied to field staff statewide in printed form, and generated on every electronic inspection report. Sanitarian Services partnered with Louisiana's Civil Service's Comprehensive Public Training Program (CPTP) team to develop and deliver Ethics and Customer Service trainings specifically for regulatory programs and personnel. These courses were conducted in each of all nine regions of the State.

Sanitarian Services administrative staff participated in the Louisiana Restaurant Association Food Expo, and distributed educational materials to expo attendees. This allowed access to both retail food establishments as well as manufacturers. Several hundred expo attendees received distributed information and staff were able to respond to questions.

Sanitarian Services Chief of Field Operations created, and administration presented, ACT 66 webinar to Sanitarian Regional Directors, Field Operations staff, and Specialty Operations staff statewide. This was done via classroom and webinar setting. The webinar was recorded to afford the opportunity for staff to view/review training at a later date.

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

Yes, two strategic priorities of the Office of Public Health are promoted in this accomplishment: Internal/External Collaboration and Workforce Development.

The mission of the Retail Food Program is to prevent and minimize food borne illness through education, monitoring, issuance of permits and regulation of food establishments. In addition, collaboration with BMAC allowed teams to work together to generate an easy to understand and well received document on new regulations. Finally, enforcement of Act 66 reduces will likely reduce the number of re-inspections required. The percentage of re-inspections as an indicator of stakeholder compliance and effectiveness of Act 66, is being closely monitored. Due to the competing variable of heightened awareness of violations, due to the extensive training, that we have done, after 3 months of full implementation we are seeing a very slight increase in re-inspections. We expect the metric to stabilize within the next 6 months and decrease by end of FY19.

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

Yes. Communication and collaboration as well as a robust training program is always a Best Management Practice. Identifying "waste" in the process, which is what re-

inspections generate, and working to eliminate it through a method that motivates the customer creates added efficiency through reduced manpower and ultimately a reduced cost of inspection.

Accomplishment #14: Louisiana Opioid Surveillance Initiative:

A. What was achieved?

With support from three federal grants totaling $1.2M for the fiscal year, the Bureau of Health Informatics (BHI) expanded the opioid surveillance initiative that was begun in 2016. BHI has hired three FTE to support a program focused on collection, analysis, and dissemination of health data related to opioid use disorder in the state; ongoing investigation of data and programmatic gaps to support additional measurement and drive prevention and treatment efforts; instigate/support collaborative efforts with outside partners and sister agencies.

B. Why is this success significant?

Louisiana has been impacted by the national opioid crisis, which caused at least 49,000 deaths across the country in 2017. The CDC predicts that the opioid epidemic will be more damaging than the AIDS epidemic. BHI's surveillance initiative was the first response of public health in addressing the opioid crisis in Louisiana through alignment of data to support the Department's programmatic activities. This effort created a foundation for programmatic decision-making initiated by BHI's skilled surveillance activities, data analysis, and health informatics.

C. Who benefits and how?

Most importantly, the citizens of Louisiana benefit through increased efforts in prevention and treatment for opioid use disorder. Results of surveillance activities are made available to decision-makers at all levels and across all sectors to inform quality actions in addressing the opioid crisis in the state and reducing overdoses and anxiety.

D. How was the accomplishment achieved?

Through the hiring of qualified, trained, passionate individuals who aggressively sought to understand the opioid crisis, both statewide and nationally, and make data available; with collaboration internal and external to the department; by establishing BHI staff as Subject Matter Experts (SMEs) on data collection, dissemination, and analytic tools; through the guidance and support of OPH and LDH leadership.

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

Yes, it addresses goals in both *Meaningful Internal and External Collaboration* and *Health Information, Technology, Infrastructure, Integration, and Utilization.*

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

Yes, and BHI is contracting with a reputable management consulting agency to develop a toolkit for data-driven prevention and a sustainability plan for the opioid surveillance program.

Accomplishment #15: Modernization of key data systems and infrastructure:

A. What was achieved?
Through the ongoing use of data and data systems for analysis, it was recognized that the more efficient methodologies and architecture could be adopted. This adoption occurred in two significant areas/data assets. First, the Louisiana Inpatient Discharge Database (LAHIDD) reflects an improvement in how data are assembled and accessed by our analysts to more quickly generate actionable data for decision making. Second, the agency-wide geospatial environment highlights an improvement in our infrastructure that will improve the adoption of complex analytic tools.

B. Why is this success significant?
The improvement in these areas above generate significant gains in innovation and efficiency. Efficiency is gained through more effective analysis of the data through the elimination of time-consuming data cleaning. Innovations gained include, but are not limited to, the development of common/standard models for geospatial presentation, more collaboration among users, and the ability to leverage more advanced tools.

C. Who benefits and how?
The community that utilizes these areas benefit greatly. This community does not only include LDH staff, but the outside research community and those partners. The community benefits by receiving information through our many external facing visualization platforms.

D. How was the accomplishment achieved?
These improvements were accomplished through collaboration and coordination with key users and with input from outside partners, such as researchers. The primary goal was to improve efficiency through the creation of smarter data and smarter systems.

E. Does this accomplishment contribute to the success of your strategic plan?
Yes, it addresses goals in both Meaningful Internal and External Collaboration and Health Information, Technology, Infrastructure, Integration, and Utilization.

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 represents a best practice because it highlights that systems and data architecture must stay current to fully leverage the contents.

Accomplishment #16: Continued funding and collaboration in the Behavior Risk Factor Surveillance System:

A. What was achieved?
(1) Data from the 2016 Louisiana Behavior Risk Factor Surveillance System was used to characterize the area surrounding Donaldsonville socio-economically, for medical need and for caregiver capacity. This information was used to help formulate 'data-driven' decisions concerning the expansion of this rural hospital to meet the needs of the people living in the surrounding parishes. Information on prevalence of chronic conditions, food and shelter insecurity, caregiver capacity and prevalence of functional disability is not readily available. BRFSS is one of the primary sources for this information nation-wide. (2) Data comparing the specific needs of Alzheimer's caregivers to the needs of caregivers to all other types of care recipients was obtained. Higher levels of stress and expense are associated with caregiving to Alzheimer's patients as compared to caregivers to all other types of care recipients. This data quantified this qualitative assessment.

B. Why is this success significant?
(1) This information helps refine the targeting of funds and development of programs and services to meet the specific needs of the surrounding area. (2) Researchers and practitioners can use this data to develop respite care and support initiatives that specifically target the needs of Alzheimer's caregivers making best use of funding and effort.

C. Who benefits and how?
People living in and around Donaldsonville, LA will have access to enhanced medical services that are tailored to their needs. Alzheimer's patients and their caregivers also benefit. As the population ages, this need will increase significantly. Understanding future needs allows the opportunity to make best use of the resources that are available.

D. How was the accomplishment achieved?
First, analysis was divided into three categories: statewide, East Baton Rouge parish and the combined parishes of West Baton Rouge, Iberville, Ascension, Assumption, St. James and Livingston to allow comparisons and to place the statistics for the Donaldsonville area into context. Second, we used data to drive the design and implementation of new support functions.

E. Does this accomplishment contribute to the success of your strategic plan?
Yes, it addresses goals in both Meaningful Internal and External Collaboration and Health Information, Technology, Infrastructure, Integration, and Utilization.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. Inclusion of BRFSS population level data will enhance the capacity for data driven decision making in any situation where the needs and strengths of a given population have not been adequately described.

Accomplishment #17: Clinical System Support:

A. What was achieved?
BHI operates the electronic health records (EHRs) system in all parish health units, through an external vendor Success EHS in coordination with the Louisiana Health Care Quality Forum (LHCQF). BHI successfully negotiated a cooperative endeavor agreement with LHCQF for continued support of the EHR. The EHR team participates in super user groups aimed at improving workflows, reducing errors, and improving documentation, which aids in the development of a system user guide in clerical and clinical domains.

B. Why is this success significant?
Two OPH staff and one ULL contractor support 500+ users and 75,000+ patients through efficient operation of the EHR, which also results in significant revenue for the Office.

C. Who benefits and how?
Public Health Units (PHUs) operate in all parishes, and 75,000 unique patients received services in 2017. Patients in PHUs receive more efficient care delivery because of the EHRs.

D. How was this achieved?
Continued coordination among the system, operations, and revenue staff in the Office of Public Health; prioritization for the efficiency of this project by OPH leadership; and a commitment to staff retention to sustain institutional knowledge.

E. Does this accomplishment contribute to the success of your strategic plan?
Yes, it addresses goals in both Meaningful Internal and External Collaboration and Health Information, Technology, Infrastructure, Integration, and Utilization.

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

Yes. Explain further?

Accomplishment #18: State Oral Health Workforce Recruitment Initiatives:

A. What was achieved?
The Bureau of Primary Care and Rural Health applied for and received an Oral Health Workforce Development grant through HRSA. The purpose of this grant is to help states develop and implement innovative programs to address the dental workforce needs of designated dental health professional shortage areas (Dental HPSAs). The aim is to encourage and support state innovation that will increase oral health services for populations living in Dental HPSAs and to sustain those programs that increase the accessibility and quality of oral health services within Dental HPSAs. The State Oral Health Workforce Grant was divided into three (3) projects: 1.) Conducting an Oral Health Statewide Workforce Assessment, 2.) Implementation of the Dental Rural Scholars Track Program, and 3.) Recruitment and Retention of Dental Professionals in

underserved areas.

Oral Health Assessment

The BPCRH partnered with the Louisiana Public Health Institute (LPHI) to perform an oral health needs assessment for the state. The assessment was conducted through an electronic survey. The group surveyed included dental hygienists, school nurses, SBHCs, ER medical directors, and LA Oral Health Coalition advocates. The results of this survey will be shared with the dentists and dental advocates via webcast by August 31, 2018.

Dental Rural Scholars Track

LSU School of Dentistry received seed funding to support the first two years of the Dental Rural Scholars Track Program through the Oral Health Workforce Grant. The purpose of the Rural Scholars Track (RST) Program is to encourage service in Louisiana's rural and underserved areas and ultimately overcome the state's problem of a substantial lack of dentists available to vulnerable populations. Numerous steps were taken to ensure smooth implementation. Specific accomplishments included developing program policy including eligibility criteria, scholarship obligations, as well as successful sustainability planning efforts that will continue the RST Program and increase the number of scholarships.

In the first implementation year (2017) Louisiana State University School of Dentistry (LSUSOD) selected one third-year dental (D3) student in the RST Program. The Louisiana portion of the D3 and D4 school years is waved for the scholar. The scholar also completed a clinical rotation at a rural federally qualified health center (FQHC).

In year 2 (2018), one D2 student was awarded the RST scholarship and will receive a tuition waver for D3 and D4 years. This scholar will complete her clinical location at a rural FQHC after her D3 year. Both scholars are committed to serve a minimum of two years at a qualified dental site upon graduation.

Dental Professional Recruitment and Retention

In order to address the problem, we first assessed and identified the gaps of awareness and education regarding access to oral health care in underserved regions of our state. Where many dental clinics exist in close proximity in urban areas, it is quite the opposite in rural communities. In addition, residents without dental insurance or low income find it extremely difficult to locate a dentist to serve them. The BPCRH Oral Health Workforce recruiters launched a campaign to get the word out to audiences that would be able to make a difference – dentists and dental students nationwide.

In September 2017, the BPCRH participated in LSU School of Dentistry Alumni Day with the purpose of educating licensed dentists of the dental shortage areas of our state and where dentist vacancies exist in the underserved regions of our state. This event captured over 100 resident students and practicing dentists.

A career job fair was another opportunity to educate and inform dental students of the professional dental shortage areas in Louisiana. In October 2017, dental students of LSU

School of Dentistry became acquainted with several Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) from across the state seeking to hire dentists for their facilities. In addition, these dental students were introduced to the National Health Service Corps Loan
Repayment Program (NHSC-LRP), National Health Student to Service Corps (NHSC-S2S), and the Louisiana State Loan Repayment Program (SLRP). Each of these programs served as an incentive to recruit dental students to serve in Louisiana HPSAs.

Lunch & Learn events at LSU School of Dentistry were another way the OH Workforce Recruiters were able to expand the awareness and education of HPSAs and the critical need for dentists in these areas. Two events were held that attracted over 40 D1-D3 students. The first event featured a PowerPoint presentation with a guest dentist from a local FQHC as the keynote speaker. The second event comprised of a panel discussion with four dentist representing corporate, private, and community-based dental practices.

By May 2018, the OH Workforce Recruiters successfully identified 22 candidates and referred them to FQHCs and RHCs throughout Louisiana. To date, three of these candidates have active contracts serving in HPSAs.

B. Why is this success significant?

Louisiana has a shortage of general and pediatric dentists serving vulnerable populations and a high number of these individuals reside in rural areas. This program will ensure that more dentists will practice general or pediatric dentistry in these dental health professional shortage areas.

C. Who benefits and how?

Dental Rural Scholars Track

First, Louisiana's underserved rural communities facing dental health disparities benefit from this program.

Next, the scholar receives a financial benefit which helps reduce the high debt (average $250,000) which follows dentists into their careers. Since new dentists graduate dental school with an average debt of $250,000 dental students interested in living and serving in rural areas will reduce the burden that is typical after graduation; hence encouraging more interest in general and pediatric dentistry.

The site that hosts the dental student on the clinical rotation also benefits as developing relationships with potential employees increases recruitment opportunities at their sites. It allows both the student and the employer to consider future employment opportunities. Although grant funding only supported one site for clinical rotations, clinical site assessments were sent to all FQHCs located in rural areas to determine their interest and ability to host LSU dental students in the future. 22 FQHCs located in rural areas have submitted site assessments voicing their interest in hosting dental students for clinical rotations. LSUSOD will work with individual clinics to identify the next steps to becoming an approved rotation site.
In addition, LSU School of Dentistry and their future students will realize long-term

benefits from enthusiastic RST alumni which are committed to serve as mentors and oral health community activists.

D. How was the accomplishment achieved?
LDH applied for and received federal grant funding from HRSA to support the program. Dedicated partners included: LSU School of Dentistry, Louisiana Board of Dentistry, the Louisiana Primary Care Association and their community health centers; and the Oral Health Commission.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
This accomplishment contributes to increasing meaningful internal and external collaborations. By collaborating with our partners mentioned in the previous section, we have been able to further expound on the strategic goals by operating as a cross-functional, cohesive agency while being innovative, responsive, and meeting national standards.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, the goal is to improve the oral health in children and adults residing in Louisiana's rural underserved areas. LSU School of dentistry plans to gradually increase the number of RST awards as a way to address Louisiana's oral health shortages in rural areas.

Dental Rural Scholars Track
Prior studies have shown that providers from rural areas are more likely to practice in rural areas once they complete their education. The first two RST recipients are from rural areas in Louisiana.

Dental Professional Recruitment and Retention

A wise motto is: *If you fail to plan, you plan to fail*. While the OH Workforce Recruiters worked to identify candidates and match them with FQHCs /RHCs across Louisiana in 2017-2018, the question is what happens now. A Recruitment and Retention plan is necessary to sustain the efforts of this program. Each federally funded dental facility is required to have a recruitment and retention plan; however, we encouraged clinics to utilize the resources of 3RNet. This organization has a tried and true recruitment and retention template that assist in creating "action" around their recruitment and retention efforts. This plan involves all level of staff, community leaders and stakeholders to design the best model for success and sustainability.

Accomplishment #19: Implementation of a High School EMS Education Program Manual:

A. What was achieved?
The purpose of this manual is to document guidelines that ensure quality and consistency

in EMS programs offered in high schools throughout the state of Louisiana. This document is intended to be distributed to high school administrators that are offering (or are interested in offering) out of hospital emergency medical training as part of their school's curriculum.

B. Why is this success significant?
This accomplishment streamlines policies and provides direct guidance for EMS education in all high school EMR and EMT classes.

C. Who benefits and how?
The students, high schools, and citizens of Louisiana benefit from the streamlining of the high school courses as this provides consistency and helps to insure quality in the EMS curriculum taught at the high school level.

D. How was the accomplishment achieved?
A committee of EMS practitioners, high school EMS instructors, and representatives from the Department of Education collaborated to develop the guidance.

E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?
This accomplishment directly contributes to the success of the BEMS' strategic plan by addressing a critical component of the Bureau's Title 40:1133.1 mandate, which is "to define and authorize appropriate education programs based on national EMS education standards for emergency medical services practitioners. All such education programs shall meet or exceed national EMS education standards."

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No. While the development of this guidance utilized common best practices (i.e. collaboration, inter-agency communication, stakeholder feedback), this accomplishment is specific to EMS education in the high schools.

<u>Accomplishment #20: City Building WellSpot Designations:</u>

A. What was achieved?
Lake Charles and New Orleans City Buildings - Well-Ahead recently worked with two cities - Lake Charles and New Orleans - to designate all city buildings as WellSpots. This includes 138 buildings and impacts over 5,000 employees. Benchmarks implemented as a direct result of Well-Ahead outreach for the City of New Orleans include promotion of the Quitline as a cessation resource and implementation of healthy vending. Benchmarks implemented as a result of Well-Ahead outreach for the City of Lake Charles include implementation of a comprehensive tobacco-free policy, worksite wellness programming and a healthy meeting policy.

B. Why is this success significant?

- As a result of Well-Ahead outreach, 89 City of New Orleans buildings and parks and 49 City of Lake Charles buildings and parks were designated as Level 2 WellSpots.
- By implementing healthy vending, City of New Orleans employees now have access to healthier snack options.
- City of New Orleans employees are now aware of cessation resources offered by the Quitline and are encouraged to stop smoking.
- City of Lake Charles employees now have a working environment with smoke-free indoor and outdoor air.
- By implementing worksite wellness, City of Lake Charles employees will now be given access to physical activity opportunities, as well as educational information for healthy eating.
- City of Lake Charles employees will also have access to healthier options in meetings through implementation of their Healthy Meeting Policy.

C. Who benefits and how?

The 4500 employees of New Orleans and 900 employees of Lake Charles, as well as the visitors to all city-owned buildings and properties.

D. How was the accomplishment achieved?

By implementing the following benchmarks:

- Promotion of the 5-2-1-0 nutrition and physical activity message
- Promotion of self-assessment tools for prediabetes and heart health among employees
- Beginning implementation of a worksite wellness program
- Promotion of the Louisiana Tobacco Quitline and another approved cessation service organizations
- Having 50% of vending or provided snack options meeting healthy vending guidelines

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

Well-Ahead has identified target parishes based on need, readiness to change, and collaborative partnership opportunities. Strategic outreach is planned in these target parishes across the state. Both of these cities were in target parishes and the designation of these city facilities can be an example for other businesses to follow in creating a healthy community.

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

Gaining the support from leadership for worksite wellness, tobacco policies, and other benchmarks represents a best practice that should be shared with other agencies.

Collaboration among the Well-Ahead team to implement WellSpot Designation across the state represents best practice.

<u>Accomplishment #21: LDH Upgrades Its Online Data Exploration Tool to Provide Residents with Better Health Information:</u>

A. What was achieved?

As the two year anniversary of the Louisiana Department of Health's Health Data Portal launch approaches, the Bureau of Health Informatics (BHI) and the Environmental Public Health Tracking Program(Tracking) have teamed up to roll out an upgraded version of this online data exploration tool. http://healthdata.dhh.la.gov/

B. Why is this success significant?

LDH's Health Data Portal 2.0 most recently includes birth defects and updated cancer and birth outcomes data as well as new features including a searchable glossary, zoomable maps and "pop-out" display windows which expand and provide simultaneous data view.

C. Who benefits and how?

Louisiana residents and other Portal users have access to additional health, environmental, exposure and population data and tools.

D. How was the accomplishment achieved?

Five additional years of Centers for Disease Control and Prevention (CDC) funding has made it possible for the Department to host additional statewide health, environmental and population data, and to continue to add and update its website and data portal. Since June 2017, the Department has been tirelessly working with its IT consultants to maintain and enhance the Health Data Portal. A growing list of health agency and external partners have contributed to the success of the program by sharing their information and data and providing the Tracking Program with technical assistance to ensure that the web content and data are comprehensive and accurate.

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

Yes. This effort is supported by the "Health Information Technology, Infrastructure, Integration, and Utilization" mandate of the strategic plan. The data portal was developed to enable health, environmental, population and exposure information and data to be viewed and analyzed in one place. The portal reflects the vision and core values of OPH: to demonstrate transparency by making quality health data available and to employ and promote science-based best practices towards continuous improvement.

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

Yes, Louisiana is one of 25 states and New York City to be awarded funding from the CDC's Tracking Program to provide city and state officials, residents, public health practitioners and others with better health data. Ultimately, the data could be used to "identify communities at risk, inform health policies, educate residents, inform state and city planning and develop targeted prevention activities"(CDC, 2017).

Accomplishment #22: Prevent Lead Exposure in Indoor Shooting and Firing Ranges:

A. What was achieved?

LDH/OPH's Section of Environmental Epidemiology and Toxicology (SEET) carried out

a successful outreach campaign aimed at reducing lead exposure among shooting range workers and patrons.

B. Why is this success significant?
Between 2015 and 2016, SEET observed a 320% increase in the number of elevated blood lead tests (>= 25 µg/dL) among firearm instructors working at indoor shooting ranges. Since the implementation of the outreach campaign, the number of firearm instructors with elevated blood lead levels has decreased by 76%.

C. Who benefits and how?
Anyone who works or visits an indoor shooting range can benefit from information on lead exposure prevention.

D. How was the accomplishment achieved?
A factsheet entitled, *Prevent Lead Exposure in Indoor Shooting and Firing Ranges*, was developed and disseminated to approximately 117 gun shops, shooting ranges, shooting clubs, and police departments; to 13 physicians who were identified as providing care to the majority of adult patients with elevated blood lead levels; and approximately 930 concealed firearm instructors in the state. Factsheet posters were placed in the Louisiana State Police joint emergency services training centers in Zachary and Baton Rouge, as well as at the ammunition warehouse. The topic was featured in a radio interview on the Louisiana Radio Network and in a Fox 8 evening news segment in New Orleans in late October 2017. SEET placed advertisements in the Louisiana Sportsman magazine and on BayouShooter.com (a Louisiana-based firearm discussion board for fans of shooting sports).

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

Yes. Please refer to the OPH section of the strategic plan, specifically Program A (Public Health Services); Activity: Environmental Epidemiology and Toxicology; Objective X:

- Strategy 1.8: "Obtain and evaluate all laboratory reports for heavy metal and carbon monoxide exposures that are reportable conditions."

- Strategy 1.10: "Count and investigate injuries, illnesses, and deaths involving Louisiana workers. High risk industries, occupations and vulnerable populations are targeted to help prevent deaths, injuries, and hazardous exposure."

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 outreach campaign was presented to state and federal partners at a CDC/National Institute for Occupational Safety and Health (NIOSH) meeting. In fact, a number of occupational health programs in other states have adapted the factsheet for use in their state. Additionally, the Occupational Safety and Health Administration (OSHA) recently

released a factsheet and quick card on this important topic https://www.osha.gov/Publications/OSHA3772.pdf.

Accomplishment #23: Re-establishment of Mycobacterium tuberculosis testing at the OPH Laboratory

A. What was achieved?

The OPH began testing for Mycobacterium tuberculosis (MTB) in-house on October 31, 2017, after outsourcing the testing to the Texas Public Health Laboratory since 2014. The testing now being offered in-house includes smear, MTB Nucleic Acid Amplification Test (NAAT), and culture. Following the re-opening of the OPH TB laboratory in October of 2017, the Louisiana State TB Control Program made marked improvements in meeting the CDC grant deliverables. Between the first quarter of 2017 and the first quarter of 2018, the percentage of specimens received by the laboratory within 1 day following collection increased from 1% to 71%. During that same time period, the percentage of MTB NAAT results reported within 2 days from the receipt of specimens from confirmed MTB cases increased from 15% to 93%. In addition to offering new testing, the project also resulted in the development of a Cost per Test Calculator tool, a collateral benefit that can be leveraged for other cost benefit analyses. The cost to bring MTB testing in-house was illustrated, using the cost calculator, to be approximately 30% in cost savings. In addition to the lab savings, the overall cost savings to the Office of Public Health, however, is significant. The TB program is able to use funds from CDC grant for testing costs when the OPH Laboratory performs testing, and the number of HPLC (High-Performance Liquid Chromatography) tests decreases because the OPH Laboratory uses a different testing algorithm, resulting in annual cost savings of approximately $150,000.

B. Why is this success significant?

Because of the establishment of in-house testing, MTB results are delivered faster by eliminating the mailing of samples and reducing risk of exposure. It also resulted in improvements in patient care, which includes adjustment of medications with harsh side effects more quickly, reductions in patient isolation time and associated costs, and a 30% reduction in the cost per test by using a more cost efficient testing algorithm, which amounts to an approximate annual savings of $150,000.

In the process a cost calculator tool was created that can be used for cost benefit analysis to drive more efficient test decisions. The cost tool was developed in a manner that it can be used for any test performed by the OPH Laboratory. This tool is a best practice. Very few other state public health laboratories have developed such an objective method of cost benefit analysis.

Lean Six Sigma (LSS) quality improvement methods were used and taught to OPH laboratory staff over the course of this project. Certification of a laboratory staff member, which is pending completion, will poise the lab to run additional improvement projects

C. Who benefits and how?

The reduction in time from specimen collection to TB results has potentially led to the following *improvements* in patient care and public health:

- Patients are released *from isolation sooner*, reducing both hospital and patient costs.
- Patients are put on the *appropriate medication sooner*, reducing total treatment time and reducing unnecessary risks of medication-related side effects.
- Patients are able to *return to work faster*, leading to less lost wages and family economic hardship

Efficiencies created by the laboratory have benefited the OPH TB Program by demonstrating significant improvements in the CDC grant benchmark metrics, and therefore, supporting the continued funding of the program through the grant.

Development of a Cost-per-Test Calculator tool allowed the OPH Laboratory to establish a standard method of calculating cost per test. Establishing costs-per-test enables the laboratory to perform a business analysis before adding and/or removing tests from the OPH Laboratory test menu, allowing the OPH programs to budget more accurately.

D. How was the accomplishment achieved?

This accomplishment was achieved utilizing the Lean Six Sigma (LSS) quality improvement method through the efforts of a multidisciplinary team, including laboratory staff, TB program staff, and the Deputy Assistant Secretary of Community Preparedness and Health Protection. Having a certified LSS Master Black Belt on board ensured robust project activities and yielded the training of a "Green Belt" candidate in LSS. The facility had the capability, but had not yet begun using, the Biosafety Level 3 Laboratory (BSL3). This project team worked through the startup and certification of the BSL3 facility. This creates additional capacity for the OPH Lab in handling additional infectious materials.

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

This accomplishment aligns with the strategic plan in that the OPH Laboratory increased the internal and external collaboration with the Lab and the TB Program, as well as through workforce development by training staff on Lean Six Sigma methods. Additionally, by using the newly created cost calculator, a template was formed to use in evaluating costs per test, an endeavor that will increase OPH's financial stability. By working closely with the TB program and Public Health Units, the Laboratory enhanced internal and external collaboration to achieve a common goal. The financial stability of OPH is largely impacted by the cost savings of in-house MTB testing, so this accomplishment was important.

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

The LSS approach to improvement and the laboratory-program collaboration between a program and a support service unit demonstrates a Best Management Practice that should be shared with other agencies. The Cost per Test Calculator tool provides a template for cost benefit analysis that can serve as a model to evaluate actual costs, including indirect overhead.

Accomplishment #24: Establishment of the Long Term 2 Enhanced Surface Water Treatment Rule (LT2ESWTR) at OPH Laboratories

A. What was achieved?
Beginning in October 2017, both the OPH Amite Regional Laboratory and the OPH Shreveport Water Laboratory started processing LT2ESWTR *Escherichia coli* (*E. coli*) Enumeration as part of an Environmental protection Agency (EPA) Source Water Monitoring program. This was a new requirement by the EPA to not only detect fecal contamination, but to quantify the degree of contamination.

B. Why is this success significant?
The purpose of the Long Term 2 Enhanced Surface Water Treatment Rule (LT2ESWTR) is to reduce illness linked with waterborne contaminants within Louisiana's drinking water systems. *Escherichia coli (E. coli)* bacteria normally live in the intestines of people and animals. *E. coli* by themselves are usually not pathogenic; they are indicator organisms, which means they may indicate the presence of other pathogenic bacteria. The presence of *E. coli* bacteria in aquatic environments is a good indicator that the water has been contaminated with the fecal material of man or other animals. Fecal material has the potential to carry pathogens or disease producing bacteria or viruses.

C. Who benefits and how?
The LT2ESWTR applies to all public water systems that use surface water or ground water under the direct influence/contact of surface waters. The direct monitoring of public water systems (surface and ground waters) will prevent the consumption of water contaminated with *harmful pathogens* by the public. Consumption of contaminated waters can cause minor to severe cases of gastrointestinal illness, which may be severe and sometimes fatal for people with weakened immune systems.

D. How was the accomplishment achieved?
This accomplishment was achieved utilizing a multidisciplinary team, including OPH laboratory, engineering services, and sanitarian personnel. Throughout the project, the Louisiana OPH Laboratory contacted statewide public health laboratories for best practices and program development.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
This accomplishment does align with the strategic plan in that the OPH Laboratory is maintaining accreditation as required by the Safe Drinking Water (SDW) Program. By working closely with Engineering Services, the Laboratory enhanced internal and

external collaboration to achieve a common goal. The financial stability of OPH is largely impacted by the funding associated with the SDW program, so this accomplishment was important.

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

This OPH program collaboration utilized and demonstrated over the course of this project represent a Best Management Practice that should be shared with other agencies. This program will enable the EPA and LDH to effectively monitor and evaluate the quality of source drinking waters within the State of Louisiana.

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?

VITAL RECORDS AND STATISTICS

Yes, the agency's strategic plan is on time for accomplishment. A primary goal of Vital Records is to continue to improve the quality and timeliness of vital event data. Vital Records' partnerships with external record registration and issuance partners are critical to its mission of registering vital event data and providing the service of issuing certified copies of vital records to the public.

Vital Records achievements during the previous fiscal year align with the goal to improve data quality for all vital event data and to increase and support participation by Louisiana Clerks of Court in issuing vital records as a walk-in service to the public statewide. As such, four additional Clerks of Court began issuing vital records in their parish this fiscal year.

BUREAU OF EMERGENCY MEDICAL SERVICES

Yes, the agency's strategic plan is on time for accomplishment. In the strategic plan, the Bureau of Emergency Medical Service's (BEMS) objective is to develop an adequate medical workforce by mobilizing partnerships, developing policies and plans, enforcing laws, regulations, and assuring a competent workforce.

A recent review of the initial plan, as it has transitioned to being the comprehensive 5-year plan, reveals that the anticipated outcomes—goals and objectives—are being attained as expected (even better in some cases) and that the BEMS' strategies are working as expected and proceeding on schedule.

CENTER FOR COMMUNITY PREPAREDNESS

Yes, the agency's strategic plan is on time for accomplishment. In the strategic plan, our objective for the Community Preparedness activity is to build healthy, resilient communities and enhance Louisiana's state and local public health agencies capacities to prepare for, detect, and respond to chemical and biological terrorism and other communicable disease threats.

Louisiana's emergency preparedness efforts contribute to the overall success of the agency's core function of emergency preparedness. Louisiana's efforts in emergency preparedness are considered best practices and have been spotlighted in the Center for Disease Control's publications, "*Public Health Preparedness: Strengthening the Nation's Emergency Response State by State" and "Trust for America's Health: Ready or Not? Protecting the Public from Diseases, Disasters, and Bioterrorism."* The Department's all-hazards preparedness approach to disasters has been tested through many exercises and real-world events.

Once tested, the agency reviews, reevaluates and updates plans according to those lessons learned and national standards. This process has proven effective in moving the state towards being a leader in emergency preparedness planning and response.

It should be noted that the American College of Emergency Physicians report ranked Louisiana 3rd in Disaster Preparedness. Louisiana has been seen as having strong plans and protocols to serve medical fragile patients as well as above average rates of nurses who received emergency training.

- **Where are you making significant progress?** If you are making no significant progress, state "None."

NONE

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

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? Not applicable

OPH's strategic plan revision remains important to LDH Leadership and for the OPH staff and is a constant reminder that the agency is moving forward to its commitment

to its mission and goals:

- Focus on accountability
- Need for new approaches
- Effective utilization of resources
- Importance of continuing learning and 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.

The formulation of the OPH strategic plan adheres to management strategies implemented by the Executive Management Team. These strategies, at a minimum, include:

- **Training:** Ongoing training is provided to ensure staff develops the necessary skills to understand and apply the concepts of the OPH strategic plan.
- **Input:** Gathering input from all levels of the agency's functional areas. Discussions are conducted with Team Leaders and participants representing functional areas essential to support agency priorities.
- **Communication:** Receiving and sending information at the central office.
- **Performance measurement:** Formulation of objectives that are specific, measurable, attainable, results oriented and time-bound. Performance indicators are formulated to ensure monitoring of progress in goal/objective attainment.
- **Evaluation:** The Strategic Plan has been revised, as warranted, to reflect fiscal, managerial and programmatic changes. These revisions will be conducted using the same strategies as the original plan, as warranted. Plan revisions utilize strategies that are pertinent to the task at hand.

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

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

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

reports and evaluations at the end of this form.

No department management or operational problems exist.

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

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

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

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

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

   5. Do corrective actions carry a cost?

      ☐ No. If not, please explain.
      ☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital

resources—people, budget, physical plant and equipment, and supplies.)
Please discuss the following:

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

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

A. Check all that apply. 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 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 and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

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

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

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

☒ Peer review

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

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

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

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

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

Bureau of Family Health

1. Title of Report or Program Evaluation:
   Targeted Chart Review

2. Date Completed:
   Quarterly audits with central office review

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Chart reviews are a standard quality assurance practice in direct service

4. Methodology used for analysis or evaluation:
   Review tool designed by program, which is commensurate with industry standards and reflects Quality Family Planning (QFP) Guidelines

5. Cost (allocation of in-house resources or purchase price):
   Staff costs: Nurse Consultant time and field staff time; there was no cost for the report itself.

6. Major Findings and Conclusions:
   Top Opportunities for Improvement Noted:
   1. All documents which required signature and dates completed
   2. Visit Type documented
   3. Any required referral & follow-up documented
   4. Most current forms used
   5. Medicaid eligibility verification document available from date of visit (if appropriate)

7. Major Recommendations:
   All areas have implemented corrective actions to correct and monitor these activities. All indicators have demonstrated steady improvement each quarter.

8. Action taken in response to the report or evaluation:
   Nurse Consultant provided regional technical assistance to all regions regarding results and corrective action plan.

9. Availability (hard copy, electronic file, website):
   Electronic version is available.

10. Contact person for more information, including
    Name:Tammy Bennett
    Title: Office of Public Health, Bureau of Family Health Nurse Consultant
    Agency & Program: Office of Public Health
    Telephone: 504-568-3504
    E-mail: Tammy.Bennett2@la.gov

Bureau of Family Health

1. Title of Report or Program Evaluation:
   Clinic Flow Analysis

2. Date completed:
   Automated quarterly reports provided to field staff by Bureau of Family Health-Reproductive Health Program (BFH RHP)

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Clinic flow analyses are a standard quality improvement practice in direct service and are a cornerstone of the program's goal to improve productivity and patient experience.

4. Methodology used for analysis or evaluation:
   Review tool was designed by program, which is commensurate with industry standards.

5. Cost (allocation of in-house resources or purchase price):
   Staff costs: Nurse Consultant time; CQI Coordinator time; and field staff time; there was no cost for the report itself.

6. Major Findings and Conclusions:
   Top Opportunities for Improvement Noted: The data collected in these analyses show a need to continue monitoring and improving clinic flow in order to increase productivity and patient experience.

7. Major Recommendations:
   The bottlenecks and opportunities for improvement included:
   1. Staff utilization (esp. Registered Nurses & support staff)
   2. Space utilization (includes both use and availability of space for clinic)
   3. Scheduling
   4. Registration process

8. Action taken in response to the report or evaluation:
   Nurse Consultant and QI Coordinator provided regional technical assistance to all regions regarding results and corrective action plan.

9. Availability (hard copy, electronic file, website):
   Electronic version is available.

10. Contact person for more information, including
    Name: Tammy Bennett
    Title: Office of Public Health, Bureau of Family Health Nurse Consultant
    Agency & Program: Office of Public Health
    Telephone: 504-568-3504
    E-mail: Tammy.Bennett2@la.gov

In addition to the reports above, an annual comprehensive site assessment is completed in the fall according to the Federal Title X quality assurance tool.

Sexually Transmitted Disease/Human Immunodeficiency Virus

1. Title of Report or Program Evaluation:
   2017 Targeted Evaluation Plan (TEP)

2. Date completed:

January - December 2017 (in progress)

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   The purpose of the 2017 (STD/HIV) Program Targeted Evaluation Plan was to evaluate the effectiveness of the program's implementation of nucleic acid amplification tests (NAATs) for the detection of rectal and pharyngeal gonorrhea and chlamydia (GC/CT) in 10 parish health units (PHUs) providing STD services throughout the state.

4. Methodology used for analysis or evaluation:
   Six parish health units (PHUs) were selected in addition to the four pilot sites to implement rectal and pharyngeal testing. Staff was trained and the Louisiana state lab completed validation activities to process rectal and pharyngeal nucleic acid amplification test (NAAT) specimens. Rectal and pharyngeal testing began at these sites in June/July 2017,. This project was evaluated based on the following: 1) the number of PHU clinical staff trained, 2) the number of PHUs successfully implementing rectal and pharyngeal gonorrhea and chlamydia (GC/CT) testing, 3) the number of rectal and pharyngeal GC/CT samples collected, 4) the number of positive rectal and pharyngeal tests detected, and 5) the number of individuals with positive rectal and pharyngeal GC/CT tests that had negative urine, urethral, or cervical GC/CT at the same visit.

5. Cost (allocation of in-house resources or purchase price):
   The OPH State Laboratory conducts all testing, so costs are associated with lab processing costs. The cost was approximately $103,000 before Medicaid reimbursement.

6. Major Findings and Conclusions:
   As of April 28, 2018, 8,629 rectal and pharyngeal tests had been successfully collected and tested. There were 485 positive Gonorrhea (GC) detected and 232 positive Chlamydia (CT) detected using this method of testing. Of the individuals testing positive with rectal and pharyngeal GC/CT testing, 280 cases of GC and 156 cases of CT would have been missed if rectal and/or pharyngeal testing had not been done. Among these individuals testing positive, a higher positivity rate was noted in rectal vs. pharyngeal testing and there was more positivity in males compared to females tested.

7. Major Recommendations:
   Based on the results of this Targeted Evaluation Plan, it is recommended that rectal and pharyngeal testing continue to be offered at parish health units to clients reporting sexual exposure at these sites. There is conclusive evidence of GC and CT infections that may be undetected, undiagnosed, and left untreated without this method of testing available.

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

Based on the successful implementation and significant findings of this Targeted Evaluation Plan, the Sexually Transmitted Disease/Human Immunodeficiency Virus (STD/HIV) will continue to implement rectal and pharyngeal testing in FY 18-19 and will monitor the data to determine if testing should be expanded to additional sites.

9. Availability (hard copy, electronic file, website):
   Hard copy or electronic file is available.

10. Contact person for more information, including:
    Name: DeAnn Gruber
    Title: Director, Bureau of Infectious Diseases
    Agency & Program: Louisiana Department of Health - Office of Public Health, STD/HIV Program
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Annual Management and Program Analysis Report

Fiscal Year 2017-2018

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 Church, 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?

Accomplishment #1: Medicaid 1115 Demonstration Waiver Approval

A. What was achieved?

On August 15, 2017, the Louisiana Department of Health submitted an application for a Medicaid 1115 Demonstration Waiver for Substance Use Disorder (SUD) residential facilities to maintain access to care for beneficiaries in need of Opioid Use Disorder and Substance Use Disorder (OUD/SUD) services. Louisiana received approval of its application, effective February 1, 2018 through December 31, 2022.

B. Why is this success significant?

Section 1115 Medicaid demonstration waivers provide states an avenue to test new

approaches in Medicaid that differ from federal program rules. While there is great diversity in how states have used waivers over time, waivers generally reflect priorities identified by states and the Centers for Medicare and Medicaid Services (CMS). When Centers for Medicare & Medicaid Services imposed a new requirement limiting the number of days a patient could stay in a residential substance use facility, LDH submitted an 1115 demonstration waiver to CMS. The purpose of an 1115 is to request permission to exercise Section 1115 of the Social Security Act giving the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches for things such as providing services not typically covered by Medicaid.

C. Who benefits and how?

The waiver is necessary to provide services to beneficiaries residing in Institutions for Mental Disease (IMDs) for stays with durations longer than 15 days. Traditionally, Medicaid beneficiaries aged 21 to 64 are not eligible for medical assistance (and thus federal Medicaid dollars called FFP) while they are patients in an institution of Mental disease called an IMD. Institution for Mental Disease (IMD) is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases. This waiver was needed because after implementation of some new managed care rules in the code of federal regulations (CFR) released last year, CMS allowed the traditionally excluded use of IMD's but placed a day limit of 15 days on its usage. This waiver "waived" the cap of 15 days for Louisiana.

As a result of waiver approval, Louisiana is able to receive federal financial participation (FFP), i.e. the Medicaid match, for the continuum of services to treat addictions to opioids and other substances.

LDH will conduct periodic public forums to engage stakeholder feedback and provide updates on the waiver. All documents, including the monitoring documents, will be posted to the LDH website when they are available.

D. How was the accomplishment achieved?

In 2017, LDH did the leg work for CMS's approval including submission of the waiver and public hearings to accept feedback and public testimony.

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

Approval of this waiver (which occurred February 2, 2018) allows LDH to waive the monthly day limit thus allowing people to receive treatment for the most appropriate amount of time, not capped at an arbitrary limit.

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

The actual process for achieving permission to proceed with an 1115 demonstration waiver is mandated by CMS. Approximately only a dozen states have applied for and been granted SUD related 1115 waivers to date. At the time of approval, five states, which include Louisiana, had been given approval for such 1115 SUD IMD waivers according to Washington Post article quoting Health and Human Services Secretary Alex Azar on March 2.

Accomplishment #2: State Targeted Response (STR) Grant

A. What was achieved?

Hired and trained staff at the Local Governing Entities (LGE), the Opioid Treatment Programs (OTP) and the Department of Public Safety and Corrections (DPS&C) to provide training, education, and outreach to the community. Staff assessed gaps and needs within their community and worked with the Office of Behavioral Health (OBH) to find ways to address needs and gaps through meetings with various influential community leaders and organizations. Enrolled five hundred fifty-eight (558) individuals into Treatment Services, provided Recovery Support Services to six hundred sixty (660) individuals, provided "Overdose Education and Naloxone Distribution" training to four hundred twenty-six (426) individuals, and provided Opioid Specific Trainings to two thousand (2,000) individuals.

Prevention

- Nine (9) Training, Education and Technical Assistant Coordinators were hired at nine (9) of the Local Governing Entities (LGE)s.
- Distributed four thousand (4,000) Naloxone Kits to the LGEs and one (1) OTP.

Recovery Support Services

- Nine (9) Peers were hired in eight (8) of the LGEs. Three (3) were certified when hired and six (6) completed the training after their hire date.
- All Peers received training in data collection, as well as best practices and guidelines in how to reach the target population.
- New connections have been made with EMS/first responders, law enforcement, pharmacists, local healthcare providers, detox and rehabilitation centers, social services providers, and many more.

Treatment Services

- Twenty-three (23) clinicians were trained on the Addiction Severity Index (ASI), at eight (8) of the nine (9) OTPs.
- Patients were referred to the LGE for Medicaid applications, peer support services, and behavioral health treatment services.
- Resource Coordinators assisted patients with obtaining transportation through Medicaid.
- Resource Coordinators worked closely with the peer located at the LGE.
- Medication Assisted Treatment (MAT) has been expanded to the uninsured/underinsured.

B. Why is this success significant?

Prevention

- This success has been significant in increasing awareness and prevention of opioid use and overdose, decreasing the stigma, increasing pathways of access for treatment, prevention and recovery support services.

Recovery Support Services

- The use of Peers for outreach, and to provide recovery support services is a best practice recognized by SAMHSA, and has been shown to provide a significant increase in successful outcomes.
- All data collected is reported to both the Louisiana Office of Public Health and SAMHSA as part of much larger data-gathering exercises. The results from these surveillance efforts allow more targeted and effective future interventions, and are already helping to reshape response efforts to the opioid crisis.
- The majority of the individuals enrolled in STR have not previously had access to MAT, or to Peer-led recovery support services, both of which are shown to increase the chances of long-term recovery.
- The connections made through STR will continue to pay dividends not just to this grant, or even the opioid crisis, but to a wide variety of public health and substance use challenges.

Treatment Services

The ASI, is a standardized, semi-structured, multi-focused screening and assessment instrument used to establish the nature and severity of possible Medical, Employment, Drug, Alcohol, Legal, Family, social, and/or Psychiatric problems a person may present with. This assessment is very useful when developing a treatment plan which is utilized in determining areas of need. It helps determine the severity of the challenges the patient may have. This is important when treating someone who has multiple challenges, especially, when there may be a dual diagnosis and behavioral health services may be needed. After the needs of each patient have been identified, the clinician can then determine which services are available at the OTP and which services need to be referred to other agencies, such as the LGE. Resource Coordinators at the OTP refer patients to the peer at the LGE to obtain further services not available at the OTP, therefore, utilizing existing resources.

C. Who benefits and how?

Prevention

In order to distribute the Naloxone kits to this high need population, a coordinated effort between the Office of Behavioral Health, nine (9) Opioid Treatment Providers and the ten (10) Local Governing Entities was formed. All parties benefited, as all of the Naloxone kits were distributed to those in need, lives were saved and others will be saved.

Recovery Support Services

- Louisiana is home to a large number of OUD users who were unable to access and/or afford MAT prior to the STR Grant. All of these individuals and their loved ones now have a much better opportunity for a positive outcome.
- The state has gained a valuable source for new data, and is able to directly respond to the opioid crisis in a more proactive manner.
- The human services districts and OTPs are treating and supporting a new set of clients who may not have otherwise been identified.

Treatment Services

By being trained on the ASI, all clinicians have a uniform way of assessing the patients. The clinicians are able to obtain detailed information on the patients, which assists with placing the client in the appropriate level of care. The ASI will also help the clinician determine what services are needed for each individual patient. The Resource Coordinator determines how those services will be accessed. The clinicians, as well as the patients, benefit from the training on the ASI because it allows the counselors to help determine problem areas for the patient and what needs to be addressed immediately. The patient benefits from this because he/she is able to receive the care he/she needs.

D. How was the accomplishment achieved?

Prevention

The Office of Behavioral Health support staff, contract staff and structure was achieved through STR funding. This structure helped with the successful distribution on Naloxone Kits across to the state and to multiple providers.

Recovery Support Services

All nine (9) eligible LGEs chose to take part in the STR Grant, and were awarded funds based on need in their region. Peers were given additional training specific to their role in the STR Grant as soon as possible following their recruitment. Monthly conference calls, regional site visits by the STR Statewide Peer Recovery Support Specialist for both monitoring and additional training. The Peers are also partnering with Resource Coordinators at their local OTPs to ensure a warm hand-off and continuity of services as individuals are referred in both directions to receive necessary services.

Treatment Services

The ASI training was completed online within thirty (30) days. A post-test at sixty (60) days and another post-test at ninety (90) days. This was done to ensure that the clinician retained the information from the online training. Because the OTPs cannot provide all resources that the patients need, it is necessary to refer patients to existing resources in the community. By partnering with the LGEs, patients are able to access an array of services, so referrals are made for continuation of care according to the needs of the patient.

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

Prevention

The strategic plan addressed the delivery of the Naloxone kits statewide. The strategic plan was accomplished by the LGE assessing their local providers in order to determine the number of Naloxone kits needed. The kits were ordered by the OBH, then shipped to the LGE directly. The LGE would then educated the provider and the clients on the administration of the Naloxone kit. The OTPs ordered their kits directly in order to distribute to the STR clients.

Recovery Support Services

Through the use of evidence-based recovery support strategies, Peers are assisting STR clients in building the skills and resilience they need to achieve long-term recovery. Furthermore, they are able to connect individuals with additional health and support services through the LGE that many clients had not previously accessed.

Treatment Services

By recognizing problem areas through the ASI, and connecting the patients to resources within the community with the LGEs, we are decreasing the chances of an overdose. We are encouraging the patients to take part in self-care and giving them the resources to do so.

F. Does this accomplishment or its methodology represent a best management practice that should be shared with other executive branch departments or agencies?

Prevention

This Naloxone kit distribution accomplishment reflects what other states have done with their Naloxone distribution, so this does not need to be shared with other executive branch departments or agencies.

Recovery Support Services

The methodologies utilized represent, demonstrate and prove best practice in the field of Peer Support. Louisiana is amongst the leading states in its deployment of Peer Recovery Support Services, and would serve as an excellent model for states with similar population profiles and geographical dispersal.

Treatment Services

Cognitive Behavioral Therapy, Motivational Interviewing, Medication Assisted Treatment and the Addiction Severity Index are evidence based practices, in which the STR grant is based upon.

<u>Achievement #3: Comprehensive Opioid Abuse Site-Based Program (COAP) Grant</u>

A. What was achieved?

The Comprehensive Opioid Abuse Site-based program was developed as part of the CARA legislation signed into law on July 22, 2016. In FY 2017, the LDH – OBH was awarded Category 4A of Comprehensive Opioid Abuse Site Based Program Grant (COAP) by the U.S. Department of Justice, Office of Justice Program (OJP), and Bureau of Justice Assistance (BJA) in the amount of $100,000. The Category 4a award is designed to support the development of a coordinated plan between the SAA and the SSA to assist localities in

engaging and retaining offenders with opioid use disorders in treatment and recovery services; increase the use of diversion and/or alternatives to incarceration; and/or reduce the incidence of overdose death.

The program formulated a multi-agency planning team and achieved the goal of the Category 4a grant by developing a plan to address opioid use disorder among offenders. This multi-disciplinary approach included a large number of community partners, including the Louisiana Commission on Law Enforcement and Administration of Criminal Justice, LDH's Office of Public Health/Bureau of Health Informatics, the Department of Public Safety and Corrections, DOC Probation and Parole, MHSD, FPHSA, CAHSD, JPHSA, The 22nd Judicial District Court of Louisiana, Orleans Parish Day Reporting Center, St. Tammany Parish Government, Department of Children and Family Services, Gulf Coast High Intensity Drug Trafficking Area, New Orleans Health Department, and the New Orleans Division of the U.S. DEA.

B. Why is this success significant?

High rates of pain medication prescribing behavior result in concomitant misuse, abuse, and overdose deaths. According to the Centers for Disease Control and Prevention (CDC), while the opioid prescribing rate for Louisiana has steadily decreased since 2012, Louisiana's ranking when compared to other states has increased. During the years of 2012-2015, Louisiana has ranked either 7th or 8th. In 2016, Louisiana had the 5th highest rate in the nation at 98.1 prescriptions per 100 persons, which is 47.5% higher than the national rate (66.5). According to CDC's 2013 Prescription Behavior Surveillance System (PBSS) report, Louisiana ranked 1st out of eight participating states for opioid prescribing (1.02 prescriptions per resident).

Overdose death rates provide an indication of the opioid problem without relying heavily on interpretive opinions of coroners or toxicology results. Also, opioids have been projected to be responsible for 60% of all overdose deaths in the U.S. Age-adjusted death rates from overdoses in Louisiana have steadily increased since 1999 and have consistently been higher than national averages in all recent years except 2012. In 2016, Louisiana's age-adjusted overdose death rate was 10.1% higher than the national average (21.8 and 19.8 respectively). Louisiana's rate increased by 15% from 2015 to 2016 and was one of 26 states with a statistically significant increase.

According to the Treatment Episode Data Set (TEDS), state and federally funded substance abuse treatment facilities in Louisiana treated 1,129 persons for heroin and 743 persons for all other opiates in 2017. Combined, heroin and other opiates amounted to 13.5% of all facility admissions. Additionally, in 2016, Louisiana's imprisonment rate was the highest in the nation at 760 per 100,000 people, which is 69% higher than the US rate of 450.8 The Louisiana Department of Public Safety and Corrections (DPS&C) reported that approximately 84% of inmates who enter correctional facilities were under the influence of some type of illicit drug.

While commissions and councils have been created to address opioid use and criminal justice as separate issues, very little had previously been done to address opioid use in this

population.

C. Who benefits and how?
As none of the current federal opioid grants target offenders in local parish jails, who make up the majority of all inmates incarcerated and released back into the communities of Louisiana, providing funding specific to individuals with OUD in the local jails and the New Orleans Day Reporting Center (DRC) will make a significant impact. EBR and Orleans parish jails will have the staff necessary for screening, assessment, peer support, and counseling for inmates with OUD, as well as assistance in accessing recovery support services upon release. LaCOAP will also allow the New Orleans DRC to provide treatment programs specific to offenders with OUD from Orleans and Jefferson Parishes, greatly enhancing their chances for recovery. St. Tammany Parish will be able to create a screening and referral process in collaboration with FPHSA for adult diversion court programming, as well as provide a peer to work with the specialty court to find treatment and recovery support services in the community.

These objectives align with the LaCOAP objectives of implementing strategies that support treatment and recovery service engagement and expanding law enforcement diversion programs, while the use of multi-agency, cross-sector planning teams support comprehensive cross-system planning and collaboration. Providing these services where none existed before will increase the recovery rates of these offenders who are often "high frequency" users of multiple systems, including health care, child welfare and criminal justice, ultimately resulting in fewer overdoses and overdose deaths.

D. How was the accomplishment achieved?
Last year, with the award of the Category 4a COAP funding to develop a strategic plan. Cross-sector planning teams involving multiple agencies were created in each of the four targeted parishes to conduct needs assessments that identified existing resources and treatment gaps for this population. Gaps were examined between the amount of services needed in each parish and what currently exists, including current grant funding on the state and local level. Based on the gaps identified individual plans were developed to address the needs of OUD justice involved individuals in each parish of focus.

E. Does this accomplishment contribute to the success of your strategic plan?
Yes, OBH recognizes the impact of justice-involved individuals with an OUD on Louisiana's individuals, families, and communities, and strives to enhance policies, regulations and protocols to reduce the prevalence of justice-involved individuals with OUDs.

LaCOAP's collaboration with other federal grants such as Opioid STR, MAT-PDOA and SPF-Rx will also create educational opportunities for DPS&C staff and community treatment providers about the opioid epidemic, the latest evidence-based approaches and how to access resources. This will help enhance collaborations and increase the utilization of resources available through LaCOAP and other federal grants.

F. Does this accomplishment or its methodology represent a best management practice that

should be shared with other executive branch departments or agencies?

Yes, this accomplishment represents a best management practice, which should be shared for the purpose of further collaboration with those entities who serve the same population.

Accomplishment #4: Medication Assisted Treatment – Prescription Drug and Opioid Abuse (MAT-PDOA) Grant

A. What was achieved?

MAT-PDOA surpassed all outcomes that were initially predicated with the grant. We are also in the process of covering services for an additional 13 person for medicated assisted treatment enrollment. In addition, due to the additional grants that were awarded to the Office of Behavioral Health, the grant enrollees will have sustainability due to every enrollee qualifying for Medicaid.

B. Why is this success significant?

This success is significant because prior to MAT-PDOA there was no coverage of medicated assisted treatment. All patients affiliated with ten Methadone providers made cash payments for treatment. This success has been significant in increasing awareness and prevention of opioid use and overdose, decreasing the stigma, increasing pathways of access for treatment, prevention and recovery support services. The overarching goal of the MAT-PDOA grant is to increase access to Medicated Assisted Treatment (MAT); increase the number of minorities, women with children and pregnant women who receive MAT. The success is significant because prior to the grant, the census was Caucasian males age 19-34 and approximately 1% of the census included pregnant women. Through funding of the grant, we have increased treatment for 252 persons. Enrollees also receive 1 visit per year by a primary care provider and all enrollees are now Medicaid eligible which facilitates sustainability of services thereby, maintaining recovery.

C. Who benefits and how?

The grant benefits persons with no insurance coverage and under-enrolled persons who do not have behavioral health coverage that covers medicated assisted treatment. The grant was approved to expand access to medicated assisted treatment for minorities, pregnant women and women with children.

D. How was the accomplishment achieved?

The grant provides services to the greater New Orleans area which has some of the highest incidence of drug overdose. The network of providers participating in the grant provides holistic, individualized services which facilitates the success we have achieved.

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

MAT-PDOA grant accomplishments contribute to the success of the strategic plan by increasing access to medicated assisted treatment and supporting patients in recovery. The grant supports patient centered, individualized care by providing a primary care visit and services that facilitate recovery support.

The grant funds resource coordinators at each of the providers included in the grant. Their role provides support and case management; an ASI is utilized as the assessment tool and patients are assisted to receive care with the grant providers. The grant accomplishments contribute to the success of the strategic plan by funding treatment, increased access to medicated assisted treatment and prioritizing treatment of pregnant women.

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.

Area of Significant Progress #1: Heroin and Opioid Prevention and Education (HOPE) Council

- **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?

  ACT No. 88 of the 2017 Regular legislative Session established the Drug Policy Board's Advisory Council on Heroin and Opioid Prevention and Education (HOPE Council). Consisting of thirteen (13) members, including the Louisiana Department of Health, Department of Children and Family Services, the State Superintendent of Education, Department of Public Safety and Corrections, State Police, Commissioner of Higher Education, Louisiana Workforce Commission, President of Senate, Speaker of the House of Representatives, the Attorney General, Commissioner of Insurance, and a judge from a drug division of a district court, the HOPE Council met for the first time in November 2017, then again in December 2017, February 2018, and in May 2018, having engaged participation and input from many statewide stakeholders.

- **Where are you making significant progress?** If you are making no significant progress, state "None."

Significant progress has been made under OBH leadership regarding technical assistance and facilitation.

In efforts to establish an Interagency Heroin and Opioid Coordination Plan for submission annually to the board, the governor and others required in ACT No. 88, workgroups were identified and developed to review Parish-level data on opioid overdoses, dispensing of overdose-reversing medication, as well as identifying impacts to agencies in addressing education, treatment, including use of medication treatment (MAT), prevention, overdose, and recovery. The Interagency Coordination Plan and Data Surveillance Workgroups each met weekly to every other week with numerous stakeholders, working to develop a survey

instrument to inventory existing education/outreach, intervention, treatment and recovery programs in place statewide to address opioid use disorder. Similarly, the Data Surveillance workgroup inventoried existing and available data on opioid overdoses, overdose deaths, dispensing of overdose-reversing medications, and other priority data elements relevant to the opioid crisis.

On June 6th, 2018, Pew Charitable Trusts was invited into Louisiana, agreeing to provide technical assistance and to assist Louisiana and the HOPE Council in efforts to expand access to quality, evidence-based treatment for substance use disorders, with specific focus on opioid use disorder.

To date, a survey has been developed, distributed and returned by over 84 respondents, listing types of services and initiatives provided statewide, and a compiled list of data sets has been developed for possible inclusion in the HOPE Council's public-facing website. In addition, a draft website map has been developed, and additional work on the Louisiana Data and Surveillance Dashboard has been completed by the Louisiana Office of Public Health, which may help supply some data to the HOPE Council's proposed site.

Progress to date has largely been the result of motivated and committed HOPE Council membership, which has been organized into efficient and structured workgroups with clear scopes of work and assigned tasks, led and facilitated by the Office of Behavioral Health. OBH has allocated significant resources to the HOPE Council. The Chairman of the HOPE Council is OBH Medical Director, James Hussey, M.D. OBH also provides significant support, facilitation and technical assistance to the HOPE Council at large, as well as to each of the workgroups. OBH Deputy Assistant Secretary Janice Petersen, PhD, and OBH Program Managers Catherine Peay and Brad Wellons have been critical to the success and progress of the HOPE Council.

While contributions from the Office of Public Health, which has worked hand-in-hand with OBH, as well as support from the Louisiana Department of Health's Deputy Secretary and Chief of Staff have helped assure successes of the HOPE Council, the Office of Behavioral Health has led, organized, and facilitated all HOPE Council activities.

As OBH continues to lead all HOPE Council activities, continued and accelerated progress is expected to continue. As Interagency Coordination Plan Workgroup survey results come in and Data Surveillance activities continue, Pew Charitable trusts will work with OBH to identify gaps in informant and planning, and assist in the development of the Interagency Heroin and Opioid Coordination Plan and Website, which will be completed on or before December 31, 2018, then updated annually thereafter.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

  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 has not adjusted our strategic plan to speak to the HOPE Council directly, but it has been edited to involve our work around the opioid epidemic and providing greater access and services to those affected.

- **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?**

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.

Area of Significant Progress #2: Hospital Assessments

- **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 Louisiana Department of Health, Office of Behavioral Health (OBH) operates two inpatient psychiatric hospitals: Central Louisiana State Hospital (CLSH) and Eastern Louisiana Mental Health System (ELMHS). CLSH operates approximately 120 beds providing intermediate care for civil patients. ELMHS consists of two divisions: The East Division serves civil patients; and the Forensic Division, serves patients remanded by the criminal justice system. ELMHS has approximately 780 beds, making it one of only 16 large inpatient psychiatric hospitals (over 500 beds) in the United States.

Recognizing the challenges that facility administration and staff face when dealing with hard-to-serve populations and the continual pressures placed on them by multiple systems, such as the justice system, community advocates, and accreditation agencies, OBH prioritized enhancement and streamlining of the administrative relationships with the facilities, establishing goals to evaluate both CLSH and ELMHS to determine efficiency and quality of policies, procedures, and quality initiatives.

- **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?

To accomplish this, OBH initiated an externally conducted needs assessment of both CLSH and ELMHS in May and June of 2018. The needs assessment of CLSH and ELMHS was part of a broader project initiated by the Deputy Secretary of LDH that included two other facilities operated under the LDH umbrella: Villa Feliciana Medical Center and Pinecrest Supports and Services Center. The task involved having a 360-degree evaluation of the operation of the facilities, their management, their staffing, their programming, their performance measures, their population specific outcomes, strategic plans, and critical events. In addition, LDH administration wanted an honest and transparent evaluation of the perception of the organizational structure of the management of the facilities from the perspective of the CEOs of those facilities. Through these assessments, OBH seeks to define priorities and objectives for improving oversight, crafting strategy, shaping a positive culture, responding to facility needs, enhancing facility support, and designing vertical systems of quality management, so as to standardize an efficient reciprocal communication structure and utilize a standard set of quality metrics across facilities.

In April of 2017, LDH contracted Joseph Comaty, PhD, MP, former Chief Psychologist and Quality Management Director for OBH, to develop a scope of work, deliverables and a set of tasks for these assessments across all four facilities, and on February 8th, 2018 LDH/OBH entered into a contract with the National Association of State Mental Health Program Directors Research Institute. Inc. (NRI) to provide the organizational assessment of ELMHS based on the scope of work designed by Dr. Comaty. NRI has a twenty-year history of working with state hospitals, including working directly with staff at CLSH and ELMHS since 1999 on their quality reporting for the Joint Commission and the Centers for Medicare and Medicaid Services (CMS). Dr. Comaty has already completed reviews of both Villa Feliciana Medical Center and Pinecrest Supports and Services Center. Full reports were issued and a formal exit conference detailing the results of the external evaluation have been provided to the administrative staff of each of those facilities. Dr. Comaty has also completed

the external needs assessment of CLSH, including but not limited to review of critical documents, existing Quality Monitoring activities, and has conducted personal interviews with Quality Management team staff, administrative staff, clinical department heads, ward staff, as well as patient interviews at CLSH. His findings and recommendations have been submitted as a draft report to LDH administration for review.

Dr. Comaty will assist with NRI's external needs assessment at ELMHS. NRI has completed a detailed document review and a thorough data integrity review at ELMHS. They will next be onsite for the comprehensive interviews of administrative staff, clinical staff, direct-care staff, Quality Management staff, and patients to complete the needs assessment process. They will submit a complete report of their assessment for review by LDH/OBH and Dr. Comaty will use this information to add to information collected at the other three facilities to formulate recommendations for crosscutting metrics across facilities as well as providing insight into the perception of LDH organization structure by the leadership of the respective facilities. Dr. Comaty will coordinate with NRI to harmonize recommendations for both CLSH and ELMHS suggesting standardized quality reporting functions and organizational relationship between the facilities and LDH/OBH.

It is anticipated that the assessment work at both facilities will be completed and both facility reports summarized on or before September 31, 2018.

1. **To what do you attribute this success?**
   Success and progress associated with this project are the result of OBH and LDH leadership action to initiate the project on behalf of the two facilities. The OBH Assistant Secretary and Medical Director identified this project as a priority and initiated the process of developing goals, objectives and tasks associated with this project. No such assessment would have been initiated without OBH leadership and resources.

   OBH worked with the LDH Deputy Secretary, LDH Facilities Management Director, as well as the CEO's of both CLSH and ELMHS to identify both budget and human resource needs required for project completion. OBH Leadership also identified the most qualified consultants to conduct the assessments.

   Progress is a result of the work done within the Office of Behavioral Health, in collaboration with the LDH Deputy Secretary, LDH Facilities Manager, Dr. Comaty, NRI, and both clinical and administrative leadership at CLSH and ELMHS.

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 and result in improved administrative and clinical operations at both facilities, improve facility monitoring and reporting of both safety and clinical quality outcomes at both facilities moving forward and on a continual basis.

- **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 needs assessment took place in June of this year, the Strategic Plan has not been updated to reflect this specifically. However, it does speak to our 24-hour hospitals and OBH's commitment to those patients and facilities.

- **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.

<u>Area of Significant Progress #3: Mental Health Rehabilitation (MHR) Reform</u>

- **Please provide a brief analysis of the overall status of your strategic progress.**
  The reform of the mental health rehabilitation (MHR) program began following a $49 million dollar reduction to both psychosocial rehabilitation (PSR) and community psychiatric support and treatment (CPST) during FY 18. MHR reform was also needed due to increased growth of the provider network, increased expenditures, and quality management concerns expressed by MHR providers, legislators, and other stakeholders. Under the leadership of the Office of Behavioral Health (OBH) an internal task force was developed in collaboration with Medicaid to create a plan to reform the MHR program to address these concerns.

- **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?

This plan included the establishment of a MHR Provider Reform Workgroup and a Managed Care Organization (MCO) Reform Workgroup to collaborate with the task force. The task force also conducted outreach to advocates and stakeholders through the Behavioral Health Advisory Council and the Behavioral Health Advocates meetings. Although MHR reform in ongoing, the following has been accomplished:

1. Established a facility need review (FNR) process prior to licensing new MHR providers to manage network growth while ensuring sufficient providers in underserved areas of the state
2. Implemented the use of an assessment tool for recipients under the age of 21 years old to establish a standard functional level of care for initial and ongoing eligibility. A similar assessment tool for recipients for adults 21 years and older was implemented in 2012.
3. To address service duplication and reduce cost, OBH established a member choice form and policy. This new form and policy helps to prevent recipients from receiving MHR services from more than one MHR provider unless it is determined by the recipient's MCO to be medically necessary.
4. OBH amended the eligibility criteria in the adult mental health rule and provider manual to target MHR services for adults with serious mental illness and to ensure recipients with a co-occurring illness have symptoms of mental illness. These policy changes will reduce cost by clarifying medical necessity for MHR services and help to prevent recipients with a higher or lower level of need from accessing PSR and CPST.
5. OBH and Medicaid, with feedback from MHR providers and the MCOs, developed and revised 17 policies in the Behavioral Health Services Provider Manual to clarify critical programmatic areas including non-billable activities, the value and importance of family engagement, established standard treatment plan elements, developed policy regarding the delivery of appropriate services and level of intensity, developed new policy regarding the delivery of services in specific locations including schools, clarified the need for providers to track and report member progress, expanded the policy regarding staff supervision of non-licensed staff, and further clarified policies related to service documentation.

1. **To what do you attribute this success?**
   The MHR reform process has been the result of the task force led by OBH working collaboratively with the MHR provider and MCO reform workgroups. The task force includes the Assistant Secretary, the medical director, clinical and program staff from OBH and Medicaid staff. The MHR provider workgroup represents large and small, urban and rural, adult and youth providers located throughout the state. All five MCOs participated in the reform efforts with representation from each of their functional areas

including provider network, utilization management, member services, quality management, clinical services, and other administrative staff.

The OBH led task force met with each workgroup monthly for the first 9 months of the reform and as needed to establish the priorities and proposed solutions. The MHR provider and MCOs workgroups contributed ideas, recommendations, and drafted actual policy language. LDH collected and responded to approximately 125 recommendations from providers and the MCOs. These recommendations resulted in rule and manual changes LDH anticipates will help to improve service quality, improve recipient outcomes and reduce costs.

2. **Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?**
   The process of ensuring continuous quality improvement, improved recipient outcomes, cost containment will be ongoing. OBH and Medicaid will continue to collaborate with MHR providers, MCOs, and stakeholders to ensure MHR services meet the clinical needs of Medicaid recipients.

- **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?

  Specifics regarding MHR reform are not included in the strategic plan, as

this is a new initiative that only began in FY18.

- **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.

Area of Significant Progress #4: Opioid Work with the PEW Charitable Trusts

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

  In November 2017, the PEW Charitable Trusts (PEW) engaged Louisiana to become a valued partner in our efforts to combat the issue surrounding opioid abuse. During the months following, there were numerous phone conferences and meetings. LDH sent the formal ask proposition, signed by the Governor, and Louisiana was officially chosen in May 2018. Through this partnership, PEW will be providing technical assistance and much needed data support as we combat this epidemic.

- **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?

Since May of 2018, PEW has continued to engage LDH, other local/statewide/federal stakeholders with an official kick-off meeting occurring on July 9, 2018 at Louisiana's State Capitol. Additionally, when in Louisiana, PEW met with the Department of Corrections, Board of Regents, and other leaders who are also affected by the opioid epidemic.

PEW will also be coming back to Louisiana in August, where they will present and further engage the HOPE Council on their work. Ultimately, they seek to advise the Drug Policy Board and LDH by establishing an interagency plan and coordinating a central online data resource for Louisiana to use as we reach recommendations for effective action.

1. **To what do you attribute this success?**
   Ultimately, the success of PEW's work has been a group effort and the collaboration between all involved, to ensure that PEW has access to all the information and data it needs.

   Additionally, this project was supported by state leaders across the board, as evidenced by their co-signing the original letter sent to PEW, asking for their assistance.

2. **Is this significant progress of a one-time gain? Or is progress expected to continue at an accelerated pace?**
   PEW's progress will be ongoing into next year with the ultimate goal that the will help us craft potential legislation and policy changes that will make positive impacts towards opioid education and awareness.

- **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?

  LDH's opioid work is brand new; we only began to meet with PEW in June of 2018.

- **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.

Area of Significant Progress #5: LDH/Department of Justice Agreement

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

  In 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.

- **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?

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.

The first of the two main components, that we have already begun, is the diversion and pre-admission screening piece, which requires the State to develop a plan for a diversion system that will identify individuals in the target population seeking admission to nursing facilities and provide intervention and services to prevent unnecessary institutionalization. Specifically:

- LDH has implemented changes to the screening process for nursing home admissions and is now authorizing more temporary stays rather than long-term "permanent" stays. This means that the need for continued stay in a nursing facility will have to be justified and will come under review more often.

- OBH has formally standardized the utilization of temporary authorizations. For pre-admission PASRR (Preadmission Screening and Resident Review) Level II requests, authorization request will not exceed 90 days (or 100 days for persons approved for convalescent care by LDH). Additionally, all individuals will receive a new PASRR Level II evaluation annually.

- Finally, newly hired LDH Transition Coordinators have begun to perform face-to-face transition assessments with members of the target population. The pace of these assessments will increase over the next several months as staff who have already been hired become more proficient and as additional staff are on-boarded.

1. To what do you attribute this success?

The success of this effort lies on the willingness of LDH to work with the DOJ to correct this issue efficiently and effectively. LDH has partnerships with the MCOs and the LGEs that also assist.

2. **Is this significant progress of a one-time gain? Or is progress expected to continue at an accelerated pace?**
   The LDH/DOJ project will continue well into 2019. The first phase of implementation will run from June 6, 2018 – December 6, 2018 with Phase Two release tentatively scheduled for December 2019.

- **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 strategic plan has not been updated to include our DOJ work, as that is also a rather new initiative. The agreement with the DOJ was not signed until June 2018.

- **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.

Department Issue: OBH Organizational Structure

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   The organizational structure of OBH doesn't align with our subject matter areas, and is deficient in certain areas of priority.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   This issue does impact our efficiency, which ultimately reduces our ability to most effectively progress with our strategic plan.

3. What organizational unit in the department is experiencing the problem or issue?
   This issue impacts all of the units within OBH.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Due to the decentralized nature of staff working within the same subject matter areas, communications with outside stakeholders such as other LDH offices, LGEs, providers and other state agencies, are at risk of not being transparent or consistent.

5. How long has the problem or issue existed?
   This issue has existed, to some degree, since OMH and OAD were merged in FY11.

6. What are the causes of the problem or issue? How do you know?
   Some of the causes leading to OBH's organizational structure issues include the merger of OMH and OAD, the decentralization of administrative control of regional behavioral health services from OBH to the 10 LGEs, the implementation of Medicaid managed care for the provision of behavioral health services and an increasing prevalence of opioid abuse and the resulting need for treatment. An overarching issue is the loss of state general fund dollars over the last several fiscal years, and the increased need to pursue other funding sources.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   We need to build capacity in certain core areas, as well as streamline and centralize processes that are currently scattered as well as duplicated, across the Office. Without rectifying these issues with our current organizational structure, we will not be able to address OBH's priorities in the most effective and efficient manner.

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

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

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
      A business reorganization through Civil Service.

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
      No

   4. Are corrective actions underway?
      a. <u>If so</u>:
         - What is the expected time frame for corrective actions to be implemented and improvements to occur?

           Yes, corrective actions are underway. Our goal is to successfully implement by the spring of 2019.

         - How much progress has been made and how much additional progress is needed?

           With the assistance of a national consultant, we have developed a set of targeted priorities for the office, and identified where our current organizational structure is not in line with those priorities. We have drafted revised organizational charts based upon

our needs, and shared preliminary versions with both LDH Human Resources and Civil Service. Our next steps are to update all of our job descriptions accordingly, and move forward with the Civil Service review and approval process.

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.
Our business reorganization does not include requests for additional TO or other resources, so we don't anticipate any significant cost.

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

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

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

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

☒ **Internal audit**
The Office of Behavioral Health executive management team ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste & abuse by conducting risk-based audits and compliance investigations. The

Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

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

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

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

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

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

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

the information gained from this review should be used to improve strategic and operational planning, as well as agency and program management department-wide.

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

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

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

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:
   Not yet completed - due December 31, 2018

3. Subject / purpose and reason for initiation of the analysis or evaluation:
   The Office of Behavioral Health (OBH) is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the SAPT is the primary funding source for prevention services. It requires 20% of the grant be set aside for primary prevention services. An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report is a continuing process to measure the number of services we provide and the populations that are served.

4. Methodology used for analysis or evaluation:
   The data in this report is from the Prevention Management Information System (PMIS), the primary reporting system for the SAPT for prevention services.

5. Cost (allocation of in-house resources or purchase price):
   There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from PMIS to generate this document. Data is entered into PMIS by the LGE prevention staff, their contract providers statewide and OBH staff.
6. Major Findings and Conclusions:
   During FY 2017, Prevention Services provided evidence-based services to 79,546 enrollees.

   FY 2017 block grant funded one-time services provided to the general population reached 2,937,629 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, 2017

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 $73,125.00 ($65.00 per compliance check x 1125 checks). The total cost to prepare and complete the Annual Synar Report was $70,000.00.

6. Major Findings and Conclusions:
   The objective of this study was to estimate the non-compliance rate for tobacco sales in Louisiana among youth under age 18. Annual targets were established to decrease the state's non-compliance rate to 20% by FY 2002. However, Louisiana achieved 20.3% non-compliance in FY 1999, only two years after the start of the Louisiana Synar Initiative, and three years ahead of the scheduled target date. The current rate of tobacco sales to minors in FY 2017 is 14.1%.

7. Major Recommendations:
   OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2017 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 FY 2017 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:
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Annual Management and Program Analysis Report

Fiscal Year 2017-2018

Department: **Louisiana Department of Health (LDH)**
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: Developmental Disabilities (DD) Council Partnership: Expansion of Provider Partnerships

A. What was achieved?

This collaboration with the Louisiana Developmental Disabilities (DD) Council continued this year with completion of an extension with the pilot provider as well as an additional provider. 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 involves commitment on 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. Significant outcomes were achieved and maintained by both providers. Pilot provider efforts resulted in: 1) decrease in emergency room visits by 73%; 2) decrease in critical incidents by 70%; 3) elimination of staff injuries due to behavioral or medical challenges and needs from staff; 4) reduction and sustainability of staff turnover; 5) increased community connections and family involvement for individuals; 6) increased independence and reduction in needed support from staff; and 7) focus on competitive employment and actions toward employment. Second provider outcomes included: 1) reduction in emergency room visits by 40%; 2) reduction in psychiatric hospitalizations; 3) reduction in falls by 60%; 4) increased community connections and family involvement for individuals; and 6) increased independence and identification of employment goals. Two additional providers are engaged in partnerships at this time.

B. Why is this success significant?

The success of the two 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. OCDD is working with stakeholders to set service criteria and requirements to implement this in the upcoming fiscal year with Centers for Medicare & Medicaid Services (CMS) approval.

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 shapes 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 choose 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 professionals (DSP) 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.

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. (See Section of listing of 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. 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: Expansion of Provider Engagement with OCDD Leadership

A. What was achieved?

OCDD Leadership conducted bi-monthly provider calls and face-to-face visits with provider agencies across the state at the request of providers. Through calls and visits, providers were routinely updated with changes occurring within OCDD, other Louisiana Department of Health (LDH) offices (i.e., Health Standards, Program Integrity, Medicaid Program Supports and Waivers), and the Medicaid Data Contractor Statistical Resources Inc. (SRI). Bi-monthly calls provided a forum for providers to submit topics and questions which affect OCDD programs. Questions and answers as well as links to important websites were posted on the OCDD website so providers could access information at any time. Members of OCDD Executive Management Team visited Home and Community-Based Services (HCBS) provider agencies, vocational provider agencies, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) providers, and support coordination agencies at the request of each agency over the past year. The purpose of these provider visits was to ensure providers' understand of OCDD's major initiatives, as well as to allow OCDD to hear from providers about strengths of their agencies and system challenges they are facing.

B. Why is this success significant?

This initiative helped to create an atmosphere of transparency as well as support to the provider community. Providers could submit topics for which additional information or clarification was needed. It also allowed the same message to be heard by all participants [Local Governing Entities (LGEs), support coordination, ICFs/IID, and provider agencies] which helped eliminate confusion and inconsistent interpretations across agencies.

C. Who benefits and how?

The follow benefit from the initiative:

- OCDD benefits by discovering the topics that are important to providers and gaining the ability to provide the same message to all.
- LGEs, support coordination agencies, and providers benefit because they all receive the same information as it pertains to state-wide issues and concerns. This limits confusion and inconsistent messages, especially through posting of questions and answers (Q&A).
- Providers benefit because they are given information on resources to assist them in the delivery of services.
- Participants in developmental disability programs ultimately benefit when useful information is given which offers guidance to providers on the requirements of the program and resources.

D. How was the accomplishment achieved?

- Announcements for the bi-monthly provider calls and requests for agenda items were submitted to all Home and Community-Based Services (HCBS) and ICF/IID provider agencies, support coordination agencies, and LGEs.
- The Q&As for each call, as well as websites referenced, were posted on the OCDD website in the Provider Bi-Monthly Call section.
- Face-to-face provider visits were coordinated through Central Office at the providers' request.

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

Yes. Three of OCDD's Strategic Plan goals are supported by this initiative: goals II, III, and IV.

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

Yes. Routine engagement of state level agencies and provider groups ensures that consistent information is relayed to agencies that must work together in delivery of services.

<u>Accomplishment #3: Implementation of Tiered Waiver System for Developmental Disability Population</u>

A. What was achieved?

OCDD currently operates four Home and Community-Based Services (HCBS) waivers, including the Children's Choice Waiver, the Supports Waiver, the Residential Options Waiver, and the New Opportunities Waiver (NOW). There are approximately 11,000 individuals receiving services through these four waivers.

Through stakeholder engagement efforts, it was identified that it is difficult for individuals and providers to navigate the four separate waivers, and it was proposed that there be a consolidation of the four developmental disabilities waivers. Louisiana is proposing this consolidation with a target implementation date of fiscal year 2020-2021. As a first step towards that consolidation, OCDD has operationalized the four developmental disabilities HCBS waivers into a tiered waiver system of service delivery, which will allow for individuals to be supported in the most appropriate waiver. OCDD received approval from the Centers for Medicare & Medicaid Services (CMS) for the Children's Choice Waiver and Supports Waiver in February 2018 and for the Residential Options Waiver and the New Opportunities Waiver in March 2018. Three major changes were achieved with the move to the "Tiered Waiver" System:

1. Waiver offers are no longer made on a first-come, first-served basis. They are made based on a person's urgency of need and his/her registry date.
2. There will only be one waiting list/registry and when the person receives a waiver offer he/she will participate in a needs-based assessment and person-centered planning to determine the most appropriate waiver to meet his/her needs.
3. The age limit for the Children's Choice Waiver has increased to 21 years of age. This aligns with the age for Medicaid State Plan Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. The combination of EPSDT services and Children's Choice Waiver comprises the children's package in the developmental disabilities service delivery system.

B. Why is this success significant?

The move to a priority-based system allows Louisiana to address the 25-year-old waiting list while meeting people's needs. The move to a tiered waiver system will have the following benefits:

1. Individuals will receive the most appropriate waiver that best meets their needs rather than immediately receiving the NOW, which is the most costly waiver.
2. This system will allow OCDD to have a move-responsive system to meet unmet urgent needs of those individuals who are waiting for service.
3. The system will allow for more predictable estimates of budget requests needed for developmental disabilities waivers to meet the needs of those with unmet urgent needs.

C. Who benefits and how?

Individuals and families will benefit from implementation of the tiered waiver service delivery system. Having information about the needs of people who are waiting will allow the Department to make more informed budget requests related to Home and

Community-Based Services Waiver options and will allow for system changes that are both fiscally and programmatically responsible. The overall system will benefit by aligning needs with availability of supports and by having a consistent waiver process.

D. How was the accomplishment achieved?

The accomplishment occurred through use of a Core Stakeholder group, analysis of available data for individuals currently on the Request for Services Registry (RFSR) as well as those being served in OCDD's waivers, and research into best practices in other states. OCDD worked closely with other LDH offices and Centers for Medicare & Medicaid Services (CMS) to complete waiver amendments and develop processes for implementation. In addition to the Core Stakeholder group, as part of the waiver amendment process, public input was sought throughout the entire process.

In March and April 2018, OCDD conducted an extensive outreach and education campaign focusing on statewide community meetings geared at informing individuals who were on the RFSR and would be moved into the new tiered waiver system what those changes would mean for them. In collaboration with community partners, two sessions per Local Governing Entity (LGE) region were offered, a morning and an evening session. More than 689 individuals attended OCDD's statewide tiered waiver discussions. In addition to these sessions that were offered in the community, OCDD provided education to other program offices within LDH as well as to the Managed Care Organizations.

All service providers, support coordination (SC) agencies, and LGE offices received in-depth training regarding changes made to OCDD's waiver programs. Training focused on the tiered waiver process as well as expectations regarding each entity's role in the process. Twelve sessions were held for service providers and seven sessions were held for SC agencies and LGE offices. Finally, in an effort to support these groups in their roles, OCD D followed training sessions with LGE offices and SC agencies with regional/ agency specific technical assistance calls to focus on agency level issues/concerns. OCDD facilitated 18 calls with SC agencies and LGE offices during the first two weeks in June 2018. OCDD plans to continue to provide training and technical assistance to all entities as we continue to move forward with implementation of tiered waiver.

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

Yes**.** Five of OCDD's Strategic Plan goals are supported by this initiative: goals I, II, III, IV, and VI.

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

Yes. The approaches OCDD continues to utilize in tying a comprehensive system analysis to a multi-phase strategic action plan and involving stakeholders and

incorporating national best-practice recommendations are consistent with nationally recognized strategies for success in large-scale system transformation.

Accomplishment #4: Request for Services Registry Prioritization Project

A. What was achieved?

Carried over from the prior fiscal year activities, in FY 2017-2018 the Office for Citizens with Developmental Disabilities (OCDD) continued research, design, and implementation activities related to System Transformation with primary focus during this fiscal year on implementation of the prioritization of individuals on the Request for Services Registry (RFSR). OCDD attempted contact with all persons identified on the RFSR, and to date over 10,000 screenings have been conducted. Of the screenings conducted, 15% of the individuals screened fell into the Emergent or Urgent category, meaning they have immediate need for waiver services. Eighty-five percent (85%) of the individuals screened were identified as having no current unmet needs that could be met with waiver services.

With additional funding available for FY 2017-2018, OCDD with feedback from stakeholders opted to seek approval from the Centers for Medicaid & Medicare Services (CMS) to move to a single Developmental Disability RFSR and change the manner in which waiver offers would be extended from first come, first serve to prioritizing offers based on need. CMS approved waiver amendments for Children's Choice and Supports Waiver at the end of February 2018 with the Residential Options Waiver and the New Opportunities Waiver being approved at the end of March 2018.

With these approvals from CMS, OCDD has been able to move forward with offering waiver services based on urgency of need. As of June 30, 2018, offers have been made to all individuals that were identified as having emergent needs as well as many of those that were identified as having urgent needs. Moving into FY 2018-2019 there were only 193 individuals remaining on the RFSR identified as having urgent unmet needs. With additional funding approved for FY 2018-2019, OCDD anticipates that all individuals identified as having emergent/urgent unmet needs will receive a waiver offer.

B. Why is this success significant?

With these changes there is no longer a waiting list for services and OCDD has established a responsive system in that as people are identified to have emergent/ urgent unmet needs offers for waiver will be immediately available to them.

C. Who benefits and how?

Individuals with developmental disabilities and families will benefit from modifications to the RFSR. Having information about the needs of people who are waiting will allow the Department to make more informed budget requests related to Home and Community-Based Services Waiver options and will allow for system changes that are both fiscally and programmatically responsible. The overall system will benefit by aligning needs with availability of supports and by having a consistent waiver process.

D. How was the accomplishment achieved?

The accomplishment occurred through use of a Core Stakeholder group, analysis of available data for individuals currently on the RFSR, and research into best practices in other states. The pilot screening process for individuals receiving the Supports Waiver and on the New Opportunities Waiver (NOW) RFSR was completed utilizing currently available resources during the annual support planning process. Screening for the remaining persons on the NOW RFSR was initiated through Cooperative Endeavor agreements with Local Governing Entity offices utilizing dollars budgeted for fiscal year 2016-2017, and OCDD staff completed remaining screening for persons on the RFSR, persons needing re-screenings as they had experienced a change in status, and those persons newly added to the RFSR during FY 2017-2018.

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

Yes**.** Components are aligned with five goals of OCDD's strategic plan: I, II, III, IV, and VI.

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 method of handling requests for services is now utilized by a number of other states and is considered a best practice.

Accomplishment #5: Intermediate Care Facility Programmatic Unit

A. What was achieved?

The Office for Citizens with Developmental Disabilities (OCDD) successfully established a new program to engage private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) provider agencies in a partnering to improve the quality of services provided at ICF/IID facilities. Not to serve as a regulatory agency, such as the Health Standards Section, the ICF/IID Programmatic Unit's purpose is to ensure that supports and services are planned and provided in a truly person-centered manner and that they are having the desired outcomes. Additionally, this program, which is now operational statewide, provides technical assistance, guidance, and training to facilitate the successful partnering with private ICF/IID provider agencies. An ICF/IID Programmatic Unit Handbook has been developed and serves as a reference tool to assist providers in delivering quality services. Experienced and qualified staff have been incorporated into the unit from other areas within the OCDD as the Office continues with its transformation of the services system. A pilot program was initiated with six ICF/IID providers who have chosen to partner with the unit, and the unit has completed training with these providers on the unit's five core training areas. Monitoring, technical assistance, and further training with the pilot providers is ongoing. Additionally, the unit

has mechanisms in place to gather information regarding its effectiveness and utilizes this information to improve unit processes and procedures. Performance indicators, which will be developed by the unit staff and outside stakeholders, will allow ongoing program evaluation.

B. Why is this success significant?

Prior to establishment of this new unit, an official systematic process was not in place to address quality of supports and services in private ICFs/IID. To meet the intent of the Developmental Disability Law and to facilitate enhanced quality of life outcomes for individuals residing in ICFs/IID, OCDD developed this program to engage private ICF/IID provider agencies in a partnership to improve quality. This program ensures that person-centered planning/thinking are in place as services are planned and delivered and that services are having the desired outcomes. Additionally, the Office's provision of technical assistance, guidance, and training gives the private ICF/IID providers a resource to seek assistance to improve the quality of the services they provide.

C. Who benefits and how?

Establishment and success of the OCDD ICF/IID Programmatic Unit benefits all individuals being served by private ICF/IID providers across the state, and it also benefits the providers by giving them the knowledge and tools they need to provide more effective and better-quality services. This program will enhance and build capacity of ICF/IID services statewide.

D. How was the accomplishment achieved?

- The commitment of LDH Secretary, Dr. Rebekah Gee, to improve the quality of services for all individuals residing in Louisiana's ICFs/IID facilitated the partnering with providers, thereby improving overall quality of life for participants.
- Through reallocation of resources from a number of different areas within the Office, necessary staff were assigned to the unit to fulfill the ICF/IID Programmatic Unit goals in a cost-effective manner.
- Due to the success of the initial outreach with providers regarding the unit, a number of providers volunteered to partner during the pilot. Because of their willingness to partner with the unit, the unit successfully initiated the pilot beginning with provider trainings statewide.

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

Yes. This accomplishment aligns with the two goals OCDD's Strategic Plan: II and III.

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 works to ensure improved quality of private ICF/IID services.

Accomplishment #6: Acceptance into CMS Innovation Accelerator Program for Value-Based Payments in a HCBS Setting

A. What was achieved?

The Office for Citizens with Developmental Disabilities (OCDD) was one of ten states' similar offices selected to participate in Center for Medicare & Medicaid Services (CMS) Innovation Accelerator Program (IAP). This program is a collaboration between the Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare and Medicaid Innovation (CMMI) designed to build state capacity and support ongoing innovation in Medicaid. The Medicaid IAP is intended to build the knowledge base and capacity of states to begin increasing state adoption of strategies that tie together quality, cost, and outcomes in support of community-based Long-Term Services and Supports (LTSS) through one-on-one technical support focused on designing Value-Based Payment (VBP) strategies for Home & Community-Based Services (HCBS). The focus of VBP with this initiative will be on Home and Community-Based Services waivers and tying provider incentives to person-centered outcomes.

B. Why is this success significant?

This one-on-one technical support program will include peer-to-peer learning opportunities and tailored coaching focused on two key objectives:

- Building state knowledge and capacity to design a VBP strategy for HCBS; and
- Moving states toward implementation of a VBP strategy for HCBS.

The successful implementation of a VBP strategy will incentivize quality and program outcomes. The quality of care provided to waiver participants will improve.

C. Who benefits and how?

Program participants will benefit from the diverse mix of quality services including increased utilization of employment related training and community integration. Providers who deliver high quality services that meet predetermined benchmarks will benefit from supplemental payments based on performance. OCDD will benefit from the programmatic outcomes associated with a VBP strategy and will have the potential to offer additional resources to individuals not currently receiving services.

D. How was the accomplishment achieved?

OCDD applied for the grant in March 2018. In the expression of interest, OCDD highlighted the office's preliminary work in the design of a VBP model and explained the anticipated benefits to the Department, stakeholders, and State.

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

Yes. Two of OCDD's Strategic Plan goals are supported by this initiative: II and III.

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

Yes. Successful implementation of Value-Based Payment (VBP) strategies will incentivize quality and program 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?

OCDD is making timely progress in its 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 2017-2018. Progress on objectives remained steady, and current strategies were effective. The Office continues to build on successes in the areas of customer responsiveness, rebalancing, person-centered thinking, early intervention, waiting list prioritization, supports for people with complex behavioral needs, and employment. The success of these initiatives in FY 2017-2018 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."

#1: Supporting Individuals with Complex Behavioral Health Needs to Live in their

Community

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.

This success is attributed to 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.

This significant progress is not the result of a one-time gain; 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.

#2: 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. Foundational training has been completed. The second phase of the grant has involved intensive mentoring and technical assistance with each provider to modify assessment and treatment practices for individuals with these co-occurring needs.

OCDD contributes this success to the clinicians OCDD employs who have 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.

This significant progress is not the result of a one-time gain; 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.

#3: Person-Centered Initiative

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 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 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. Automation of the format has also been completed, and OCDD is evaluating the Information Technology (IT) requirements to roll out this eISP (electronic Individual Support Plan).

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 service system with person-centered thinking skills and tools. Louisiana has received national recognition for its *Guidelines for Support Planning* in the New Opportunities Waiver which sets a good foundation for improvements in this arena. The new initiative and workgroup provide additional resources and focus to ensure ongoing quality improvements as well as improved implementation and sustainability of person-centered practices.

This significant progress is not the result of a one-time gain; progress is expected to continue. The new planning format has been implemented with enhanced individual (and family) driven practices in place. Automated processes will be implemented as IT supports and resources allow.

#4: EarlySteps' Success in Exceeding Performance Standards related to Development and Implementation of Individualized Family Services Plans

One of the primary program purposes of EarlySteps is to enhance the capacity of families to meet the needs of their infants and toddlers with disabilities. A key measure of success for meeting this need is timely service delivery to eligible infants and toddlers. Performance is measured through two indicators:

Development of Individualized Family Services Plans (IFSPs) within 45 days of referral:

A focus on improving the State's compliance related to this requirement has been in place since 2008. A performance indicator (#24664) is included in OCDD's Strategic Plan and Operational Plan to monitor compliance with this requirement. The current performance standard for this indicator is 97%. In FY 2017-2018, this standard was exceeded with achievement of 100%.

EarlySteps can generate reports from its data system and closely track timelines for completion of IFSPs by its entry offices. During the previous fiscal year, 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 2017-2018.

Progress has been steady and is expected to be maintained.

Implementation of the EarlySteps State System Improvement Plan (SSIP):

Fiscal year 2017-2018 marked Year 3 of the state's IDEA, Part C State 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 shown improvement in the number of children who exit the system at the level of their typical peers through implementation of early intervention evidence-based practices [Division of Early Childhood Recommended Practices (DECRPs, 2016)], specifically in the teaming and collaboration practice area.

To accomplish improvement, EarlySteps targeted two main areas of system support: infrastructure improvements and practice area improvements.

Infrastructure Improvements: There were two major areas of infrastructure improvements implemented in FY 2017-2018.

- An improved child outcome measurement process was implemented in 2017. This process was designed to result in a more sensitive measure of a child's 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 and an 80% decrease in the number of children who did not show measurable progress compared to FY 2015-2016 (the last year that a full twelve months of data using the previous measurement was available). In addition, there was a 30% increase in the number of entry to exit scores available from which to run comparison scores. These changes will align Louisiana's results with those of other states in child outcomes from early intervention.
- There was a new focus on team-based decision making with IFSP team training and implementation of a standard process for making service decisions based on child and family service needs. As a result of this focus, there was an 80% increase in participation in the team-decision process compared to the previous fiscal year.

Practice Improvements: Through a stakeholder involvement process, the DECRPs were selected as the evidence-based practices to improve provider practices across the early intervention system. The teaming and collaboration focus area of the DECRPs has resulted in a 4% increase in IFSP team meeting participation compared to the previous year.

This significant progress is not the result of a one-time gain; progress in these areas is expected to continue, due to the system's focus on ongoing implementation fidelity. For each of the areas outlined above, training and monitoring procedures have been developed. For example, for the child outcome data measures and the team meeting activities, new data reports were developed to monitor improvement. Each quarter a report is generated and shared with regional staff for their review. Staff review performance for their region, report the results at the quarterly EarlySteps staff meetings, and implement follow-up activities with regional programs. Improvement activities are designed to ensure

that the practices are being implemented with fidelity. These activities are based on specific components from the National Implementation Research Network and are designed to promote the practice of implementation science, that is, that effective practice change depends on the key features of: stakeholder involvement and communication, careful practice selection and design, adult professional development practices including coaching, and measurement of fidelity of implementation.

#5: Approval of State-Wide Transition Plan for Home and Community-Based Services Settings

In January 2010, the Center for Medicare & Medicaid Services (CMS) issued the Home and Community-Based Services (HCBS) Settings Rule. The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for home and community-based services. 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. This rule required states to develop a state-wide transition plan to detail how the state and its provider agencies would come into compliance with the regulations outlined in the rule within a five-year period. OCDD has completed necessary activities to receive initial approval on Louisiana's State-Wide Transition Plan (STP). Several activities must be completed to achieve final approval from CMS on the STP including completion of the site-specific assessment/ validation analysis and implementation of the corrective action strategies. OCDD will focus on these areas during FY 2018-2019.

OCDD has worked closely with all involved stakeholders in the development of provider self-assessments, individual experience surveys, validation processes, and overall systemic review of agency rules/regulations/policies to address required components of the CMS regulation through the STP. Additionally, OCDD has dedicated significant staff resources to the development, training, and ongoing data collection/monitoring of the process to ensure success.

This significant progress is not the result of a one-time gain; progress is expected to continue at an accelerated pace. OCDD will continue to work closely with individuals and/or their families, Local Governing Entity offices, support coordination agencies, and service providers to achieve final approval on the STP by CMS as well as the identified outcomes within the plan. This is one step in OCDD's overall System Transformation, and OCDD resources will continue to be dedicated to the project.

#6: State-Wide Employment Initiative - DD Council Grant

The Office for Citizens with Developmental Disabilities (OCDD) state-wide employment training initiative which was made possible through partnering with the Louisiana Developmental Disabilities (DD) Council to secure a grant which is funding employment training for vocational service providers, support coordination agencies, and the Local Governing Entities. The grant is providing the funding for a contract with Direct Course/Elsevier to provide the training. OCDD will help coordinate the trainings

statewide and will be an integral part of this project. This training will provide a foundation for all service provider organizations in reaching their maximum potential in providing integrated employment for individuals with intellectual/developmental disabilities. The training will enhance Louisiana's position in maintaining its Employment First state status and will continue to offer employment options for individuals in our programs. This training will give all relevant entities the tools needed to help secure the best community jobs for individuals within the Louisiana Developmental Disabilities (DD) Services System. It will provide the knowledge necessary for the Local Governing Entities (LGEs) and the support coordination agencies to assist the service providers in planning for employment services for their individual participants. The training will also help provider agencies to abide by the HCBS Settings rule, which is to be fully implemented by 2020.

Individuals with intellectual/developmental disabilities benefit tremendously. They will be integrated in the community with individual jobs and be a part of the workforce. Service providers, the LGEs, and support coordination agencies will have a foundation on which to build, making sure that all new individuals coming into the DD Services System will seek individualized employment automatically.

OCDD identified the need for additional resources to assist providers in achieving initiatives related to helping people to have meaningful employment opportunities. OCDD worked with the DD Council to identify these training needs. OCDD has also worked in collaboration with the DD Council to ensure that training is based on best practices and promotes desired outcomes.

This significant progress is not the result of a one-time gain; progress is expected to continue at an accelerated pace as training will be conducted in FY2018-2019.

#7: Provider Night-Rate Increase and Personal Care/Complex Care Add-On Service - CMS Grant

OCDD received $19.9 million in statutorily dedicated funds through the New Opportunities Waiver (NOW) Trust Fund, and the funds are being used to fund two of the more desperately needed service enhancement projects. The first is an increase in the NOW Individual and Family Support (IFS) Night Rate. The second service enhancement project is the creation of a complex care add-on service for persons in the New Opportunities Waiver and the Residential Options Waiver (ROW) with complex medical and or behavioral needs that require an additional level of specialized care above that currently provided.

Previously, dollars appropriated to the NOW Trust Fund were limited to the provision of waiver opportunities. However, the passage of Senate Bill 43 (Hewitt) during the 2018 Regular Louisiana Legislative Session changed the rules to allow the Trust Fund to be used to advance any OCDD Home and Community-Based Services initiative identified by working in conjunction with the Louisiana Developmental Disabilities Council.

The current rate structure for individual and family support under the NOW has been in place since the waiver's inception in 2003. Subsequent rate increases (2007) and

decreases (2011) brought us to the current rate of $2.17 per quarter hour. This rate, when adjusted for one hour of service, paid approximately $8.68 per hour. This hourly rate did not allow enough money to provide the service and pay a sustainable wage. With an appropriation amount of $14 million (state and federal), the IFS-Night rate was raised to $2.75 per quarter hour and an average of 27% per each IFS-Night service. It is believed that the new adjusted rate of $11.00 per hour of service provided moves the needle on being able to pay the providers rates that will allow them to hire, maintain, and retain competent staff for night services.

The second service enhancement project is designed to give providers the additional resources needed to purchase and provide the enhancements needed to allow individuals in the NOW and the ROW who have complex medical/behavioral needs requiring an additional level of specialized care above that currently provided through current waiver services to remain safely in the community. The proposed enhancement complex services rate of $38.88 per day will not replace personal care attendant services but will provide a daily supplemental amount for our most medically fragile and behaviorally challenged community participants. It is also versatile enough to provide flexibility in its use with providers being allowed to determine how best to obtain the optional value to the participants through its use.

This significant progress is not the result of a one-time gain; progress is expected to continue as full implementation is scheduled to begin in FY2018-2019. The increased night rate is able to be initiated with internal approvals only; however, the complex care rate will require CMS approval via waiver amendments. While these two programs serve to provide much needed financial relief to our provider populations and increased skilled care to our participants, OCDD recognizes that there is still a greater need for a review, redetermination, and redesign of our services and rate setting structure.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

#1: Enhanced Support for Individuals with High-Risk Needs

Crisis referrals for longer term placement at OCDD's Supports and Services Centers had decreased and stabilized between 2012 and 2014. Referrals began to increase in 2015 and 2016 with an increasing number of individuals referred who are in high risk situations with complex needs (over 40% in psychiatric treatment facilities and another 17% in jail). While overall referral numbers are now down for 2017 due to the continued efforts of the Resource Center staff (as noted in the progress section above), the complexities of those referred remains high with over 70% of individual referred being in some form of institutional setting/services already (over 40% in psychiatric hospital/treatment facility, 12% in jail and remaining in other institutional settings). Supporting these individuals at OCDD's remaining Supports and Services Center (SSC) continues to bring considerable challenges. Additionally, other developmental disability support and living options are also challenged in successfully supporting these individuals without access to additional supports/ treatment. A final complicating

consideration continues to be an increase in readmissions to the SSC following discharge, along with difficulties in transitioning to other options once admitted to the SSC.

We attribute this lack of progress to significant changes which have occurred across multiple agencies/systems including: privatization of some services, challenges related to fiscal needs within all agencies, and move of many services to managed care. While many positive changes have occurred following these systems modifications for many people receiving services, individuals with needs crossing systems present complexities that are often outside the existing options available within a single system/agency. Collaboration and coordination across systems is challenging and often not clearly outlined in process and expectations, and impact on some groups with changes as outlined were not always able to be foreseen.

The lack of progress is due to a set of circumstances. LDH is supporting OCDD and its sister agencies (Office of Behavioral Health and Medicaid) in collaboration with other departments (Department of Children and Family Services, Office of Juvenile Justice, and Department of Education) to develop proposals for better meeting the needs of the individuals with coordinated cross agency options.

#2: Development of an integrated, full-scale data-driven quality process

In spite of staff efforts, the development of an integrated, full-scale data-driven process was delayed during FY 2017-2018.

This lack of progress is primarily due to shortfalls in the area of Information Technology (IT).

- There is only one full-time programmer who is responsible for all OCDD IT projects;
- Requests have been made to consider hiring an additional programmer to assist;
- There are other competing IT priorities within OCDD;
- Due to other priorities, the Business Analytics /IT/programmer staff was unable to assistance with the redesign of the integrated database;
- The position in the business analytics department whose primary function was supporting the quality section was vacant; and
- Replacement of antiquated on-line Incident Management System, which is shared by other LDH agencies, has been delayed due to issues discovered during the testing phase of the new application.

It is noted that one component of the new integrated database (Complaints) was completed during the past year.

Executive management staff set the priorities for this year and the major projects have now been implemented; therefore, it is hopeful that the one full-time programmer will be able to re-focus on this project.

- **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 2018 through 2022. Updates included revisions to program objectives, strategies and indicators to reflect Office direction, to build on successes, to provide strategies in areas where success has not been as substantial or where changes in program direction indicate such, and to improve performance assessment.

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

Community settings lack adequately trained professionals and direct support staff to deliver needed (1) behavioral services, including qualified persons to deliver applied behavior analysis to people with autism, and (2) services and supports, including skilled nursing services, to individuals who are medically fragile

A. Problem/Issue Description

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

   There continues to be a lack of adequately trained professionals and direct support staff to deliver needed behavioral and medical/nursing services to individuals with complex needs in community settings, including a lack of qualified professionals to deliver applied behavior analytic therapies to persons with autism. There is a shortage of trained staff to provide services and supports for individuals with significant medical needs, including skilled nursing services for individuals who are medically fragile and reside in community settings.

   Adequate behavioral supports can be very effective in improving quality of life and reducing behavioral symptoms/challenges for individuals with 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 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 developmental disabilities. National reports continue to indicate that there is a general shortage of behavioral health professionals in many areas of the country with access for those with co-occurring developmental disabilities and behavioral health needs even more challenging. The cost of providing nursing services in individual settings and challenges in terms of isolation in these arrangements negatively impact the access to needed medical/nursing supports. Both the increasing number of persons with developmental disabilities now being served in the community and the downsizing of institutional services, generally considered to be positive and progressive developments in developmental disabilities services, have contributed to an increased need for medical/nursing and behavioral/psychiatric supports in the community. In addition, private Supported

Independent Living (SIL) providers serving persons in waiver settings and private community home providers generally conduct and are required to conduct very little training with direct support staff on positive behavior supports and medical/nursing needs.

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

   Consequences include: 1) a significant number of people with 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:

   - Continue with expansion of partnership with the Louisiana Developmental Disabilities Council to offer a formal incentive-based training, technical assistance, and consultation opportunity to community waiver providers supporting individuals with complex needs.
   - Develop and implement Enhanced Service Option for individuals with complex needs via the OCDD waiver options with funding secured in this legislative session.
   - 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 developmental disabilities.

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:

   - Partnership with the Louisiana Developmental Disabilities Council began in June 2016 and will continue through FY 2019.
   - OCDD's statewide Positive Behavioral Supports (PBS) curriculum for direct service workers has been expanded to include statewide certified trainers and has been incorporated into the OCDD Resource Center transformation as an ongoing option with local accessibility.
   - OCDD continues its statewide offering of Medical/Nursing Direct Service Worker (DSW) training via Money-Follows-the-Person (MFP) Rebalancing Demonstration.
   - OCDD continues to offer Board Certified Behavior Analysts (BCBA) continuing education opportunities as well as other behavioral and psychological continuing education options.
   - OCDD continues to provide consultation and technical assistance via the OCDD Resource Center.
   - OCDD continues to work with Medicaid to support Applied Behavior Analysis (ABA) services via the State Plan and has increased routine coordination with Office of Behavioral Health (OBH) related to mental health needs for individuals with 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 DD Council partnership is funded solely through funds dedicated to this purpose by the DD Council; 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).

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 additional funding. Although funding was requested for the IT Project during the state budgeting process, the project was not chosen.

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/Comprehensive Plan of Care (ISP/CPOC) 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?

   Additional funding is needed to implement, test, correct, and maintain the data infrastructure necessary to implement the electronic ISP, 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 waiver.

3. Has this recommendation been made in previous management and program analysis reports?

   No.

4. Are corrective actions underway?

   Funding has been requested in the FY 2018-2019 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 past twelve years, eight former supports and services centers have either privatized their operations or closed. However, OCDD continues to bear responsibility for the ongoing costs associated with six of these eight facilities. These costs may include acquisitions and major repairs, the payment of risk management premiums, building and grounds maintenance, utilities, and/or loss prevention/security. Other ongoing, or legacy costs, include group insurance benefits for retirees. No State General Fund (Direct) funds have been provided for these mandated 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 facility 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?

The problem is caused by mandatory duties related to state-owned property insured by Office of Risk Management (ORM). Also, though vacated, the properties remain the property of the State and efforts must be made to keep the physical plant in good condition and prevent theft or destruction of property.

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

   The consequence of this issue is 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. 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. In regard to OCDD efforts to find a proposed best use for former facilities:

   - 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.
   - 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 current plan is to surplus the property at the termination of each CEA, so that the property may be appropriately liquidated. It is unknown what time frame may

be associated with the disposition of the property. Progress is dependent upon the process used by the State to dispose of surplus property. To the extent the property may be liquidated, the risk management costs are determined by the Office of Risk Management schedule for removing property from the premium allocation assigned to the agency.

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.)

   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.

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

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

☒ **Internal audit**

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

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste 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 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 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 Services (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 n otes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

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

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

☒ **Benchmarking for Best Management Practices**

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

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

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

☐ **Peer review**

☐ **Accreditation review**

☒ **Customer/stakeholder feedback**

☐ **Other** (please specify):

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

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

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

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

1. Title of Report or Program Evaluation:

National Core Indicators Project

Since FY 2008-2009, the Louisiana Office for Citizens with Developmental Disabilities (OCDD) has participated in the National Core Indicators (NCI) Project, which is co-sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). NCI projects that thirty-nine states are planning to contribute survey data for the upcoming 2019 survey cycle. 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 2018, OCDD mailed Child/Family surveys to a random sample of the families of children with developmental disabilities participating in various 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 total of 400 completed surveys. The actual

number of completed surveys OCDD received was 277. Additionally, the OCDD Resource Center and the Intermediate Care Facility (ICF) Programmatic Unit deployed personnel to conduct face-to-face interviews with 442 randomly selected adults with developmental disabilities for the NCI Adult In-Person survey. 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 2018 survey cycle, OCDD decided to focus on sending the Child Family mail survey and conducting the Adult In-Person survey. This decision was the result of OCDD's need to re-establish procedures after significant changes in Resource Center management and the establishment of the OCDD ICF/IID Programmatic Unit, as well as the need to more thoroughly analyze the data and develop improvement strategies before the beginning of another survey cycle. The responsibility for conducting the face-to-face surveys and data entry was assigned to these two sections with new leadership and procedures in place for the functional supervision of the personnel conducting the tasks. Final reports from NCI on the aggregated data will be available in January 2019.

Reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services and delivered to OCDD in 2018:

- *National Core Indicators Adult Consumer Survey 2017 Final Report*: This report provides an aggregated summary of the results of interviews with adults receiving any developmental disability services in any setting and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Family Guardian Survey 2017 Final Report:* This report provides an aggregated summary of the results of the survey which was mailed to families of adults receiving developmental disability services in any setting other than the family home and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Adult Family Survey 2017 Final Report:* This report provides an aggregated summary of the results of the survey which was mailed to families of adults receiving developmental disability services and who reside with their families and provides comparisons between Louisiana and the national average of other participating states.
- *National Core Indicators Child Family Survey 2017 Final Report:* This report provides an aggregated summary of the results of the survey which was mailed to families of children living and receiving developmental disability services in the family home and provides comparisons between Louisiana and the national average of other participating states.

2. Date completed:

   Surveys and interviews were completed between January and June 2017. Final reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services were published in January 2018.

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

   Surveys and interviews were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. Interview questions concerned satisfaction, quality of care and quality of life. Analyses compared Louisiana statewide results with results of other states participating in the National Core Indicators Project.

4. Methodology used for analysis or evaluation:

   The primary tools used for this evaluation were family surveys and consumer interview questions. Analyses reported both the number and percentage of responses to each question. Comparisons were reported among the participating states.

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

   The three family-mail-out surveys were printed by State Printing for $7,497 and mailed by Office of State Mail Operations for $7,345. All other activities were performed using OCDD material resources and Central Office and Resource Center personnel. Approximately 250 hours of staff time were used to obtain the random sample and verify contact information for families for the mail-out surveys and participant interviews. Scheduling interviews, completing background information, and interviewing individuals took approximately 1,400 hours of staff time. Entering family survey data and consumer interview data into the NCI database took approximately 180 hours of staff time. Postage cost for a Business Reply Permit and return postage cost were approximately $1,950. Travel costs to conduct 400 interviews were approximately $6,000.

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 cycling the mail surveys at lesser frequencies to provide time for OCDD to thoroughly assess the findings and implement strategic initiatives that could impact responses. The In-Person interview surveys should continue to be administered annually.

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 and Implementation 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:

    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 2017-2018

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**

Assistant Secretary: **Tanya M. McGee**

I. What outstanding accomplishments did your department achieve during the previous fiscal year? For each accomplishment, please discuss and explain:

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: Technology Upgrades within Behavioral Health Electronic Health Record

A. What was achieved?
In December 2013, Imperial Calcasieu purchased an electronic health record (EHR) to replace the utilization of paper records within the behavioral health division. The program purchased was ICANotes. Since that time, Imperial Calcasieu Human Services Authority (ImCal) has looked to implement some of the technological advances within the industry to incorporate more efficient and effective clinical processes and management of client case records. During this past year, ImCal worked to implement three new technological advances in the current ICANotes system. They include the

following: 1) implementation of text messages appointment reminders; 2) implementation of electronic prescribing which includes the utilization of e-scripts; and 3) integration with the Aegis software program which allows for the automatic upload of laboratory results into the ICANotes system.

B. Why is this success significant?
This success was significant for a number of reasons. The implementation of new processes and new technology within any system is a vast endeavor, especially over a large department/division. These changes were implemented across the entire Behavioral Health Division which included all four behavioral clinics in Allen, Beauregard, Calcasieu and Jefferson Davis Parishes. This accomplishment in enhanced technology directly affected over 2,800 clients and 40 behavioral health staff within ImCal.

C. Who benefits and how?
With the implementation of the text messages reminders, there is a noteworthy reduction in the workload of the administrative support staff who previously were tasked with calling clients individually to remind them of appointments. This also benefits the clients in that they are able to receive reminders via a method of communication they frequently utilize, and are less likely to miss their scheduled appointment. The implementation of e-prescribing benefits the prescribers, pharmacist and clients served. Electronic prescribing provides a time-efficient and proficient method for ensuring prescriptions are getting to both the in-house clinic pharmacy, as well as external pharmacies of the client's choosing. E-prescribing also provides a mechanism for documentation of prescriptions which can be monitored and audited, thus resulting in less risk for errors in prescribing. And finally, the integration with the Aegis software program allows for the automatic upload of laboratory results from urine drug screen collections into ImCal's EHR. This benefits staff, clients and the agency. Previously, results were faxed to the respective clinics and staff had to scan and upload into the system. This enhancement reduces the administrative burden on staff, reduces error rates in possible uploading into the incorrect case record and helps protect client confidentiality by eliminating the faxing of protected health information which is less secure than an automatic upload into the EHR.

D. How was the accomplishment achieved?
ImCal BH Division Director and IT Specialist worked closely with the programming department at ICANotes to devise a plan for successful transition of all three technological advancements. Each required technical adjustments within the system itself, as well as changes in policy and procedure in all the clinics. For each, an implementation plan was developed and communicated with programmers and staff. Each piece was piloted on a small scale prior to full implementation. Any deficiencies or issues were identified within the pilot and corrected prior to full implementation.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. Included in ImCal's overall mission, we strive to adhere to the principles of

effectiveness and efficiency and implement efforts to maximize all resources within our control.

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: Beauregard Behavioral Health Clinic Beautification Project

A. What was achieved?
The Beauregard Behavioral Health Clinic (BBHC) is housed within a state-owned building in Deridder. The building is old, in frequent need of repair, and aesthetically unappealing. Many needed improvements to the building were identified by the clinic director in order to improve safety for staff and clients. Some of these safety and repair projects included the following: install awnings on the back two entrances for staff in an effort to help prevent falls during a weather event, repair damaged and falling ceiling tiles throughout common areas in the building, repairs to two of the bathrooms within the building, repairs to the HVAC system, and add a stable walk path to a storage shed located behind the building. In addition to these much-needed repairs, the clinic manager requested additional projects to improve the look and function of the building. Some of those included full interior and exterior paint job, replacement of outdated lighting fixtures, removal of overgrown bushes in the front and back of the building, a check out window at reception, and new signage.

B. Why is this success significant?
This was significant because it reduced risk to injury for clients and staff. In addition, it created a much more aesthetically pleasing facility inside and outside. Research shows a more pleasant, more satisfied clinical session when the environment is pleasing to the eye. In addition, to continue to strive to collect more in self-generated revenue and recruit 3rd party insurance clients, ImCal has worked to brand themselves as a quality provider in the community and move away from the old, mundane state agency appearance.

C. Who benefits and how?
Over 500 clients served in the Beauregard BHC and ten staff now have a clean, safe and pleasant facility to work.

D. How was the accomplishment achieved?
The Clinic Manager submitted a request list of projects she and the BBHC staff decided were needed to improve the facility. The list was presented to Executive Management team for discussion, prioritization, and budget review. Projects were categorized into three groups: 1) critical/safety concern; 2) moderate need; and 3) not a need, but nice to have. A project plan was implemented which included assignment of tasks to maintenance staff, a bid process for the larger projects, timelines, budget and responsible party.

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: Administrative & Developmental Disability (DD) Divisions Move to New Location

A. What was achieved?
Since 1985, the Region V Office for Citizens with Developmental Disabilities (OCDD) and the Office for Behavioral Health (OBH) offices were located within leased space on 5th Avenue in Lake Charles. Not long after ImCal HSA assumed control of the Region V services, the building on 5th Avenue changed owners. Over the last several years, the new building owner did not dedicate resources to the building which was in major need of repair. Examples of problems within the leased building included a leaking roof which required clean up after a major rain event; uneven walkways and broken concrete in the parking lot which caused multiple staff accidents and falls; HVAC system which caught on fire at DD office; uncontrollable pest problem; overgrown landscaping; a broken fence behind the building; poor outdoor lighting and lack of responsiveness from maintenance crew. In addition, the location on 5th avenue became more unsafe and fraught with criminal activity including a forced break-in at the ImCal office, break-ins to staff vehicles and damage to ImCal fleet. After months of searching for affordable office space, ImCal signed a lease to move the Admin and DD office to the Capital One Tower located in downtown Lake Charles.

B. Why is this success significant?
This was significant because it required a move of 48 staff and close to 15,000 square feet of office space. In addition, the Lake Charles Behavioral Health Children and Youth Services location also moved off of 5th Avenue and back into the Lake Charles BH Adult Clinic on Kirkman Street.

C. Who benefits and how?
The staff and clients who frequent the Administrative and DD offices. The new location at the Tower is well-maintained, has covered garage parking, and 24 hour security. In addition, the Tower also houses the Region V Medicaid Office, the Region V Office of Aging and Adult Services, and the Medical Resource Group (MRG) which is the contracted Region V support coordination agency for DD waiver services. This co-location lends itself to improved communication and collaboration between the agencies as well as convenience for clients visiting multiple agencies in one day. In addition, the move of Lake Charles Children Services back into the main clinic was of

benefit to children and youth staff who now have on-site access to their colleagues for clinical back-up.

D. How was the accomplishment achieved?
ImCal HSA Executive Management Team (EMT) met with the Property Manager and Architect in early 2017 to design the buildout of the new office space which encompasses the entire 20th floor of the Tower. EMT created and implemented the Move to the Tower Plan which included projects and tasks focused on record retention and destruction, property inventory and purchase, IT buildout, and the actual logistical move which occurred in early December 2017.

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?

Imperial Calcasieu Human Services Authority (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 abide by all State and Federal guidelines.

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

- **Where are you making significant progress?** If you are making no significant progress, state "None."

  None.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

  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 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?
   Imperial Calcasieu Human Services Authority (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.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   Not at this time

3. What organizational unit in the department is experiencing the problem or issue?
   The Behavioral Health Division within ImCal HSA.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   The individuals served by ImCal are affected by waiting lists to access services.

5. How long has the problem or issue existed?
   Since ImCal's inception.

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

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   The agency will possibly struggle in filling vacancies and providing needed services to the community.

B. Corrective Actions

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

☒ **Internal audit**
The ImCal 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.

LDH 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 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 Services (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)**

ImCal coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis. Explanatory Notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made to management if modifications or additions are needed.

☒ **In-house performance accountability system or process**
ImCal reviews all objectives, performance indicators and strategies and recommendations are made if modifications or additions are needed. Also, at the close of a fiscal year, agencies and programs review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, as well as agency and program management department-wide.

☐ Benchmarking for Best Management Practices
☐ Performance-based contracting (including contract monitoring)

☒ **Peer review**

☒ **Accreditation review**

☒ **Customer/stakeholder feedback**

☐ Other (please specify):

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

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

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

1. Title of Report or Program Evaluation:
   Louisiana State Civil Service Drop-in Review

2. Date completed:
   September 20, 2017

3. Subject or purpose and reason for initiation of the analysis or evaluation
   The mandated Civil Service Audit occurs every 2 years, and the Drop in Review is conducted within the alternating year within that 2 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:
   One recommendation was to create a procedure to ensure new hires are entered into LA Careers within 30 days of hire.

8. Action taken in response to the report or evaluation:
   Human Resource staff reviewed policy and procedures related to the appropriate documentation of qualifications of new hires, and implemented a check list to be completed for each personnel action.

9. Availability (hard copy, electronic file, website):
   Electronic file available upon request.

10. Contact person for more information,
    Name: Sheryl Meek
    Title: LDH Monitor, Corporate Compliance Officer
    Agency & Program: ImCal HSA
    Telephone: 337.475.3100
    E-mail: sheryl.meek@la.gov

1. Title of Report or Program Evaluation:
   Office of Risk Management (ORM)

2. Date completed:
   March 5, 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Mandated Safety Audit conducted by ORM/Sedgwick

4. Methodology used for analysis or evaluation:
   Review of policy and procedures, safety manuals, inspection certificates, safety training logs, incident reports, and a walk-through of all ImCal sites.

5. Cost (allocation of in-house resources or purchase price):
   There was no cost to ImCal.

6. Major Findings and Conclusions:

ImCal Administration scored: 94.36% Compliance
Behavioral Health: 95.55% Compliance
DD: 90.51% Compliance

7. Major Recommendations:
   Two recommendations were noted:
   1) Ensure a signed and dated driver list of either approved or unapproved drivers verified by Official Driver Records is available.
   2) Ensure DA 2054 forms that have been signed and dated annually are available on all authorized drivers.

8. Action taken in response to the report or evaluation:
   Administration, Corporate Compliance and Safety staff reviewed policy and procedures and implemented checklists to ensure compliance with recommendations.

9. Availability (hard copy, electronic file, website):
   Electronic file available upon request.

10. Contact person for more information:
    Name: Sheryl Meek
    Title: LDH Monitor, Corporate Compliance Officer
    Agency & Program: ImCal HSA
    Telephone: 337.475.3100
    E-mail: sheryl.meek@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2017-2018

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?

<u>Accomplishment #1: Sustained Increase in Self-Generated Revenue:</u>

A. What was achieved?
Central Louisiana Human Services District (CLHSD) was able to generate over $1.1M for the second straight year.

B. Why is this success significant?
This is significant because it demonstrates that the strategies we implemented in 2016-2017 were effective and produced reliable self-generated revenue.

C. Who benefits and how?
The State of Louisiana, LDH, and the District benefit because it eases the burden on the state general fund revenues at all three levels. It also helps the District absorb potential budget reductions without having to reduce services, which benefits our clients.

D. How was the accomplishment achieved?
1) Medicaid expansion resulting in approximately 600 additional covered clients.
2) Credentialing with both Medicaid and non-Medicaid health plans and additional Medicare plans, and attempts to align clinicians with health plans which they are credentialed to receive reimbursement.
3) Allocating sufficient resources by reassigning existing resources and converting vacant positions to create accounting positions to create a billing department.
4) Improved proficiency of clinic staff (schedulers and fee assessors) through training and specific issue resolution.
5) Improved production of clinical staff by conducting performance audits and addressing production with individual clinicians.
6) Substantial decrease in denial/rejection of claims by reducing the claims error rates through training.
7) Numerous changes to the electronic health record (EHR) and training of staff to improve efficiency and decrease coding errors.
8) Targeted scheduling interventions to reduce "no-show" rate.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Certainly. The strategic plan that was created for the District, was done at the time the District actually transitioned from a Region to a District. The District has completed the transition and is moving forward in its new incarnation. Thus, the strategic plan was revised. However, self-generated revenue and the need to produce it and increase it will always be a vital part 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?
I am not certain that this methodology, in and of itself, is a Best Management Practice, but it certainly illustrates the need to employ a multi-faceted approach to such a complex issue very well (organizationally and individually; internally and externally; administratively and clinically).

<u>Accomplishment #2: Increasing Public Awareness of the District and its Services:</u>

A. What was achieved?
The public's awareness of the District and its services has improved.

B. Why is this success significant?
This is significant because the identity of the three separate systems (OMH, OAD, OCDD) providing services to the Region became unclear when it transitioned to and became the District, coupled with contractors providing services for the District that the

Region used to provide itself. The integration requires the three service delivery systems to re-identify themselves to the public and to assure the public that the District is still what they previously knew the Region to be.

C. Who benefits and how?
The State of Louisiana, LDH, the District, and all of the citizens needing services provided by the District, both within the eight-parish District and statewide (residential addictive disorders treatment for adolescents and adults).

D. How was the accomplishment achieved?
1) The position created last fiscal year was filled and according to the strategic marketing plan, our staff were able to meet individually with 137 people in five parishes and another 234 people in group/event settings in all eight parishes.
2) Ongoing participation at the eight parish monthly Healthy Initiatives Coalition meetings.
3) Display booths at and participation in periodic conferences/events (e.g. Health Disparities Forum, Out of the Darkness Walk, Town Hall Meetings, REC2U, Good Food Project, etc.).
4) Television Media- District staff appear on morning news programs such as Early Jam and Jambalaya to provide information and educate.
5) Social Media- the District created a Facebook page and routinely posts about its services and community events. The CLHSD Facebook page has reached 73,167 people (23% of the total population for CLHSD) with 187 posts, with 306 people following us.
6) Website- the District did not have a website, so we created one. The website lists all of the Board members and Administrative staff, all of the clinic locations and services offered with contact information, all of the contracted services provided and the locations and contact information, all of the Healthy Initiatives Coalition meetings, and all of the community events occurring each month in all 8 parishes, along with website links to local and state organizations/agencies.
7) Community partnerships/linkages- the District has partnered with the courts through Mental Health Court, law enforcement through Crisis Intervention Training (CIT), the university (LSUA) through service delivery to the students, United Way, Volunteers of America, The Extra Mile, Tulane University Medical School, and several others.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Certainly. The more people know about the District and its services, the more likely we will be able to meet their needs.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
I am not certain that this methodology, in and of itself, is a Best Management Practice, but it certainly illustrates the need to employ a multi-faceted approach to such a complex issue very well (organizationally and individually; internally and externally;

administratively).

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.

The strategic plan that was created for the District, was done at the time the District actually transitioned from a Region to a District. The District has completed the transition and is moving forward in its new incarnation. When I began as Executive Director last year, the AMPAR was due a couple of weeks later, thus I did not have sufficient time to do everything necessary to revise/update the strategic plan. However, since last year I began implementing what I knew would be a part of the strategic plan (Accomplishment 1 and 2 above) and developed an updated strategic plan.

The updated/revised strategic plan consists of the following:

1) Increasing self-generated revenue.
2) Increasing public awareness and becoming a community leader.
3) Acquiring a better electronic health record that is a combination product (i.e. health record and payment management system in one).
4) Continue to expand credentialing with health plans.
5) Acquiring office space sufficient to house our Pineville clinic operations, Developmental Disabilities operations, and our Administrative operations under one roof.
6) Reviewing all contracts and services provided to determine if the service fits well within the framework and function of the District or if there would be a better fit with another service.
7) Establishing relationships with community institutions/agencies that are aligned with the District's mission/goals/objectives, in order to better meet the needs of the community.
8) Revising all contracts (formatting, language and content- statement of work, deliverables, performance indicators/measures), so as to be clear enough for all vendors to understand exactly what is expected of them, and to remove any ambiguity on the part of the contract monitors, so that they know exactly what the vendors are and are not required to do. In addition, contract monitoring forms will be developed which exactly mirror the statement of work, deliverables, and performance indicators/measures.
9) Preparing for site visits and surveys.
10) Ensuring that the District's Board composition and Developmental Disabilities funding meets the requirements of Act 73 of the 2017 Regular Legislative Session.
11) Expand Prevention programs.

◆ **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?

The overall timeliness and progress toward accomplishment of the strategic plan objectives and goals is ahead of schedule in some areas (e.g. self-generated revenue, improving morale, and expanded credentialing with health plans), right on track in other areas (e.g. increasing public awareness and becoming a community leader, acquiring a better electronic health record that is a combination product, reviewing all contracts and services provided to determine if the service fits well within the framework and function of the District or if there would be a better fit with another service, establishing relationships with community institutions/agencies that are aligned with the District's mission/goals/objectives in order to better meet the needs of the community, preparing for site visits and surveys, and ensuring that the District's Board composition and Developmental Disabilities funding meets the requirements of Act 73 of the 2017 Regular Legislative Session, acquiring office space sufficient to house our Pineville clinic operations, Developmental Disabilities operations, and our Administrative operations under one roof), and the remaining component (revising all contracts) of the strategic plan continues to be a work in progress. Expanding Prevention programs will be undertaken this fiscal year.

The strategies employed are achieving exactly what was intended and the returns are being realized.

- **Where are you making significant progress?** If you are making no significant progress, state "None."

  We are very close to implementing the new electronic health record, which, in and of itself, is a major accomplishment. It has taken great sustained effort to get to this point and once implemented, it should positively improve our self-generated revenue, as it has real-time insurance verification, insurance card scanners and auto-population features, credit card transaction terminals for copays, deductibles, and self/private payments, e-prescribing, in addition to being its own billing clearinghouse. Lastly, we have signed a lease on a building which will house all of our operations located in Alexandria (Pineville Clinic, Administration, and Developmental Disabilities). This new location is in a prime area of town, where new developments are occurring constantly, which will still be a prime area 30 years from now. The new location is on the bus route of a major thoroughfare, which will make access much easier for our clients. The new location will also make us more appealing to those with private insurance and allow us to compete with the existing private providers, thereby increasing our potential to raise self-generated revenue.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None."

  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 strategic plan has been updated/revised as stated above.

- **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 employs an Executive Management Team (EMT) and 11 Workgroups to identify issues/needs/requirements/regulations that need to be addressed and these discussions include whether or not the issue/need/requirement/regulation needs to be included in the strategic plan. The EMT serves to coordinate the strategic plan components relevant to their department and the Workgroups serve to implement the strategic plan within and across departments.

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.

Nothing significant to report.

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

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

B. Corrective Actions

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

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

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

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

5. Do corrective actions carry a cost?

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

the upcoming fiscal year or in previous department budget requests?

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

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

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

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

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

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

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

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the

Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory Notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed.

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

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

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

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

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:
   Legislative Auditor's Procedural Report

2. Date completed:
   July 5, 2018

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Bi-annual review
4. Methodology used for analysis or evaluation:
   Legislative audit guidelines

5. Cost (allocation of in-house resources or purchase price):
   Varies from fiscal year to fiscal year. FY18 $11,565; FY19 $16,408

6. Major Findings and Conclusions:
   a. Inadequate Internal Controls
   b. Electronic health record staff permissions
   c. Health insurance credentialing, prior-authorization, claims write-offs
   d. Sub-recipient vs. Vendor designations

7. Major Recommendations:
   a. Reconcile bank statements monthly; delegate CFO duties; Deposit self-generated revenue monthly
   b. Remove certain staff permissions
   c. Become credentialed with additional health plans or discontinue serving clients whose health plan has not credentialed us, assign staff to clients whose health plan credentials them and will reimburse us for services provided; Discontinue providing intensive outpatient services prior to receiving health insurance authorization; process write-offs according to policy and procedure.
   d. Make sub-recipient or vendor determinations and follow policy and procedure for each.

8. Action taken in response to the report or evaluation:
   a. All bank statements reconciled; delegated CFO duties; implemented policy and procedure to ensure deposits are made monthly.
   b. Removed staff permissions from electronic health record.
   c. Providing notice to clients of certain health plans that we are not credentialed with their health plan and giving them 60 days to secure a new provider who is credentialed with their health plan; Instructed staff schedulers to assign clients to staff clinicians that are credentialed with the clients health plan when possible; Instructed staff to serve clients at the level of outpatient treatment until the authorization for intensive outpatient treatment is received; Implemented a write-off policy and procedure.
   d. Completed sub-recipient/vendor checklist for all contracts.

9. Availability (hard copy, electronic file, website):
   www.lla.la.gov

10. Contact person for more information:
    Name: Michael R. DeCaire, Ph.D.
    Title: Executive Director
    Agency & Program: Central Louisiana Human Services District
    Telephone: 318-487-5081
    E-mail: Michael.Decaire@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2017-2018

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?

Accomplishment #1: Bienville Community Coalition (BCC):

A. What was achieved?
Both underage alcohol use and prescription drug use in Bienville parish were decreased by effectively implementing the Louisiana Partnerships for Success (LaPFS) grant. Education achievements included hosting a state-wide youth conference called the Louisiana Youth Leadership Initiative which spanned two days and provided prevention and leadership training to 300 high school students from across the state as well as 100 of their adult sponsors. Prevention achievements included implementing "Project Medicine Drop," an initiative which involved installing prescription drop boxes in two Bienville Parish Sheriff's Department locations so that residents could have a safe and

easy way to dispose of unused and expired medications. This prevention initiative greatly decreases the chances of youth accessing these medications and serves to prevent accidental overdoses.

B. Why is this success significant?
Bienville was the parish in our service area with the highest rate of underage drinking and prescription drug misuse/abuse as well as an area with a serious lack of local resources to address such issues. BCC established a wealth of parish-wide resources that were effective in significantly reducing both underage drinking and prescription druse misuse/abuse within the community.

C. Who benefits and how?
The focus was on improving the lives of youth and young adults, so they were the primary beneficiaries of the coalition. The parish benefited by seeing higher graduation rates, less crime, and a healthier community. An added benefit is the confidence the community has in their ability to effect a positive change in their youth going forward.

D. How was the accomplishment achieved?
By collecting and analyzing data at the community level, creating a logic model and action plan detailing evidence-based practices, policies, and programs specific to problems indicated by the data, then effectively implementing the action plan. We must point out that the key to our success was the hiring of a very dynamic leader with the skills and passion to develop, implement and see to fruition the success of the grant.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. Community outreach and use of grant funds are specific aspects of our strategic plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
This grant was a pilot project in one parish of each of the 10 local governing entities, so its infrastructure has already been shared with all relevant agencies. What makes the Bienville Community Coalition an outstanding accomplishment is how well the grant was operationalized in our area and the significant results that were generated.

<u>Accomplishment #2: Internet Technology (IT) Security and Network Stabilization:</u>

A. What was achieved?
Northwest La. Human Services District dramatically improved the security of clinical records from ransomware and other cyber-attacks through the purchase of updated servers and firewall software. We also significantly improved network stabilization through the replacement of older routers, desktops, and laptops.

B. Why is this success significant?
The risk of cyber-attacks and domain failure is very high when using older servers,

outdated firewall software, and old operating systems. This is especially problematic when the security of medical records for our mental health and addiction clients are at risk. An independent, third-party IT System Administrator performed a risk assessment of our domain and assisted in implementing the changes necessary to harden and stabilize the network.

C. Who benefits and how?
The primary beneficiaries are our mental health and addiction clients. Their records are much more secure and our ability to serve them is greatly enhanced by a more stable network.

D. How was the accomplishment achieved?
One-time funds were identified and used to fund the IT risk assessment and the recommended network improvements.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. The effective use of an electronic medical record (EMR) in treating clients and the reporting of electronic data to the Office of Behavioral Health Databank are two key aspects of our strategic plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No. Not all departments or agencies are responsible for the security and operation of electronic medical records, so they may not need the same level of IT security and network stabilization as we do.

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?

  Progress was made in the last six months of the fiscal year to accomplish annual goals and objectives. We believe anticipated returns on investment were realized.

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

No significant progress was made this fiscal year. However, we were able to catch up and meet our annual goals and objectives in the last half of the fiscal year

- **Where are you experiencing a significant lack of progress?** If you are experiencing No significant lack of progress, state "None."

  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?

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

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

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

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

   5. Do corrective actions carry a cost?

      ☐ No. If not, please explain.
      ☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital

resources—people, budget, physical plant and equipment, and supplies.)
Please discuss the following:

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

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

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

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

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

effectiveness, and operation of state programs and activities.

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

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

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

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

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

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

☐ Peer review

☒ **Accreditation review**
Northwest Louisiana Human Services District (NLHSD) currently operates under a 3-Year CARF (Commission on Accreditation of Rehabilitation Facilities) Accreditation. This accreditation includes an annual conformance review process.

☒ Customer/stakeholder feedback
Northwest Louisiana Human Services District **(**NLHSD**)** solicits input from LaPAS and C'est Bon surveys, comments on the NLHSD website, oral 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: