Jeff Landry
GOVERNOR

Michael Harrington, MBA, MA
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

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

FROM: Drew Maranto
LDH Undersecretary

RE: FY 2024 Annual Management and Program Analysis Report (AMPAR)

DATE: December 4, 2024

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 2024 fiscal year. These reports summarize the activities of each LDH agency as it relates to management and program analysis, outstanding accomplishments, areas where we are making significant progress, and any specific management or operational issues that may exist.

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

09-300	Jefferson Parish Human Services Authority
09-301	Florida Parishes Human Services Authority
09-302	Capital Area Human Services District
09-303	Developmental Disabilities Council
09-304	Metropolitan Human Services District
09-305 & 306	Medical Vendor Administration & Medical Vendor Payments
09-307	Office of the Secretary
09-309	South Central Louisiana Human Services Authority
09-310	Northeast Delta Human Services Authority
09-320	Office of Aging & Adult Services (OAAS)
09-324	Louisiana Emergency Response Network Board (LERN)
09-325	Acadiana Area Human Services District
09-326	Office of Public Health (OPH)
09-330	Office of Behavioral Health (OBH)
09-340	Office for Citizens with Developmental Disabilities (OCDD)
09-350	Office of Women's Health & Community Health
09-375	Imperial Calcasieu Human Services Authority
09-376	Central Louisiana Human Services District
09-377	Northwest Louisiana Human Services District

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department:	Louisiana Department of Health (LDH) 09-300 Jefferson Parish Human Services Authority
Department Head:	Michael Harrington, MBA, MA LDH Secretary
Undersecretary:	Drew Maranto
Executive Director:	Rosanna DiChiro Derbes, PsyD

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: Support for Adolescents with Intellectual and Developmental Disabilities during the Transition into Adulthood

A. What was achieved?

During FY24, Jefferson Parish Human Services Authority's (JPHSA's) Developmental Disabilities Community Services division, through collaboration with local stakeholders: Louisiana Rehabilitation Services (LRS), Families Helping Families (FHF), and Jefferson Parish School System (JPSS), worked with students with

intellectual impairments: autism, and other developmental disabilities as they prepared to transition from high school (i.e., secondary education). The effort sought to help address some of the challenges faced during the transition into adulthood with a focus on maintaining structured activities that can be lost after leaving secondary education by promoting and providing resources toward continued education, volunteerism, vocational training, employment, or day habilitation program that included community integration.

B. Why is this success significant?

This collaboration helps bridge the gap by providing resources and structured support, which can lead to better outcomes in employment, education, and community involvement. By offering resources, guidance, and services, individuals we support can enhance independence and quality of life to navigate new experiences while reducing the anxiety that may be experienced during this life transition.

C. Who benefits and how?

Individuals with intellectual impairments, autism, and other developmental disabilities, their families and caregivers, prospective employers, educational institutions, and the community.

D. How was the accomplishment achieved?

JPHSA collaborated with local stakeholders (LRS, FHF, and JPSS) who are experts in areas that play a significant role in this transition into adulthood. Together, we meet with adolescents and their families who are currently in school but expect to transition in the next three years to provide education, guidance, and resources and develop a plan based on their personal goals and desires for the future.

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

Yes, JPHSA's collaboration and partnership with our stakeholders in providing services in the community furthers our mission to help residents living in Jefferson Parish lead full, healthy, independent, and productive lives; thereby advancing the support of the sustainability of resources through the implementation of evidence-based and promising practices, which is the first goal of our strategic plan.

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

Yes, providing structured transition services is a best practice recognized in the fields of education and developmental disabilities. Key components of transition services highlighted in our efforts include individualized or person-centered planning, collaboration, ongoing support, and skill development.

Accomplishment #2: Behavioral Health Community Care Center (BHCC), Eunoia Center, Operating 24/7 As Part of Louisiana's Crisis Services System

A. What was achieved?

JPHSA's Behavioral Health Community Care Center (BHCC), named Eunoia Center- an in-person crisis respite/crisis de-escalation program designed to reduce hospitalizations, began operating 24/7 as part of Louisiana's Crisis Services System in April 2024.

B. Why is this success significant?

Over the last several years, the Office of Behavioral Health (OBH) has worked to finalize the service design associated with a crisis system of care that is modern, innovative and coordinated. JPHSA has been part of this initiative since the very beginning, implementing 3 out of the 4 crisis services under this system (Mobile Crisis Response, BHCC, and Community Brief Crisis Supports). Specific to BHCC, JPHSA worked diligently to open the Eunoia Center even before OBH's system went LIVE. The vision for the Center was The Living Room in Illinois. Starting in 2018, JPHSA leadership worked with OBH, Managed Care Organizations, Health Standards and Jefferson Parish leadership to finally open The Eunoia Center in March 2021. Since then, JPHSA worked to increase referrals to Eunoia Center, and went 24/7 operations in April of 2024. There is nothing else like it in Jefferson Parish, and there is only one other 24/7 center in Louisiana.

C. Who benefits and how?

The entire community benefits, residents and stakeholders.

D. How was the accomplishment achieved?

One time funding from Office of Behavioral Health allowed expansion to 24/7, as well as the diligent and relentless work of JPHSA staff (both program and operations).

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

Yes, a 24/7 BHCC addressing crises for all individuals, in person, at all times of day or night furthers our mission to help residents living in Jefferson Parish lead full, healthy, independent, and productive lives; thereby advancing the support of the sustainability of resources through the implementation of evidence-based and promising practices, which is the first goal of our strategic plan.

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

Yes, this is a Best Practice model used in other states.

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

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

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

Throughout Fiscal Year 2023-2024 JPHSA remained on target for its stated Strategic Plan Goals and Objectives. Strategies outlined in the Strategic Plan continued to be effective and were strengthened by a strong commitment to continuous Performance and Quality Improvement throughout every division and program within the agency.

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

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

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

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

JPHSA made progress toward reaching this goal in Fiscal Year 2023- 2024. As discussed above, JPHSA initiated collaborative programs in its Developmental Disabilities Community Services Division to ensure prompt, effective, and continued care and services for individuals in need; and, expanded a best practice to better serve the needs of the community in its Behavioral Health Community Services Division. JPHSA was able to maintain resources and utilized external resources to extend its reach.

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

JPHSA made progress toward reaching this goal in Fiscal Year 2023-2024.

Please note in particular:

- Throughout Fiscal Year 2023-2024, JPHSA used brand management as a recruitment tool.

- Throughout Fiscal Year 2023-2024, JPHSA continued to use online job postings for certain hard-to-fill positions beyond the State Civil Service website and its own website by recruiting on external websites including Indeed, LinkedIn, Facebook, and Handshake. Other recruitment efforts included advertising with professional networks, such as the local Behavioral Health Taskforce, attendance at career fairs, outreach events, and collaborating with local colleges and universities.

- Throughout Fiscal Year 2023-2024, JPHSA's Executive Management Team monitored staff member retention rates and ensured all staff members received appropriate monitoring, supervision, and development by launching an on-going Supervisor Leadership series. Topics included 'Setting and Communication Expectations' and 'Staff Development and Supervision Guidelines'.

- Throughout Fiscal Year 2023-2024, JPHSA continued to utilize an intensive first thirty-day orientation for new staff members as a tool to ensure up-front investment and engagement with JPHSA practices and policies.

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

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

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

JPHSA is not experiencing a significant lack of progress.

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

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

☒ No. If not, why not?

Jefferson Parish Human Services Authority (JPHSA) did not submit a revised Strategic Plan for this Fiscal Year and continues to make strides to reach its current goals.

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

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

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

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

Additionally, the JPHSA PQI Committee works with the Executive Management Team to develop, adopt, and implement cross-divisional PQI Initiatives to further support

Mission, Priorities, and achievement of the Strategic Plan. The PQI Committee incorporates input from all levels and areas of the organization through its diverse membership. Every JPHSA staff member is designated as a Full or Ad-Hoc Committee member.

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

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

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

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

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

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

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as

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

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

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**
Jefferson Parish Human Services Authority's (JPHSA's) Compliance & Performance Support (CPS) Division provides ongoing monitoring of service delivery, business, and administrative functions as well as staff development and supervision activities. Audit tools with identified criteria and standards are utilized; results are reported; and appropriate Performance and Quality Improvement and/or corrective actions are implemented. Further, the CPS

Division audits JPHSA performance using benchmarks set forth in Council on Accreditation standards and in adherence to federal, state, and local laws and regulations. Improvement and/or corrective action plans are developed and executed as needed. The Division monitors progress on plan implementation as well.

Each JPHSA Division establishes an annual plan containing measurable outcomes in support of the Strategic Plan. Outcomes are tracked and reported on a quarterly basis. JPHSA's Finance Operations division provides ongoing monitoring of JPHSA resources using standard accounting practices. Further, a fiscal monitor is assigned to each Division for ongoing monitoring of both budgets as well as grants and contracts, using standard accounting practices, and in the case of grants and contracts, the scope of work and deliverables as well as budgets. On-site monitoring of contractors is standard operating procedure with improvement or corrective action initiated as a need is identified.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
JPHSA goes through an annual audit through the Office of the Legislative Auditor. The Fiscal Year 2023-2024 audit is preparing to start as of the time of this writing. The FY 22-23 audit had no findings.

The Louisiana Department of Health's Office of Behavioral Health (OBH) and Office for Citizens with Developmental Disabilities (OCDD) audit JPHSA as set forth in the Accountability Plan, i.e. ongoing data reporting, annual peer review, and annual on-site audit. The OCDD and OBH Fiscal Year 2023-2024 audits were conducted during the Fiscal Year, with JPHSA receiving no findings or recommendations.

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

☒ 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, in conjunction with the Compliance Officer and JPHSA's General Counsel, has overall responsibility for ensuring legal and regulatory compliance. The Executive Management Team, under the direction of the Executive Director, is responsible for short- and long-term planning. The Executive Director informs and seeks consultation from the JPHSA Board of Directors as appropriate and according to Board policy and the Policy Governance Model. The Executive Director provides the Board with monitoring reports as specified in Board policy. The PQI Committee, a chartered committee chaired by the CPS Quality Improvement Specialist, is responsible for the review and update of JPHSA's PQI Plan (with feedback from the Executive

Management Team and key staff and stakeholders), and for the collaborative development and ongoing monitoring of JPHSA PQI Initiatives. All staff members complete annual PQI training. Further, in compliance with Council on Accreditation standards, JPHSA has a variety of time-limited work groups in place at all times.

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

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

☐ Program evaluation by contract

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

☒ **In-house performance accountability system or process**
JPHSA utilizes the following to model its performance accountability process: Council on Accreditation Standards and Rating System; JPHSA Staff Development & Supervision Guidelines in conjunction with the Louisiana Department of State Civil Service Performance Evaluation System; JPHSA's PQI Plan in conjunction with PQI Initiatives; JPHSA's legal and regulatory compliance in conjunction with applicable federal and state laws and regulations; ongoing internal monitoring with appropriate follow-up activity inclusive of the EBP fidelity monitoring; and, ongoing data collection, mining, and analysis for decision support.

☒ **Benchmarking for Best Management Practices**
Developmental Disabilities services data is obtained through the Office for Citizens with Developmental Disabilities software. Comparative studies are enabled through other Local Governing Entities reporting into the LaPAS system as well as through benchmarking against national standards for evidence-based and best practices (Multi-Systemic Treatment, Functional Family Therapy, First Episode Psychosis Navigate Model, various Prevention programming, Assertive Community Treatment, Supported Employment etc). 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
JPHSA is paired with another LGE yearly to complete the Peer Review process.

☒ Accreditation review
JPHSA is fully accredited by the Council on Accreditation (COA). In Fiscal Year 2023-2024, JPHSA was awarded a four-year reaccreditation, the longest COA grants, without any findings or recommendations. JPHSA's next reaccreditation cycle will begin in Fiscal Year 2025-2026 with a reaccreditation deadline of February 29, 2028.

☒ Customer/stakeholder feedback
JPHSA fields the Telesage Quality of Care Survey within its Health Centers on an ongoing basis. JPHSA also participates in the C'est Bon survey yearly with the Office of Behavioral Health. JPHSA invites confidential feedback on its internet site and offers service recipients and their families the means of expressing their view of services received and/or other interactions with JPHSA. This feedback is received and processed by JPHSA's Quality Improvement

Specialist, who ensures a response is provided to the individual who gave the feedback within prescribed timelines, and tracks data for use in developing internal Performance and Quality Improvement initiatives. JPHSA requires contractors delivering community-based behavioral health services to field satisfaction surveys with their service recipients and to share results with JPHSA. Staff members also have access to this same feedback process. The members of the Board of Directors, per the Policy Governance Model, actively engage in "community linkages" and report the outcomes of these community stakeholder interactions during each Board meeting. Additional feedback is obtained through active participation in the monthly Jefferson Parish Behavioral Health Task Force meetings and in the quarterly Regional Advisory Committee meetings for Behavioral Health and Developmental Disabilities. JPHSA also participates on the Jefferson Parish Children and Youth Planning Board.

☐ Other (please specify):

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

☐ Yes. Proceed to Section C below.

☒ No Skip Section C below.

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

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

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

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

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

Executive Director: Richard Kramer

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

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

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

Accomplishment #1: Certified Community Behavioral Health Clinic (CCBHC) Grant

A. What was achieved?
Florida Parishes Human Services Authority (FPHSA) applied for and received a federal grant from Substance Abuse Mental Health Services Administration (SAMHSA) of $1M per year for four years to become a CCBHC and meet the associated federal requirements.

B. Why is this success significant?
A Certified Community Behavioral Health Clinic (CCBHC) is the gold standard best practice for community behavioral health care. It requires provision of 9 core services

and improves outcomes for those engaged in services. Additionally, the model represents a more effective and efficient funding mechanism for providing community behavioral healthcare once the state system to support the model is complete.

C. Who benefits and how?
The clients served by the improved programs as well as their families and community at large. Taxpayers benefit through the improved funding mechanism so that their dollars are spent more wisely to achieve better outcomes.

D. How was the accomplishment achieved?
FPHSA recognized the opportunity to apply for this grant and submitted a successful application.

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. Three other LGEs are already participating in the same program and the others are encouraged to do so.

Accomplishment #2: Implementation mobile outreach clinics with mobile unit

A. What was achieved?
Florida Parishes Human Services Authority (FPHSA) began deploying its mobile unit to remote areas that are underserved by brick and mortar (physical) clinics.

B. Why is this success significant?
Many of the individuals served in our clinics are income constrained and lack easy access to transportation. Providing services nearer to their communities increases their access to care and improves outcomes.

C. Who benefits and how?
The clients served, their families and the community at large. Also, taxpayers as studies have shown that access to care improves outcomes and prevent more costly care and other expenses related to the lack of care.

D. How was the accomplishment achieved?
Grant dollars were used to purchase the mobile unit and exiting resources were redistributed to support the mobile clinics.

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

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. This is a best practice that should be replicated where appropriate and possible.

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

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

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

Yes. Recruiting and retaining has improved overall but it remains difficult for therapists. Vacancies in these positions continue to impact the number of people we can serve in our clinics on any given day. There is more need in the community than we have resource to deliver so each day is about triaging and prioritizing to try and make the most difference we can.

- **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:

Great progress has been made in treating opioid use disorder with medically assisted treatment. Providers and the community at large are more readily accepting that this is the critical first line treatment for this disease.

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

The success is due to ongoing education of current staff and recruiting of staff who have

the background and interest in providing this service.

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

It is hoped that the pace for this improvement will continue to grow until we are able to make a bigger dent in this epidemic.

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

  None.

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

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

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

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

  ☒ No. If not, why not?

  We believe the strategic plan is still on track and accurate. There is not yet reason to make significant changes. Of course, or internal plans change daily to respond to any lack of progress, or other obstacles, but the overall plan remains valid.

- **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 strategic plan guides all management decisions and is supported by the leadership team and the Board of Directors.

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

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

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

Issue #1: Staffing

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   The biggest problem continues to be a lack of resources ad related to staffing.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   To the extent that we cannot serve as many people as we otherwise could, yes, but the overall goals are still appropriate but just at a reduced capacity.

3. What organizational unit in the department is experiencing the problem or issue?
   Primarily in outpatient behavioral health clinics.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   People seeking services from us may see longer wait times before appointments.

5. How long has the problem or issue existed?
   The problem has existed for many years but was exacerbated by the trouble across all sectors following COVID-19. It has improved some in the past year but is still

problematic.

6. What are the causes of the problem or issue? How do you know?
   There is an overall shortage in the state for the types of licensed providers we need and our rate of pay is not as competitive as we'd like in order to be able to attract more applicants.

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

B. Corrective Actions

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

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

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

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

4. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?

      We intend to have our proposal to Civil Service this fiscal year.

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

      The Department of Civil Service has made some pay scale changes already which provide some relief but does not go far enough for all positions.

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

5. Do corrective actions carry a cost?

☐ No. If not, please explain.

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

a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.

Unknown as of yet. This is being explored as a part of the process to request new rates.

b. How much has been expended so far?

N/A

c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

Possibly, but this can't be answered until further work has been done.

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

N/A, this can't be answered until further work has been done.

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

Florida Parishes Human Services Authority **(**FPHSA**)** has a robust set of audit activities that is intended to identify, analyze, and resolve issues. FPHSA's audit findings feed into continuous quality improvement goals, objectives and actions that is intended to provide on-going and current measurement of program efficiency and effectiveness. Corrective action plans are used when trends are identified that if not checked in real time, would lead to loss of efficiency and effectiveness.

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

☒ **Internal audit**
All FPHSA programs conduct internal departmental audits that are intended to monitor performance and provide continuous support that outcomes are as intended. Internal audits provide the leadership team with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

One example of the use of internal monitoring activities is that FPHSA's Behavioral Health and Development Disabilities Services conduct quarterly audits that result in quality enhancement/improvement plans that address deficiencies. Audit findings afford FPHSA the opportunity to monitor for trends and evaluate program efficacy as well as implement corrective actions, in real time.

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

State of LA Civil Service, Office of Risk Management, LDH, Office of the Legislative Auditor, and the Healthy Louisiana Medicaid Plans are among those who conduct audits and reviews of FPHSA's processes, procedures and services. Corrective actions are devised and implemented in response to deficiencies. External audits may also be performed by other cohorts with whom FPHSA contracts for service delivery, such as Functional Family Therapy and the Courts. (See some examples captured below.)
There are also audits and monitoring reviews conducted on behalf of the Centers for Medicare & Medicaid (CMS,) LDH, and other credentialing 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)**
FPHSA participates in all required Louisiana Performance Accountability monitoring. This includes the compilation of reports of performance data such as data used by LDH's Division of Planning and Budget, which coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided

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

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

FPHSA conducts in-house performance based monitoring activities that align with LDH's performance based accountability monitoring activities. Internal monitoring includes, but is not limited to strategic planning, operational planning, and self-monitoring using the same monitoring tools that the State uses to conduct its monitoring

.☒ **Benchmarking for Best Management Practices**

FPHSA uses benchmarks set forth by LDH to set performance goals and objectives. 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 other providers involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary if modifications or additions are needed. Recommendations are passed on the FPHSA as required.

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

FPHSA uses funder descriptions to structure any sub-contractors in order to support LDH's goals and objectives. LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan. Subsequently, these are also required by FPHSA or any provider subcontracting with FPHSA.

☒ Peer reviews were not completed for FY 2024.

☒ Accreditation review (CARF)

☒ Customer/stakeholder feedback (Court, FFT, LLC.)

☐ Other (please specify):

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

☒ Yes. Proceed to Section C below.

☐ No Skip Section C below.

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

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

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

2. Date completed:
   Q1 – 10/27/23, Q2 – 1/29/2024, Q3 – 4/29/2024, Q4 – 8/12/2024

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

4. Methodology used for analysis or evaluation:
   The monitoring goal is verification of Performance Measures and Quality Management Initiatives for Developmental Disabilities Services through records reviews. Monitoring occurs on an annual basis for performance indicators shown in the outcome measures in Section II: D of the Human Services Accountability Plan (AP) as agreed by the Office for Citizens with Developmental Disabilities (OCDD) and the Human Service Interagency Council (HSIC). Records are also reviewed for your Systems Entry Program, Individual and Family Support Program, Flexible Family Fund (FFF) Program, Preadmission Screening and Resident Review (PASRR) Program, New Opportunities Waiver (NOW),

Children's Choice (CC) Waiver, Supports Waiver (SW) and Residential Options Waiver (ROW) to determine compliance with program policies and guidelines. Each LGE is expected to review its performance indicator data results, develop, and implement a Corrective Action Plan (CAP) when a performance standard is not met. OCDD Central Office is responsible for reviewing CAP(s) and providing technical assistance based on the best and promising practices and services provided that are consistent with statewide strategies and evidence-based principles.

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

6. Major Findings and Conclusions:
   PI# 9 during all 4 quarters, percentage of persons served employed in community fell short of the goal. PI #11 fell short of the goal in quarter 4 due to plans that were approved by support coordination agencies and not FPHSA-DDS.
7. Major Recommendations:
   Corrective action plan for PI #9 was updated and continued for all 4 quarters. Request corrective actions for PI #11 quarter 4 from support coordination agencies.

8. Action taken in response to the report or evaluation:
   During all 4 quarters, the corrective action plan for PI #9 was updated and continued. There is a statewide corrective action plan foe PI #9. PI #11 is being addressed by the support coordination agencies.

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

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

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

2. Date completed:
   Q1 – 10/18/23, Q2 – 1/23/24, Q3 – 4/23/24, Q4 – 8/5/24

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Developmental Disabilities Services (DDS) will provide services that emphasize person-centered individual, and family supports to people with developmental

disabilities. Delivery of services will result in an increased percentage of people within the FPHSA catchment area that remain in the community rather than being institutionalized.

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

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

6. Major Findings and Conclusions:
   Q1 – With rising utility costs, there is an increase in the number of diversion services requests, the 4th Quarter IFS Diversion/IFS Crisis target needs to be increased beyond the FY24 Standard. The total number of FFF slots needs to be increased beyond the FY 24 Standard to reflect the participants who are replacing those aging out of the program.
   Q2 – There was an increase in urgent requests (rent/utility) and a decrease in personal care attendant services and disposable undergarment requests. Disposable undergarments are now funded through the New Opportunities Waiver and Residential Options Waiver. There was an increase in individuals completing the PASRR nursing home service process (approved or denied nursing home admission) than anticipated. The total number of PASRR determinations needs to be increased.
   Q3 – There were fewer requests for personal care attendant (PCA) services and vocational services resulting in fewer IFS agreements. There was a decrease in the number of PASRR services; this is a positive outcome.
   Q4 – The decline in PCA/Vocational requests due to participants receiving waiver supports, the decline in disposable undergarment requests which are now funded through waiver services and the increase in individual agreement amounts resulted in fewer individuals being served. The PCA agreements were funded for larger amounts and more individuals received IFS diversion services. More individuals completed the PASRR nursing home service process (approved or denied nursing home admission) than anticipated. Eight (8) waiver participants out of 2,238 admitted to a more restrictive setting; this is a positive outcome.

7. Major Recommendations:
   Q1 – Change the FFF and IFS Diversion Quarter 4 target.
   Q2 – Change the quarter 3 and quarter 4 PASRR targets.
   Q3 – Move a portion of the IFS services funding from IFS services to the IFS Diversion/Crisis budget. Change the quarter 4 IFS Diversion and PASRR targets to the fiscal year standard.
   Q4 – N/A

8. Action taken in response to the report or evaluation:
   Q1 – FFF and IFS Diversion targets were increased.
   Q2 – PASRR targets were adjusted for Q3 and Q4.
   Q3 – A portion of funding was moved from IFS to the IFS Diversion/Crisis budget.

The IFS Diversion and PASRR Q4 targets were changed to the Fiscal Year 2024 standard.
Q4 – N/A

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

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

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

2. Date completed:
   3/11/24 (Compliance Review Year.)

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

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

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

6. Major Findings and Conclusions:
   FPHSA was rated 93.94% compliance with 4 recommendations.

7. Major Recommendations:
   Change in policy and procedure with regard to hazard communication and hazard materials was the primary recommendation.

8. Action taken in response to the report or evaluation:
   Immediately after the audit the policy and procedure were changed and relevant staff trained on hazard communication, as required.

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

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

1. Title of Report or Program Evaluation:
   Accountability Plan (AP) Administrative Review (Behavioral Health) 2nd

2. Date completed:
   1/29/24 through 1/31/24.

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

4. Methodology used for analysis or evaluation:
   Review conducted by OBH and guided by the LGE AP Monitoring Workbook Tool.

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

6. Major Findings and Conclusions:
   Screening for priority population was not completed prior to admission consistently.

7. Major Recommendations:
   Apply procedure to 100 percent of all groups being admitted including those referred from courts or DCFS, for example.

8. Action taken in response to the report or evaluation:
   Chart audits and supervisory meetings that included chart reviews were implemented to monitor compliance.

9. Availability (hard copy, electronic file, website)
   Documents submitted available in hard copy and electronic file.

10. Contact person for more information, including
    Name: Richard Kramer
    Title: Executive Director
    Agency & Program: FPHSA
    Telephone: (985) 543-4333

E-mail: Richard.Kramer@fphsa.org

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

2. Dates completed:
   8/7/23 through 8/9/23.

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

4. Methodology used for analysis or evaluation:
   Review conducted by OBH and guided by the LGE Monitoring Workbook Tool.

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

6. Major Findings and Conclusions:
   Social Drivers of Health information was not reported/collected and submitted to OBH for the entire year across all service delivery sites.

7. Major Recommendations:
   Submit client level data to the Office of Behavioral Health.

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department:	Louisiana Department of Health (LDH) 09-302 Capital Area Human Services District
Department Head:	Michael Harrington, MBA, MA LDH Secretary
Undersecretary:	Drew Maranto
Executive Director:	Janzlean Laughinghouse, PhD, LCSW-BACS, LAC, CCS

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: Prevention & Wellness/Addiction Recovery Services (ARS) - Community Narcan Trainings and Narcan Kit distribution (through the Opioid Crisis Mobile Unit)

A. What was achieved?

Four Narcan trainings with a total of 142 attendees were completed during FY2023-2024. A total of 1,019 Narcan kits were distributed in the training sessions.

Naloxone Training Dates/Locations:
July 13, 2023 – Start Corporation
March 19, 2024 – L'Auberge
April 12, 2024 – Ascension Parish Sheriff's Office
June 4, 2024 – Capital Area Human Services District (CAHSD)

CAHSD's Opioid Crisis Mobile unit is operated by Capitol Area Reentry Program Inc., a vendor contracted with CAHSD and funded by the Louisiana State Opioid Response grant. The mobile unit disseminated 3,523 Narcan kits in addition to fentanyl testing strips and wound care kits. The unit also provided syringe access, testing for HIV/AIDS, Hepatitis C, and syphilis and provided recovery coaching and referral to treatment services for people who use opioids.

B. Why is this success significant?

Narcan trainings allow CAHSD to educate and train first responders and individuals who work with or have contact with any individual who may be at risk of opioid overdose. Training includes how to administer Narcan in cases of suspected overdose.

The mobile unit's distribution of Narcan kits and other harm reduction services occurred in high impact areas of Region 2, where there are high numbers of opioid overdoses. Data from the mobile unit records show 52 reported opioid overdose reversals in FY 2023-2024.

C. Who benefits and how?

The community benefits. Prevention strategies such as education, training, and harm reduction raise awareness, reduce stigma, and increase health promotion. Healthier individuals create healthier families. Healthier families create healthier communities. Healthier communities create a healthier Louisiana.

D. How was the accomplishment achieved?

This accomplishment was achieved by distributing naloxone kits to the general public during community outreach events, by providing Narcan trainings to various organizations upon request, and targeting high impact areas for harm reduction services and Narcan distribution.

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

Yes.

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

Yes.

Accomplishment #2: Children's/School Based Services - Summer Enrichment Camps

A. What was achieved?

Two hundred one (201) children attended Capital Area Human Services District's (CAHSD) School Based Summer Enrichment Camps at nine area schools in four parishes.

B. Why is this success significant?

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

C. Who benefits and how?

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

D. How was the accomplishment achieved?

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

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

Yes.

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

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

Accomplishment #3: Prevention/ARS (Community Outreach and Faith-Based Initiatives)

A. What was achieved?

Capital Area Human Services District (CAHSD) conducted four *Driving into Recovery* events and two *Recovery Sunday* events during FY2023-2024.

Driving into Recovery Dates/Locations:	Recovery Sunday Dates/Locations:
July 15, 2023 – EBR	April 29, 2024 – Donaldson Chapel BC
September 7, 2023 – Donaldsonville	June 30, 2024 – Church of God

February 17, 2024 – Plaquemine
June 8, 2024 – Port Allen

B. Why is this success significant?

The *Driving into Recovery* outreach events have allowed CAHSD to engage with the community to distribute needed resources and inform them of services provided by CAHSD and other community partners who serve as vendors at the event. The *Recovery Sunday* initiative has afforded CAHSD the opportunity to visit numerous faith-based organizations to share information about the dangers of opioid misuse.

C. Who benefits and how?

Community residents benefit by being informed of the harms of substance misuse and how to get help if they or someone they know has a substance misuse problem. By attending the Driving into Recovery events, the community has an opportunity to receive an abundance of resources from CAHSD and partnering sponsors including food boxes, children's diapers, health insurance resources, and information about mental and physical health, substance misuse, prevention, and addiction recovery while remaining in the comfort of their vehicles.

D. How was the accomplishment achieved?

These initiatives were accomplished by partnering with communities of faith and social services vendors in Region 2. A sample list of community partners is below.
Partnering Driving into Recovery Vendors:

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

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: Community Education/Prevention (trainings/events to spread awareness of services): Including Crisis Intervention Team (CIT) training with law enforcement officers, workshops with local schools and employers, CAHSD Community Health Fair, and other community events)

A. What was achieved?

Capital Area Human Services District **(**CAHSD) held a Community Health Fair on November 4, 2023, from 9 a.m. to noon, at its Baton Rouge Behavioral Health location on Wooddale Blvd. in Baton Rouge.

CAHSD conducted the 40-hour Crisis Intervention Team (CIT) training the weeks of January 22, 2024 (16 trainees) and June 24, 2024 (12 trainees) for the 91st and 92nd Baton Rouge Police Academy. CAHSD also facilitated an 8-hr CIT training course on May 29, 2024, for Louisiana State Probation and Parole POST certification.

CAHSD organized, sponsored, and hosted seven continuing education workshops for both the community and its employees. The topics covered included working with veterans, supporting individuals experiencing homelessness, assisting persons with developmental disabilities, understanding 42 CFR Part 2, and implementing clinical interventions such as motivational interviewing techniques. These workshops were open to the public, held at the CAHS administration office on Florida Boulevard, and conducted on the following dates: 7/31/23, 8/30/23, 12/7/23, 3/28/24, 4/25/24, 5/9/24, and 6/20/24.

B. Why is this success significant?

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

Conducting CIT training and organizing continuing education workshops are effective in the enhancement of professional competence, the improvement of client outcomes, maintaining training compliance, and strengthening community relationships. It is important for persons in behavioral healthcare and related fields to stay updated on best practices, new techniques, and emerging issues. CIT training specifically focuses on equipping law enforcement and first responders with the skills to de-escalate situations involving individuals in crisis, particularly those with mental health disorders, substance abuse disorders, and/or developmental disabilities. Both continuing education workshops and CIT training provides opportunity to build community relationships and partnerships with other agencies to ultimately strengthen the continuity of care for the clients served in Region 2.

C. Who benefits and how?

The community benefits. The health fair provided a central location for people to get useful information and interact with more than 23 vendors and sponsors to receive blood

pressure and glucose checks, COVID-19 and flu vaccinations and screening and brief interventions for anxiety, depression, and problem gambling by licensed mental health professionals.

CIT training and continuing education workshops are beneficial to law enforcement officers, first responders, behavioral health professionals, department of corrections, individuals in crisis, communities, and employers and organizations. CIT training helps reduce the risk of harm, improve communication, and ensure appropriate response and intervention. CIT training and community partnerships fosters an environment for organizations to share experiences and develop effective solutions at the community level to safely meet the needs of persons served. Behavioral health professionals benefit from both CIT training and continuing education workshops by acquiring skills that help them address complex social and psychological issues more effectively, including crisis intervention, substance abuse treatment, and working with diverse populations. Overall, families, caregivers, persons served all benefit from continuing training and organizational partnerships from enhanced community safety, better service delivery, improved/restored trust in community policing, and increased public health and outcomes.

D. How was the accomplishment achieved?

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

Training law enforcement officers was achieved by maintaining community partnerships and agreements with the BR Police Dept. and LA Probation and Parole. Also, by conducting needs assessments to identify training needs within the District. Our department also seeks willing subject matter experts to present on relevant topics for both the workshops and CIT trainings.

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: Social Media and Video Outreach

A. What was achieved?

Capital Area Human Services District (CAHSD) produced and utilized unique and informative videos on YouTube, Instagram, Facebook, and BRProud television stations to reach clients and the public about CAHSD's various services for children,

adolescents, and adults. The videos were various lengths, ranging from 30-second public service announcements (PSAs) to a new program, "Two Chairs - The Conversation" that featured conversational-style interviews of CAHSD experts and clients on various topics, including addiction, recovery, mental health, problem gambling, school based services, prevention, and more. Other video and social media outreach included client testimonials and presentations by Dr. Laughinghouse and other CAHSD subject-matter experts.

B. Why is this success significant?

The advent of social media as an outreach tool has helped businesses and governmental agencies throughout the world. These outreach avenues are extremely cost effective in reaching thousands of people at a time, thus helping inform the public in cost-efficient ways.

C. Who benefits and how?

Current and potential clients benefit as well as the general public by learning about behavioral health and substance misuse threats against their personal health and the global health of their communities. Knowledge of the issues and our services gives them the tools they need to make informed decisions about prevention and treatment options.

D. How was the accomplishment achieved?

CAHSD assembled a multi-talented communications team that identified key issues, developed appropriate messaging, and produced videos, audio recordings (for radio), and related print materials that formed campaigns to convey important information.

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

Yes. Every public agency has a responsibility to communicate openly, clearly, and frequently with the public. CAHSD's Strategic Plan includes projects and programs to serve the public, and these effective communications tools help inform the public about the agency's 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. Our video production is the type if professional, broadcast quality that would be presented by top businesses, agencies, and advertisers. Governmental entities should be reflected to the public in professional, engaging ways. Our campaigns, productions, and outreach are professional in every aspect and can serve as a model for other agencies.

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

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

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

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

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

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

  CAHSD has made significant progress is upgrading technology throughout the organization.

  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.

     Success has been made possible by pursing the pursuit of grant funding. The technology upgrades will facilitate telehealth and telemedicine to expand access to

services, create a patient portal, and develop an application with mobile and desktop functionality.

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

No. This technological upgrade is not a one-time gain; however, because of the rate at which innovation occurs, the upgrade will need to be made again within a decade.

- **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:

CAHSD is experiencing a severe behavioral health workforce shortage. Our vacancies for licensed mental health professionals are very difficult to fill. The postings receive very few qualified applicants. Many of the few who show up to be interviewed often decline job offers.

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.

    This workforce challenge has many factors including State Civil Service pay rates (low in comparison to private sector salaries) and the restrictions on hiring provisionally licensed behavioral health professionals to provide services.

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

    The problem will continue without intervention. We are hoping to see some improvement because of the recent ruling that allows billing for the services of provisionally licensed mental health professionals.

- **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, the factors affecting workforce shortage are not within the organization's control.

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

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

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

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

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

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

A. Problem/Issue Description

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

and other stakeholders.)

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

CAHSD is experiencing a severe behavioral health workforce shortage. Our vacancies for licensed mental health professionals are very difficult to fill. The postings receive very few qualified applicants. Many of the few who show up to be interviewed often decline job offers.

The shortage has been fueled by several factors including the pandemic, State Civil Service pay rates (low in comparison to private sector salaries), and the restrictions on hiring provisionally licensed behavioral health professionals to provide services. The precipitating factors for the shortage cannot be rectified by our organization; however, CAHSD has taken proactive steps such as advertising on social media and with behavioral health organizations, cultivating relationships with colleges and universities to strengthen our internship programs and develop a pool of talent who may be interested in remaining at the conclusion of their internships, and engaging LDH in discussion about the issue.

The lack of personnel affects the number of person served and the timeliness of the services.

We are hopeful that the recent ruling that allows the use of provisionally licensed mental health professionals for reimbursable behavioral health services will help alleviate the workforce shortage; however, pay rates continue to be an issue.

B. Corrective Actions

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

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

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

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

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

4. Are corrective actions underway?
    a. If so:

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

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

5. Do corrective actions carry a cost?

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

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

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

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

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste and abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to

management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

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

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

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

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

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

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

programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

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

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

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

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

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

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

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

E-mail:

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

2. **Date completed:**
   Quarterly from July 1, 2023 through June 30, 2024.

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

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

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

6. **Major Findings and Conclusions:**
   None.

7. **Major Recommendations:**
   None.

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

9. **Availability (hard copy, electronic file, website):**
   https://wwwcfprd.doa.louisiana.gov/lapas/view/viewreport.cfm?ddl=3

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

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

1. **Title of Report or Program Evaluation:**
   Louisiana Legislative Auditor Procedural Engagement

2. **Date completed:**
   April 2, 2024 (Covering July 1, 2021 through June 30, 2023).

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

4. **Methodology used for analysis or evaluation:**
   From the Louisiana Legislative Auditor (LLA) procedural engagement document: The scope of our procedures, which is summarized below, was significantly less than an audit conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States. We did not audit or review the CAHSD's Annual Fiscal Reports, and accordingly, we do not express an opinion on those reports. The CAHSD's accounts are an integral part of the state of Louisiana's financial statements, upon which the Louisiana Legislative Auditor expresses opinions.

   • We evaluated CAHSD's operations and system of internal control through inquiry, observation, and review of its policies and procedures, including a review of the laws and regulations applicable to CAHSD.

   • Based on the documentation of CAHSD's controls and our understanding of related laws and regulations, and results of our analytical procedures, we performed procedures on selected controls and transactions relating to information technology access, electronic health record system billing, and cash.

   • We compared the most current and prior-year financial activity using CAHSD's
   Annual Fiscal Reports and/or system-generated reports to identify trends and obtained explanations from CAHSD's management for any significant variances that could potentially indicate areas of risk.

5. **Cost (allocation of in-house resources or purchase price):**
   $53,230.

6. **Major Findings and Conclusions:**
   From the LLA exit procedural: Our auditors reviewed the status of the prior-year finding reported in a procedural report dated June 16, 2021. We determined that management has resolved the prior-report finding related to Failure to Follow Public Bid Law Requirements.

   Based on our work performed in the current engagement, we identified the

following finding:
Inadequate Monitoring of the Electronic Health Record System Access

7. **Major Recommendations:**
   None.

8. **Action taken in response to the report or evaluation:**
   Corrective action plan submitted: Policy #802-11 Adding/Deleting User Accounts and Policy #810-15 Electronic Health Record Security revised. Changes made to management of user accounts and assigning of privileges.

9. **Availability (hard copy, electronic file, website):**
   https://app2.lla.state.la.us/publicreports.nsf/0/0be76de94a355a7086258afc005cdfa8/$file/000043eb.pdf?openelement&.7773098

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

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

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

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

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

Executive Director: Ebony Haven

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

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

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 Louisiana Developmental Disabilities Council (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. Through the Council's technical assistance provided to the grassroots Louisiana Council's Advocacy Network (LaCAN), policies were changed to improve and/or increase community services. Significant policy and practice

changes influenced by LaCAN and Council advocacy related to community-based services included: successfully advocating for an additional $500,000 for Families Helping Families Resource Centers; and successfully advocating to increase the night rate in Intellectual and Developmental Disabilities (I/DD) waivers to match the day rate.

B. Why is this success significant?

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

Increasing the night rate in I/DD waivers to match the day rate addresses the disparity between these rates and the effects this disparity has had on direct support professional (DSP) crisis in Louisiana. The rate for overnight services was only $13.52 compared to the day rate of $18.52. The cost of providing services overnight, especially as it relates to DSP wages, is actually more than when provided during the day. Providing differential pay for working nights is hard to do with the previous night rate in our waivers and providers were having to pay out more than they are being reimbursed. Due to this rate disparity, providers and families enrolled in self-direction are struggling to provide this needed and required service. This places undue hardships on people with disabilities and their families as they are the ones left to figure out how to support their needs without assistance. However, now that the night rate matches the day rate, providers will now be reimbursed at the same rate for either service, and hopefully this will help to alleviate the DSP crisis to some degree.

C. Who benefits and how?

People with developmental disabilities and their family members benefit the most directly. Increasing funding to the FHF Centers continues to ensure they will be able to provide services to assist families with navigating the very confusing developmental disabilities and special education systems here in Louisiana. Increasing the night rate to match the day rate will help alleviate the pressure that has been placed on families to find DSPs work overnight.

D. How was the accomplishment achieved?

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

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

Yes. The accomplishments directly contribute to the success of the Council's five-

year goals and annual objectives/activities.

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

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

Accomplishment #2: Capacity Building through Training and Technical Assistance

A. What was achieved?

The Council provided support to multiple capacity building initiatives. One of our initiatives provides trainings to first responders across our state. This training helps first responders identify people with intellectual/developmental disabilities and teaches them appropriate response techniques. These trainings have received a lot of positive feedback from multiple first responder entities.

Partners in Policymaking®, a leadership training program for individuals with developmental disabilities and parents of young children with DD, builds the capacity of these individuals to be leaders in systems change advocacy. This is typically a six-month long training program conducted by the Council every year from January to June. There were a total of 18 graduates which consisted of individuals with intellectual/developmental disabilities and parents of young children with developmental disabilities. Last fiscal year, there were 13 graduates. The Council anticipate this program growing back to the capacity it was pre-COVID (total of 25 participants and on average 20 graduates).

Louisiana Youth Leadership Forum (YLF) is an educational and motivational camp held every summer on a university campus. Student will work in small and large groups and work to identify resources that can help them achieve their goals while building lifelong friendships. It is critical students with disabilities identify themselves with pride, as individuals and as members of their community. YLF offers students with common experiences the opportunity to learn from each other in a framework of history and an atmosphere of encouragement. There were eleven students that completed the YLF in FY2024.

B. Why is this success significant?

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

C. Who benefits and how?

First and foremost, people with developmental disabilities will benefit from the improved quality of services delivered, first responders that take their needs into account, more opportunities post high school for education career development.

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 on time and on target for accomplishment?

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

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

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

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

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

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

    This progress is due to the Council having developed and supported large grassroots advocacy networks and family support agencies over the past thirty years.

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

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

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

The Louisiana Developmental Disabilities Council (The Council) is not experiencing a significant lack of progress in the current 5-year plan.

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

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

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

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

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

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

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

☐ No. If not, why not?

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

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

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

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

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

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

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

A. Problem/Issue Description

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

B. Corrective Actions

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

department?

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

☒ **Internal audit**
The Louisiana Developmental Disabilities Council (The Council) along with the LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

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

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

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of

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

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

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

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

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

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

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

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

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

1. **Title of Report or Program Evaluation:**
   Program Performance Report - The Council completes a federal program performance report (PPR) and an annual report that summarizes the progress of the Council's work and successes each year.

2. Date completed:
   12/30/2023.

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   The purpose of the PPR is to document DD Council results, outcomes, and impacts of Council work that occurred during the previous federal fiscal year.

4. Methodology used for analysis or evaluation:
   The Council uses data collected from the contractors on demographics and general information about participation in the activity and event.

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

6. Major Findings and Conclusions:
   See Annual Report at https://laddc.org/wp-content/uploads/2024/04/23-Annual-Report-FINAL.pdf

7. Major Recommendations:
   To collaborate with our sister agencies within the Developmental Disabilities

Network: Disabilities Rights of LA and LSU Human Development Center.

8. Action taken in response to the report or evaluation:
   The Council will be collaborating in advocacy with DRLA and in activity focused on fetal alcohol syndrome disorder (FASD) with LSU.

9. Availability (hard copy, electronic file, website): See information above.

10. Contact person for more information:
    Name & Title: Stephanie Carmona, Program Manager
    Agency & Program: DD Council
    Telephone: 225-342-6804
    E-mail: Stephanie.carmona@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department:	Louisiana Department of Health (LDH) 09-304 Metropolitan Human Services District
Department Head:	Michael Harrington, MBA, MA LDH Secretary
Undersecretary:	Drew Maranto
Executive Director:	Rochelle Head-Dunham, M.D.

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

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

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

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

A. What was achieved?

In 2023-2024, the Mental Health First Aid Collective spearheaded by Metropolitan Human Services District (MHSD) established a partnership with New Orleans Public Schools to train administrative staff, teachers, school social workers and case-managers in Mental Health First Aid. This initiative aims to equip school personnel with the skills needed to support a student who may be in a mental health or substance use crisis.

Additionally, MHSD formed a partnership with LCMC Health to provide MHFA training. MHFA training will benefit nursing staff, administrative staff and frontline personnel who already possess medical training. The training will enhance their ability to recognize and respond to mental health and substance use challenges, improving patient care and support.

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

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

D. How was the accomplishment achieved?
Continuous community outreach efforts and the support of MHSD Executive Leadership.

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

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

Accomplishment #2: MHSD CCBHC Grant Award and Activity

A. What was achieved?
In 2022-2023, Metropolitan Human Services District (MHSD) was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic (CCBHC) – Planning, Development, and Implementation Grant. The purpose of this program is to transform community behavioral health systems and provide comprehensive, coordinated behavioral health care by: (a) assisting organizations in the planning for and development and implementation of a new CCBHC that meets the CCBHC Certification Criteria (b) providing a comprehensive range of outreach, screening, assessment, treatment, care coordination, and recovery supports based on a needs assessment that aligns with the CCBHC Certification Criteria, and (c) supporting recovery from mental illness and/or substance use disorders (SUD) by providing access to high-quality mental health and SUD services, regardless of an individual's ability to pay.

In 2023-2024 the CCBHC grant has allowed MHSD to expand and improve services/activities in the following areas:

- **Veterans Services/ VA Collaboration**: Through the CCBHC project, MHSD is working to strengthen its collaboration with the Veterans Administration (VA) to ensure that veterans receive comprehensive behavioral health services. The current focus is staff training regarding veteran needs, identifying a VA liaison, and establishing referral procedures.
- **Increased access to Prevention and Treatment:** MHSD has integrated evidence-based screening tools and standardized measures into its Electronic Health Record (EHR) system. These tools are now a fundamental part of the service workflow, enabling clinicians to more effectively identify individuals who require support. The integration of these measures has also led to improved coverage of mental health (MH) and SUD screening, ensuring that more individuals are identified and receive appropriate treatment. This approach promotes parity between MH and SUD services, ensuring that individuals receive holistic care.
- **Supporting Integration and Coordination of MH and SUD Treatment with Other Health Care.** The CCBHC project has enhanced both the internal and external referral processes, making it easier for individuals to access the care they need. We hope this level of coordination will lead to better engagement in care.
- **Increased coordination of care between BH and Primary Care**
  MHSD has implemented new care coordination protocols that support integration between behavioral health and primary care services. This includes PCP referral and encouraging/monitoring PCP appointment attendance. We hope these efforts will lead to improved overall health outcomes for individuals with co-occurring physical and behavioral health conditions.
- **Increased Use of Customized Reporting**
  Through the CCBHC grant, MHSD has enhanced its EHR system to collect and report on the required CCBHC quality measures. This includes the development of customized reports that allow MHSD leadership to track key performance indicators, monitor service delivery, and identify areas for improvement. We hope these reports will become an essential tool in MHSD's ongoing efforts to provide high-quality, evidence-based care.

B. Why is this success significant?

Helps MHSD expand its core service capabilities and partnering collaborations for persons served.

C. Who benefits and how?

Persons served and their families by providing increased outreach, prevention and specialized treatment services and supports.

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

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

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

Accomplishment #3: Education and Training Opportunities

A. What was achieved?
Metropolitan Human Services District (MHSD), the behavioral health authority for the region, provides an academic series on various behavioral health topics under the management of the MHSD Training Director. The academic series continuously seeks to provide education and training opportunities to staff, partners, and the community.

In 2023-2024, Dr. Dunham, Executive and Medical Director, along with other select staff served as subject matter experts (SME), persons with in-depth, unique knowledge and expertise on a specific subject, at local, state, national, and federal meetings and conferences.

B. Why is this success significant?
Staff learn specific skills and information that will help them perform well in their roles. As SME staff share their knowledge with various audiences and promote behavioral health awareness and services.

C. Who benefits and how?
Persons served and their families and MHSD program staff.

D. How was the accomplishment achieved?
By Executive Leadership prioritizing participation in educating and training opportunities.

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: Imani Breakthrough NOLA Faith Partners Project

A. What was achieved?
The Imani Breakthrough Recovery Program is a faith-based recovery initiative designed to be culturally, spiritually, and trauma-informed, assisting individuals recovering from opioid use/abuse and other drug or alcohol problems. This program takes place in churches and involves two parts:

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

Developed out of Yale University, the project model was implemented by MHSD in collaboration with Yale in 2022. In 2023, program implementation began in two churches located in New Orleans (Central City neighborhood). Participants in the program were between the ages of 22 and 64, with 96% being African American males. To date, two cohorts with a total of 48 participants have successfully completed the 24-week program and have been referred to MHSD and other resources for long-term recovery support.

B. Why is this success significant?
Improves the standard and quality of care of the addiction program.

C. Who benefits and how?
Persons served and their families and MHSD program staff.

D. How was the accomplishment achieved?
By Executive Leadership prioritizing addiction services and supports.

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

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

Accomplishment #5: Community Integration of Services for the Unhoused

A. What was achieved?
Metropolitan Human Services District (MHSD) has laid the groundwork for a coordinated service delivery model that will provide mental health, substance use, and social services to individuals experiencing homelessness, "Unhoused Project." In

partnership with the New Orleans Health Department, MHSD is planning to implement a community psychiatry program "street psychiatry", which will bring psychiatric care directly to individuals living on the streets, further enhancing access to critical behavioral health services.

B. Why is this success significant?
Many of the people we serve are unhoused, and this program allows us to link them to social determinants of health (SDOH) resources, improving access to care and continuity of care. This initiative is significant because it addresses a critical gap in care for one of the most vulnerable populations. By planning to integrate services and develop the street psychiatry program, MHSD is working to ensure that individuals who are unhoused will have access to comprehensive care that addresses both their mental health and social needs, ultimately promoting stability and reducing barriers to recovery.

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

D. How was the accomplishment achieved?
MHSD's leadership team played a crucial role in facilitating partnerships and ensuring that services were aligned with the specific needs of the unhoused population.

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

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

Accomplishment #6: Tobacco Cessation Program Expansion

A. What was achieved?
In 2023-2024, MHSD expanded its Tobacco Cessation Program by hiring a Tobacco Champion, a dedicated staff member responsible for leading smoking cessation efforts. This role includes program monitoring, data management, and planning initiatives to increase program utilization.

B. Why is this success significant?
According to the Centers for Disease Control and Prevention article 'Smoking & Tobacco Use: Fast Facts' (2022), tobacco use is the leading cause of preventable deaths. The expansion of the Tobacco Cessation Program is significant as it directly

contributes to the reduction of tobacco-related morbidity and mortality. By providing accessible cessation resources, MHSD supports individuals in achieving long-term health benefits, reducing the burden of tobacco-related illnesses.

C. Who benefits and how?
Individuals who use tobacco, as well as their family and friends exposed to secondhand smoke, particularly those in underserved and high-risk populations, benefit from the expanded program.

D. How was the accomplishment achieved?
MHSD's leadership provided the vision and support needed to accomplish this achievement.

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

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

Accomplishment #7: AI Subcommittee and Behavioral Healthcare Technology

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

B. Why is this success significant?
The creation of the AI Subcommittee is significant because it positions MHSD at the forefront of technological innovation in behavioral healthcare. By integrating AI and other advanced technologies, MHSD can improve patient outcomes, streamline operations, and enhance data security.

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

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

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

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

Accomplishment #8: Targeted Integration Efforts between MHSD Behavioral Health and IDD

A. What was achieved?
Metropolitan Human Services District (MHSD) undertook targeted integration efforts to bridge the gap between Behavioral Health (BH) services and Intellectual/Developmental Disabilities (IDD) services. These efforts included the development of an integrated EHR and cross-training for staff to address the unique needs of individuals with co-occurring BH and IDD conditions.

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

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

D. How was the accomplishment achieved?
This accomplishment was achieved through deliberate collaboration between MHSD's Behavioral Health and IDD teams.

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.

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

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

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

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

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

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

  MHSD has made significant progress towards its initiatives related to establishing a quality Tele-behavioral Health Program, Data-based Staff Performance Initiative,

Mental Health First Aid training, and health equity programing. Success is attributed to MHSD Executive Leadership's early allocation of resources to this initiative. Progress is related to agency-wide efforts with the intention to increase access to and efficiency of care. The Certified Community Behavioral Health Clinic (CCBHC) grant has provided the financial support, staff and the consultative services.

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

Progress is expected to continue at an accelerated pace. Although fully implemented, MHSD is continuing to identify and address areas for improved efficiency and are responding to administrative and clinical needs. Future efforts will focus on improving quality of care and MHSD's corporate compliance.

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

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

    Slow progress related to Veterans Administration (VA) collaboration. It has been challenging identifying a VA liaison that can assist MHSD in developing referral procedures. Through the CCBHC project, MHSD is working to strengthen its collaboration with the Veterans Administration (VA) to ensure that veterans receive comprehensive behavioral health services. The current focus is staff training regarding veteran needs, identifying a VA liaison, and establishing referral procedures. Additionally, integrated care efforts have been a challenge because of staffing requirement and clearly defined protocols and processes.

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

    Lack of progress is due to a set of circumstances related to administrative and coordination issues. MHSD will continue to closely monitor progress with these

projects in 2024-2025.

- **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.

  Metropolitan Human Services District's (MHSD) Executive Leadership and Management team conducts weekly staff meetings where roundtable discussions are held on current projects and timelines. During these meetings, leaders from respective areas within the organization are able to provide input, communicate roadblocks and determine execution of various initiatives. The medical director meets quarterly with all medical staff. The Executive Director also meets individually on a weekly basis with Division Directors from Fiscal, Legal/Compliance, Quality, Adult, Children's and I/DD to obtain status reports. On a quarterly basis, Division Directors report on strategic plan indicators for which their divisions are responsible, and monthly the Executive Director meets with the Board of Directors and provides a status report on key performance indicators for the organization.

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

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

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

reports and evaluations at the end of this form.

A. Problem/Issue Description

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

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

B. Corrective Actions

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

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

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

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

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The LDH has a designated Audit Coordinator for financial audits. The Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept

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

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

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

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

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

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

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

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

☒ Peer review
The MHSD Peer review methodology is defined by the Louisiana Office of Behavioral Health to address federal mandates.

☒ Accreditation review
MHSD is accredited by CARF International. Accreditation methodology is defined by CARF International.

☒ Customer/stakeholder feedback
Metropolitan Human Services District (MHSD) participates in various activities (e.g., surveying, hosting community forums, RAC participation, etc.) that involve obtaining input from persons served and other stakeholders. MHSD requests and collects input to help determine the expectations and preferences of its stakeholders and to better understand how the district is performing from the perspective of its stakeholders. Findings are used to create services that meet or exceed the expectations of persons served, the community, and other stakeholders

☐ Other (please specify):

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

☒ Yes. Proceed to Section C below.

☐ No Skip Section C below.

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

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

E-mail:

1. Title of Report: **AP/Accountability Plan**
2. Date Complete: 03/07/2024
3. Subject/Purpose: To guide the delivery of addictive disorders (AD), Developmental Disabilities (DD), and Mental Health (MH) services funded by appropriations from the state.
4. Methodology: Site monitoring consisted of a joint OBH and OCDD Review team to include data reviews, chart audits, and interviews with staff.
5. Cost: Allocation of committed staff time to the process for the day.
6. Major Findings: none
7. Major Recommendations: none
8. Action taken: MHSD responded as needed in writing with a Plan of Correction (POC) to any major findings.
9. Availability: AP is available in hardcopy and electronic file; report file will be available in same format.
10. Contact person for more information, including
    Name: Rochelle Head-Dunham, M.D.
    Title: Executive Director/Medical Director
    Agency & Program: 09-304 Metropolitan Human Services District (MHSD)
    Telephone: 504-535-2909
    E-mail: Rochelle.Dunham@mhsdla.org

1. Title of Report or Program Evaluation: **MHSD Operations Risk Management Audit**
2. Date completed: July 2024
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: Status-Compliant
7. Major Recommendations: No Major recommendations
8. Action taken in response to the report or evaluation: N/A
9. Availability (hard copy, electronic file, website): Hard copy, and electronic file.
10. Contact person for more information, including:
    Name: Rochelle Head-Dunham, M.D.
    Title: Executive Director/Medical Director
    Agency & Program: 09-304 Metropolitan Human Services District (MHSD)
    Telephone: 504-535-2909
    E-mail: Rochelle.Dunham@mhsdla.org

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

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

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

Assistant Secretary: Kim Sullivan
Medicaid Executive 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: Implementation of EVV (Electronic Verification Visits) for Home Health Care Services

A. What was achieved?

The Department of Health successfully implemented an Electronic Visit Verification (EVV) system across all regions of the state for Home Health, in-home and center-based waiver services and Long-Term Personal Care Services.

B. Why is this success significant?

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

C. Who benefits and how?

The EVV system allows the department to verify that individuals are receiving the services authorized in their plans of care, reduces inappropriate billing/payment, safeguards against fraud, and improves program oversight. The department has realized cost and operational benefits through mechanisms described above.
The EVV system allows LDH employees to access and view all services collected in real time including check-in/out times for each service record. Through the department's work with its EVV contractor, several operational benefits were incorporated into the EVV system with the intent to increase system usability for both LDH staff and providers. The primary benefit is an EVV solution that is fully integrated with the existing service reporting and prior authorization system which allows providers to use a single system. Additional benefits include greater oversight and validation of services resulting in less audit findings and recoupments, access to free personnel management reports for providers, reduction in the need for manual data entry, and reduced lag time for billing reports.

D. How was the accomplishment achieved?

As part of a cross-departmental collaboration between Medicaid, the Office of Aging and Adult Services (OAAS), and the Office for Citizens with Developmental Disabilities (OCDD), staff worked diligently during the past few years to identify and secure a successful EVV solution capable of meeting all state and federal requirements. After working with the initial EVV contractor, researching best practices, and documenting system issues, the Division of Administration (DOA) approved a sole source request to include EVV for in-home services in the current prior authorization data contract with Statistical Resources, Inc. (SRI) during the fall of 2016. EVV was successfully implemented for services delivered outside of the home including center-based, vocational and transportation services on March 1, 2016 and in-home personal care service providers on May 1, 2018. EVV for EPDST personal care services was initiated on October 1, 2019. EVV for Home Health services was implemented on January 1, 2024.

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

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 and furthers good stewardship of public resources. 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.

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

Yes. LDH utilized a collaborative approach among several agencies to carefully plan and implement an EVV solution to comply with federal legislation (21st Century Cures Act, signed into law on December 13, 2016).

Accomplishment #2: Medicaid Automated Responses Chatbot (MARC) - Louisiana Medicaid launched a virtual assistant on its webpages to answer frequently asked questions from the public

A. What was achieved?

The implementation of the Medicaid Automated Response Chatbot (MARC) has provided 24/7 accessible information and services to Medicaid beneficiaries. MARC has successfully automated routine inquiries, reducing wait times for human agents and increasing overall efficiency.

B. Why is this success significant?
The MARC Chatbot has been accessed more than 35,000 times since November 2023. MARC has enhanced the overall Medicaid program's efficiency and effectiveness by automating routine tasks.

C. Who benefits and how?

Medicaid beneficiaries: Benefit from increased access to information, reduced wait times, and improved overall experience.

Medicaid staff: Benefit from reduced call volume, allowing them to focus on more complex inquiries and tasks.

The state: Benefits from increased efficiency, cost savings, and improved public perception of the Medicaid program.

D. How was the accomplishment achieved?

- Through a collaborative effort between Medicaid Technology Development team, Medicaid program staff, Office of Technology Services, and external Chatbot developers.
- By conducting thorough needs assessments and user research to identify common beneficiary inquiries.
- By implementing a comprehensive testing and evaluation process to ensure accuracy and effectiveness.

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

Yes, MARC aligns with the strategic goal of improving access to Medicaid services and enhancing beneficiary experience. The Chatbot supports the agency's mission of providing high-quality, cost-effective healthcare to 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?

Yes, the development and implementation of MARC can be considered a best management practice. The project's success in improving efficiency, enhancing customer service, and leveraging technology can be replicated in other state agencies.

Accomplishment #3: LA Wallet Digital Medicaid Cards

A. What was achieved?

The LA Wallet app made provision for a digital version of the Medicaid MCE Card and Fee for Service Medicaid Card. The scope of the project included the capability to link the digital ID cards for members covered under Managed Care and Fee for Service (FFS) Medicaid plans to LA Wallet. The scope includes all six Managed Care Organizations (MCOs) and Gainwell, which supports members enrolled in the FFS plan. The Head of Household (HOH) will be able to display the cards for all the members included in the household.

B. Why is this success significant?

The ability of Medicaid members to maintain their Medicaid member information digitally will increase the portability and availability of information, easing member access to healthcare in an increasingly digital world. The team worked diligently to see the success of the project and to assure that the vendor developed a product that is accurate, and functionally user friendly for Medicaid members.

C. Who benefits and how?

Medicaid and Fee for Service members now have the ability to download their card image into LA Wallet for quick easy access at any time.

D. How was the accomplishment achieved?

This was accomplished through collaboration between internal Medicaid staff and our vendor. The collaboration included weekly strategy meetings, and application development and testing.

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

Yes.

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

Yes, this demonstrates the Medicaid program's ability to increase our member experience.

Accomplishment #4: Implementation of the Single Pharmacy Benefit Manager

A. What was achieved?

The Single Pharmacy Benefit Manager (SPBM) was implemented to process pharmacy claims for all Managed Care Organizations (MCO).

B. Why is this success significant?
This SPBM provided administrative simplification for providers, LDH, MCOs and beneficiaries.

C. Who benefits and how?

The SPBM serves as a single point of contact for providers and beneficiaries for MCO pharmacy claims processing. Prior authorization criteria and claims processing editing are consistent across all six (6) MCOs.

D. How was the accomplishment achieved?

An RFP was issued. Magellan Medicaid Administration was awarded this contract. Design, development and implementation occurred over 9 months prior to implementation with input from LDH and MCOs.

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

Yes, this accomplishment simplifies pharmacy MCO claims processing and billing.

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

Yes, through this SPBM implementation, many lessons were learned and procedures were clarified to implement in the most efficient manner.

Accomplishment #5: Medicaid Unwind

A. What was achieved?

The 2023 Consolidated Appropriations Act ended the continuous coverage requirement, initiating the Medicaid "Unwind" process in April 2023. This process involved reviewing eligibility for all 2.2 million Medicaid Members, a process known as renewal, and closing ineligible cases. Renewals were scheduled to stagger across 12 months, taking 14 months to finish.

Louisiana Medicaid was able to complete about half of its renewals using electronic databases without contacting members. Many, however, had to respond to mail from Medicaid to complete their renewal.

The Unwind campaign advertised notice to members to check their mail and update their contact information for renewal.

Louisiana completed this process and remained in compliance with Centers for Medicare and Medicaid Services (CMS) guidance.

B. Why is this success significant?

Medicaid Unwind was a requirement of CMS.

C. Who benefits and how?

The state and its residents benefit. Medicaid is required to maintain compliance with CMS.

D. How was the accomplishment achieved?

In the beginning of the Public Health Emergency (PHE), Medicaid took steps and completed systems programming to pause closures and renewals. When the PHE ended and with guidance from CMS, Louisiana Medicaid completed system programming to complete redeterminations and renewals as appropriate.

Louisiana completed extensive outreach to keep members informed.

Louisiana maintained compliance with CMS throughout the process.

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

Medicaid is required to maintain compliance with CMS.

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

Yes.

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

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

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of

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

A significant focus of 2023-24 was implementing and making progress on Medicaid Unwind which was a requirement of Centers for Medicare and Medicaid Services (CMS). Louisiana was one of the few states to maintain compliance with CMS guidance.

- **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:

  Louisiana remained on target with monthly progress and maintained compliance with CMS.

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

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

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

  None.

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

so, please describe the problem and any recommended corrective actions in Section III below.
- Other? Please specify.

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

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

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

☒ No. If not, why not?

Louisiana Medicaid will revise its strategic plan at the end of Medicaid Unwind (May 2024) and with guidance and collaboration with the new administration and agency leadership.

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

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

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

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

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

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

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

There are no significant management or operational problems.

A. Problem/Issue Description

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

B. Corrective Actions

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

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

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

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

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

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

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

5. Do corrective actions carry a cost?

☐ No. If not, please explain.

☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
    a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
    b. How much has been expended so far?
    c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
    d. Will additional personnel or funds be required to implement the recommended actions? If so:
        - Provide specific figures, including proposed means of financing for any additional funds.
        - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

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

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

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

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

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

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

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

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

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

☐ Program evaluation by in-house staff

☐ Program evaluation by contract

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

☒ **In-house performance accountability system or process**
Performance Based Budgeting activities (including, but not limited to strategic

planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

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

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

☐ Peer review
☐ Accreditation review

☐ Customer/stakeholder feedback

☐ Other (please specify):

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

☒ Yes. Proceed to Section C below.

☐ No Skip Section C below.

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

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

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

Report #1

1. **Title of Report or Program Evaluation**:
   Continuity of Care for Newborns
2. **Date completed**:
   January 2024
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   Louisiana Department of Health (LDH) submits the following report in response to ongoing reporting provision of Act 311 of the 2013 Regular Louisiana Legislative Session. This report provides the incidence and causes of the re-hospitalization of infants born premature at less than 37 weeks gestational age and within the first six months of life.
4. **Methodology used for analysis or evaluation: Cost (allocation of in-house resources or purchase price)**:
   Act 311 requires an assessment of the incidence and causes of all re-hospitalizations of infants born premature at less than 37 weeks gestational age and within the first six months of life. The report utilizes Vital Records data obtained from the Office of Public Health for establishing gestational age and Medicaid claims data/MCO encounter data stored in the Medicaid Data Warehouse for identifying the primary discharge diagnoses that triggered the re-hospitalizations.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by University of Louisiana at Monroe (ULM) staff; falls within scope of work of contract.
6. **Major Findings and Conclusions**:
   The re-hospitalization rate for infants born during calendar year 2021 who were born prematurely at less than 37 weeks gestational age and are in their first six months of life is 4.38 percent. The re-hospitalization rate for 2020 births was 3.21 percent. This indicates that the re-hospitalization rate in this group of newborns has worsened slightly over the past two reporting years.
7. **Major Recommendations**:
   (Not Applicable)
8. **Action taken in response to the report or evaluation**:
   (Not Applicable)

9. **Availability (hard copy, electronic file, website)**:
   https://ldh.la.gov/assets/docs/LegisReports/Act311ReportJanuary2024.pdf
10. **Contact person for more information**:
    Name: Kim Sullivan
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Kimberly.Sullivan@LA.GOV

Report #2

1. **Title of Report or Program Evaluation**:
   Louisiana Medicaid Diabetes and Obesity Report
2. **Date completed**:
   January 2024
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   Per Louisiana Revised Statute (RS) 46:2616 and RS 46:2617, an annual diabetes and obesity action plan submission is necessary to the Senate and House Committees on Health and Welfare after consulting with, and receiving comments from, the medical directors of each of its contracted Medicaid partners.
4. **Methodology used for analysis or evaluation**:
   Each Medicaid managed care plan is required to complete a template that requests data designed to meet the requirements of RS 46:2617. The template consists of 12 reports that gather diabetes and obesity prevalence and utilization within each plan to address diabetes and obesity items in RS 46:2617. The resulting 60 reports aggregated across the five plans to yield 12 reports for Healthy Louisiana. The Healthy Louisiana reports are in the "Diabetes and Obesity Action Report for the Healthy Louisiana Program.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by University of Louisiana at Monroe (ULM) staff; falls within scope of work of contract.
6. **Major Findings and Conclusions**:
   Managing obesity and diabetes is a complicated endeavor, and the strategies described in this report serve as a foundation for healthier Louisiana residents. Changes must occur in multiple parts of the health care system, community settings and in personal behaviors in order to affect the obesity and diabetes epidemic.
7. **Major Recommendations**:
   a. Promote Well-Ahead Louisiana's Community Resource Guide as a tool to identify local (by parish) health-related resources. This resource is available at http://wellaheadla.com/Well-aheadcommunity/community-resource-guide
   b. Encourage the use of community and faith-based organizations to promote the importance of healthy eating and physical fitness.
   c. Encourage the use of outpatient nutritional services provided by registered dietitians for all patients and all diagnoses, not just those patients with

diabetes and obesity.

d. Promote the use of Diabetes Self-Management Education (DSME) programs or incorporate elements of these programs into case management activities for patients with diabetes. DSME programs have been associated with improved health outcomes for patients with diabetes.

8. **Action taken in response to the report or evaluation**:
(Not Applicable)
9. **Availability (hard copy, electronic file, website)**:
https://ldh.la.gov/assets/docs/LegisReports/ACT210/Act_210_Diabetes_Obesity_Report_Medicaid_4292024.pdf
10. **Contact person for more information**:
Name: Kim Sullivan
Title: Executive Director
Agency & Program: Bureau of Health Services Financing (Medicaid)
Telephone: 225-219-7810
Email: Kimberly.Sullivan@LA.GOV

Report #3

1. **Title of Report or Program Evaluation**:
Medicaid Managed Care Quarterly Transparency Reports SFY 2023
2. **Date completed**:
Quarterly 2024
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
In response to ACT 482 of the 2018 Regular Legislative Session, the Louisiana Department of Health (LDH) is required to submit the Medicaid Managed Care Quarterly Transparency report. This report includes only those expansion population counts and expenditures for individuals enrolled in an MCO for either full or partial benefits.
4. **Methodology used for analysis or evaluation**:
The methodology updates for pulling data regarding earned income started in State Fiscal Year 2023 (July 1, 2022 to June 30, 2023) to assure that the income corresponds to the current reporting period. The five MCOs received payments to manage the care of individuals in the expansion population for medical, specialized behavioral health, pharmacy, and transportation services.
5. **Cost (allocation of in-house resources or purchase price)**:
Compiled by internal staff.
6. **Major Findings and Conclusions**:
(Not Applicable)
7. **Major Recommendations**:
(Not Applicable)
8. **Action taken in response to the report or evaluation**:
(Not Applicable)
9. **Availability (hard copy, electronic file, website)**:
https://ldh.la.gov/news/5061
10. **Contact person for more information**:

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

Report #4

1. **Title of Report or Program Evaluation**:
   Healthy Louisiana Claims Report
2. **Date completed**:
   Quarterly 2023 (Note: This report is changing in FY25 per legislation from the 2023 session)
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   In response to Act 710 of the 2018 regular session of the Louisiana Legislature, the "Healthy Louisiana Claims Report" submitted to the Joint Legislative Committee on the Budget and the House and Senate Committees on Health and Welfare. The Act requires the Department to conduct a number of activities and analyses pertaining to each Medicaid managed care organization (MCO) for the purpose of ensuring each MCO's compliance with the terms of its contract with the Louisiana Department of Health ("the Department" or LDH). The Act stipulates that results of these activities and analyses used to generate an initial report to the legislature and inform the contents of ongoing quarterly reporting.
4. **Methodology used for analysis or evaluation**:
   For each of these key measures, data reported at the statewide level, at the individual MCO level, and at the individual provider category level. Each MCO is also gathering data related to each MCOs' educational efforts with providers about claims submissions, with a particular focus on those providers that have a high claims denial rate.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by Burns & Associates
6. **Major Findings and Conclusions**:
   a. Claims accepted and rejected by the MCOs
   b. Claims paid and denied by the MCOs
   c. Average time for the MCOs to process claims
   d. Top reasons for denied claims
   e. Encounter claims submitted to LDH by the MCOs that are accepted or rejected
   f. Average time for the MCOs to submit encounters
   g. Provider education related to claims adjudication
7. **Major Recommendations**:
   a. Develop a common set of definitions for claims and encounter adjudication terms that all MCOs would use as well as the LDH fee-for-service payment system.
   b. Review the MCO reports that focus on claims and consider modifying, consolidating, or eliminating existing reports, consider adding a report on

encounter submissions.
   c. Build guidance or requirements about the expectations that the MCOs will perform root causes analyses pertaining to claims adjudication and/or encounter submissions.
   d. Develop an audit protocol and conduct a periodic audit of a sample of claims denied by the MCOs to ensure that the claims denied in error by the MCO.
8. **Action taken in response to the report or evaluation**:
   Quarterly reports for claims and encounter submission, including standardization of terms and definitions, developed with stakeholder and MCO input; and data collection and reporting implemented for calendar year 2019 forward.
9. **Availability (hard copy, electronic file, website)**:
   Healthy Louisiana Claims Report | Department of Health | State of Louisiana
10. **Contact person for more information**:
    Name: Kim Sullivan
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Kimberly.Sullivan@LA.GOV

Report #5

1. **Title of Report or Program Evaluation**:
   LaCHIP Annual Report (Mid-Year)
2. **Date completed**:
   January 2024
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   This report is submitted per the guidelines in Louisiana Revised Statute 46:976 (C)
4. **Methodology used for analysis or evaluation**:
   Compilation of Medicaid eligibility program data.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by in-house staff.
6. **Major Findings and Conclusions**:
   200,363 children and pregnant women have acquired access to critical healthcare coverage in SFY 2023. Studies have found that enrollment in the program has improved school performance among low-income children.
7. **Major Recommendations**:
   (Not Applicable)
8. **Action taken in response to the report or evaluation**:
   (Not Applicable)
9. **Availability (hard copy, electronic file, website)**:
   https://ldh.la.gov/index.cfm/newsroom/detail/2238
10. **Contact person for more information**:
    Name: Kim Sullivan

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

Report #6

1. **Title of Report or Program Evaluation**:
   Medicaid Forecast Report SFY 23/24
2. **Date completed**:
   Monthly
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   Provide the budget changes because of House Bill (HB) 516 from the 2021 regular session.
4. **Methodology used for analysis or evaluation**:
   Program staff develops budget projections based on utilization trends, enrollment trends, and other known factors affecting the management of the Medicaid program. Actual year-to-date expenditures come from the Medicaid Data Warehouse and ISIS.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by in-house staff
6. **Major Findings and Conclusions**:
   (Not Applicable)
7. **Major Recommendations**:
   (Not Applicable)
8. **Action taken in response to the report or evaluation**:
   (Not Applicable)
9. **Availability (hard copy, electronic file, website)**:
   https://ldh.la.gov/news/7193
10. **Contact person for more information**:
    Name: Kim Sullivan
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Kimberly.Sullivan@LA.GOV

Report #7

1. **Title of Report or Program Evaluation**:
   Medicaid Managed Care Transparency Report - Annual
2. **Date completed**:
   June 2024
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   This report is the seventh in a series produced by the Louisiana Department of Health (LDH) to satisfy statutory reporting requirements intended to ensure certain outcomes achieved by Medicaid Managed Care Programs as per La

Revised Statute 40:1253.2.

4. **Methodology used for analysis or evaluation**:
   To the greatest extent possible, the data are extracted from state systems that routinely collect and maintain operational data on the Medicaid Managed Care Program, the Medicaid Management Information System (MMIS), Management Administrative Reporting Subsystem (MARS Data Warehouse or MDW), or ISIS the state administrative system. When unavailable from state sources, data were collected from the managed care entities or sourced from either routine reporting deliverables or ad hoc reports requested specifically for this purpose.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by internal staff
6. **Major Findings and Conclusions**:
   Not Applicable
7. **Major Recommendations**:
   Not Applicable
8. **Action taken in response to the report or evaluation**:
   Not Applicable
9. **Availability (hard copy, electronic file, website)**:
   Medicaid Managed Care Transparency Report SFY 2022 (la.gov)
10. **Contact person for more information**:
    Name: Kim Sullivan
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Kimberly.Sullivan@LA.GOV

Report #8

1. **Title of Report or Program Evaluation**:
   HCR 2 Quarterly Report – Medicaid Expansion Enrollment and Claims Data
2. **Date completed**:
   February 2024
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   In response to House Concurrent Resolution 2 (HCR 2) of the 2021 Regular Session, the Louisiana Department of Health (LDH) submits the report. The resolution requires LDH to publish on a quarterly basis a report containing data directly related to payment for health care services through the implementation of a health coverage expansion of the Louisiana medical assistance program.
4. **Methodology used for analysis or evaluation**:
   (a) Total Medicaid expansion enrollment on a monthly basis from July 2021 through June 2022.
   (b) The average monthly expansion premium paid to managed care organizations providing benefits and services to eligible Medicaid enrollees and the portion of the premium related to hospital payments for the January 1, 2022 rates.
   (c) The aggregate Medicaid expansion claims payment by provider type for July

2021 through June 2022.
(d) The total amount of inpatient and outpatient Medicaid expansion claims paid to hospitals delineated by individual hospital for July 2021 through June 2022 separated into two attachments by inpatient and outpatient.

5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by internal staff
6. **Major Findings and Conclusions**:
   Not Applicable
7. **Major Recommendations**:
   Not Applicable
8. **Action taken in response to the report or evaluation**:
   Not Applicable
9. **Availability (hard copy, electronic file, website)**:
   https://ldh.la.gov/news/6385
10. **Contact person for more information**:
    Name: Kim Sullivan
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Kimberly.Sullivan@LA.GOV

Report #9

1. **Title of Report or Program Evaluation**:
   Act 540 Uncompensated Care Cost
2. **Date completed**:
   November 2023
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   In response to Senate Bill No. 337 (SB337/Act 540) of the 2008 Regular Session, the Louisiana Department of Health (LDH) submits the enclosed report. In response to Senate Bill No. 337 (SB337/Act 540) of the 2008 Regular Session, the Louisiana Department of Health (LDH) submits the enclosed report.
4. **Methodology used for analysis or evaluation**:
   Hospitals that received Medicaid Disproportionate Share Hospital (DSH) Payments were required to report uninsured patient specific information which included name, dates of service, type of service, number of inpatient days, and number of outpatient visits, billed charges, and uninsured cash collections. Using each hospital's latest filed Medicare/Medicaid cost report, the cost to charge ratios were calculated and applied to the uninsured charges compiled from the survey to determine the uninsured costs. Inpatient routine, inpatient ancillary, and outpatient uninsured costs are separately identified.
5. **Cost (allocation of in-house resources or purchase price)**:
   Myers & Stauffer, LC: as part of contract.
6. **Major Findings and Conclusions**:

Not Applicable

7. **Major Recommendations**:
   Not Applicable
8. **Action taken in response to the report or evaluation**:
   Not Applicable
9. **Availability (hard copy, electronic file, website)**:
   https://ldh.la.gov/news/1454
10. **Contact person for more information**:
    Name: Kim Sullivan
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Kimberly.Sullivan@LA.GOV

Report #10

1. **Title of Report or Program Evaluation**:
   Medicaid PDL (MPP) Response to Act 207 of the 2003 Regular Session
2. **Date completed**:
   January 2024
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   Act 207 (Senate Bill No. 305 of the 2003 Regular Session) requires the Louisiana Department of Health (LDH) to submit certain information on a semi-annual basis regarding the Medicaid buy-in program, the Medicaid Purchase Plan (MPP), to the Joint Legislative Committee on the Budget and to the House and Senate Health and Welfare committees. The MPP is an optional Medicaid program that provides healthcare coverage to individuals with disabilities who are employed and meet specific income requirements. MPP was implemented in January 2004 and provides full medical coverage that includes prescription drugs, hospital care, doctor services, medical equipment and supplies, and medical transportation.
4. **Methodology used for analysis or evaluation**:
   The report includes the status of MPP, the total annual gross income of the program's participants, and any recommendations for expanding coverage in the program. Revised Statute 24:772 also requires that the report be submitted to the President of the Senate and to the Speaker of the House. This report contains data for the first six months of State Fiscal Year (SFY) 2023.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by internal staff
6. **Major Findings and Conclusions**:
   Expenses for these services to members, which includes capitation payments, totaled $25,528,418 during the first six months of SFY 2023. Since the inception of MPP, 28,488 individuals have been enrolled in the program.

Enrollment from July 1, 2022 to December 31, 2022 was 4,885 individuals.

7. **Major Recommendations**:
   Not Applicable
8. **Action taken in response to the report or evaluation**:
   Not Applicable
9. **Availability (hard copy, electronic file, website)**:
   https://ldh.la.gov/news/1397
10. **Contact person for more information**:
    Name: Kim Sullivan
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Kimberly.Sullivan@LA.GOV

Report #11

1. **Title of Report or Program Evaluation**:
   Medicaid Preferred Drug List Annual Report SB 689 of the 2004 RS - HB 369 of the 2005 RS – SFY 16-20
2. **Date completed**:
   March 2024
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   The Louisiana Department of Health and Hospitals (DHH) Preferred Drug List (PDL) program has been in operation since 2002 by Provider Synergies, L.L.C. Provider Synergies is an affiliate of Magellan Medicaid Administration, Inc., and a Magellan Rx Management company ("Magellan"). Louisiana is entering the twelfth year as one of six states participating in the multi-state purchasing program, The Optimal PDL Solution (TOP$). Louisiana was one of three states that initially participated in the multi-state purchasing pool, TOP$, in 2005. The six states now participating in TOP$ are Louisiana, Maryland, Idaho, Wisconsin, Nebraska, and Connecticut.
4. **Methodology used for analysis or evaluation**:
   This review summarizes the results of the PDL program for fiscal year 2021-2022 (FY 2022) and the first quarter of fiscal year 2022-2023 (FY 2023). This report includes MCO data.
5. **Cost (allocation of in-house resources or purchase price)**:
   Magellan Rx Management Company
6. **Major Findings and Conclusions**:
   The LDH PDL program continues to be very successful. Savings for FY 2022 were over $102 million, mainly due to supplemental rebates. Savings have increased from FY 2021 due to increased prescription volume and the continued growth of specialty drugs. The COVID-19 pandemic continues to result in a surge in Medicaid enrollment and in keeping some non-preferred, more expensive products in preferred status due to production shortages.

Louisiana's estimated savings for FY 2023 are over $135 million.

7. **Major Recommendations**:
   Not Applicable
8. **Action taken in response to the report or evaluation**:
   Not Applicable
9. **Availability (hard copy, electronic file, website)**:
   https://ldh.la.gov/assets/docs/LegisReports/PreferredDrugList/PharmacyPDLReportSFY2023.pdf
10. **Contact person for more information**:
    Name: Kim Sullivan
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Kimberly.Sullivan@LA.GOV

Report #12

1. **Title of Report or Program Evaluation**:
   Medicaid Financial Assistance Programs Annual Report
2. **Date completed**:
   February 2024
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   Senate Bill (SB) 259 of the 2022 Regular Legislative Session, known as the "Public Benefit Integrity Law" requires annual reports from state agencies administering federal and state social services and financial assistance programs on the policies and procedures in place to enhance program integrity; to eliminate fraud, waste, and abuse of federal and state resources. In response to the Public Benefit Integrity Law, the Louisiana Department of Health (LDH or the Department) will submit an annual report fulfilling this requirement for benefit eligibility, if applicable.
4. **Methodology used for analysis or evaluation**:
   This report consists of data from Louisiana Medicaid and the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC).
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by internal staff
6. **Major Findings and Conclusions**:
   Not applicable
7. **Major Recommendations**:
   Not applicable
8. **Action taken in response to the report or evaluation**:
   Not applicable
9. **Availability (hard copy, electronic file, website)**:
   https://ldh.la.gov/assets/docs/LegisReports/Act542/Act_542_Public_Benefits_Integrity_Law.pdf
10. **Contact person for more information**:

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

Report #13

1. **Title of Report or Program Evaluation**:
   Act No. 670 – "Lorri Burgess' Law" – Senate Bill 298 of the Regular Legislative Session 2022
2. **Date completed**:
   February 2024
3. **Subject or purpose and reason for initiation of the analysis or evaluation**:
   This report is submitted pursuant to Senate Bill 298 of the 2022 Regular Legislative Session, which requires the Louisiana Department of Health (LDH) to conduct an annual review of all medications and forms of treatment for Sickle Cell Disease (SCD) that are eligible for coverage under the Louisiana Medicaid program. The report shall be submitted to the Senate Committee on Finance, the House Committee on Appropriations, and the Senate and House committees on health and welfare.
4. **Methodology used for analysis or evaluation**:
   The annual review should include input from the general public, particularly those persons or groups with knowledge and experience of SCD treatment.
5. **Cost (allocation of in-house resources or purchase price)**:
   Compiled by internal staff
6. **Major Findings and Conclusions**:
   Study findings show that covered medications, treatments, and services are available to Louisiana Medicaid members with SCD but may be underutilized. From routine preventive care to SCD specialty care, there are multiple opportunities to better ensure that adults and children with SCD receive the recommended care.
7. **Major Recommendations**:
   Louisiana Medicaid members with SCD can benefit from additional research to identify barriers to care (e.g., geographic disparities in availability of specialists) and root causes of the disparities identified in this study. Qualitative research might also yield insights into possible care team implicit bias, as gaps in pain management include under treatment of SCD along with other conditions that are common among racial minorities. Researchers at the National Heart, Lung, and Blood Institute (NHLBI) of NIH are investigating new ways to treat SCD, including activating the enzyme Pyruvate Kinase (PKR) to relieve pain through oral therapy, which was shown to be safe in an early phase 1 clinical research trial. Interventions to increase access to a shared care model or other strategies to drive better integration of specialty and primary care merit exploration. Given the lower rates of adult members

with at least one hematologist visit compared to children, improving transitions from pediatric to adult care warrants consideration for a collaborative performance improvement project (PIP). MCO interventions to enhance case management and care coordination for members with SCD are merited. In addition, MCOs can educate PCPs and hematologists regarding SCD clinical guideline recommendations, as well as advances in SCD treatment.

8. **Action taken in response to the report or evaluation**:
   Not applicable.
9. **Availability (hard copy, electronic file, website)**:
   Act670_2022RS_LDHReport_2024.pdf (la.gov)
10. **Contact person for more information**:
    Name: Kim Sullivan
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-219-7810
    Email: Kimberly.Sullivan@LA.GOV

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

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

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

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: Governor Landry Moves Ralph Abraham from LDH Health Secretary to First-Ever Surgeon General Position

A. What was achieved?
Governor Jeff Landry shifted the LDH Secretary, and former Congressman, to Louisiana's first-ever surgeon general. According to Act 739 (HB 853) of the 2024 Regular Legislative Session, the surgeon general will lead public health efforts and set medical guidelines, thus leaving many of the financial and administrative responsibilities of Louisiana's largest state agency to the health secretary.

B. Why is this success significant?
There are only a few others states, including Arkansas, Florida, Michigan, Pennsylvania,

Texas and California that have created an office of the surgeon general offices in their state governments. This puts Louisiana ahead of the game by having a physician in charge working side by side with the secretary as CEO of the health department. This is also significant because it places a medical doctor to oversee the health plan of Louisiana, and an executive to oversee the financial and administrative responsibilities of the department.

C. Who benefits and how?
The residents of the state of Louisiana, as well as the state's medical schools, nursing programs and medical boards will all benefit from this accomplishment. The surgeon general will work to lead public health efforts, set medical guidelines, and oversee health policies of the state.

D. How was the accomplishment achieved?
At the urging of Governor Landry, Louisiana lawmakers created the new surgeon general position when they passed House Bill 853.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, this accomplishment helps us improve the outcome of health care in the state of Louisiana.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, it is a best management practice and a priority of LDH to have a doctor overseeing health policies for the state of Louisiana.

Accomplishment #2: ESF-8 Portal Enhancements

A. What was achieved?
Louisiana's Emergency Support Function (ESF-8) Portal is the web-based platform funded by the federal Hospital Preparedness Program (HPP) grant and consists of an integrated suite of applications that is used by over 1,500 facilities with over 4,000 end-users**.**

- Louisiana Hospital Preparedness Program (HPP) has advanced in-state Burn Surge readiness. LA HPP completed the Burn Surge Annex and also expanded the ESF-8 Portal to include a burn-bed availability screen. Portal notification system expanded to include all burn hospitals in the 14 states of the southern region. This allows for rapid notification of a large scale incident putting those states and hospitals on stand-by to surge as well as request a burn bed availability report. Severe burns are complicated by major trauma and usually require specialized intensive care in a burn center; resources are limited. Louisiana's four (4) burn centers update this screen daily. ESF-8 Portal has a 95% compliance rate in burn-bed daily reporting.

- Additional portal investments were made aside from expand the burn screen. Making adjustments to the utilities screen, repurposing a screen for CHEMPACK/ Atropine inventory collection, and various reports were developed to assist with situational awareness. These all came about as a result of real event improvement planning items and response to known federal shortage.

B. Why is this success significant?
The Portal is used primarily during state declarations to obtain operational data to gain situational awareness for critical resources status such as bed census, evacuation, fuel, utility, and power status. Severe burn casualties are complicated by major trauma or inhalation injury by chemical burns, high-voltage electrical burns, and scald burns during assaults, plane crashes, and explosions with airborne fragments and flames. The Portal also helps emergency managers effectively manage healthcare responses throughout an emergency.

C. Who benefits and how?
Advancing the ability to identify, message and track limited burn-bed resources, not only in Louisiana but also in the expanded area of Southern Burn Region, would assist in meeting grant requirements for achieving a robust Chemical Response Plan and a Radiological Response Plan.

D. How was the accomplishment achieved?
This was accomplished with the Louisiana Emergency Response Network (LERN) and the Southern Region Burn Network.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, the ESF-8 Portal is a gateway to a suite of applications which is used to gather emergency status information on facilities licensed by the Department and helps emergency managers effectively manage healthcare responses throughout an emergency.

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

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

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

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

realized?

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

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

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

- **Emergency Preparedness Response:** The overall strategic goal 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. Currently, ESF-8 remains vulnerable to fluctuations in federal funding. The available funding is directed to priorities (and fixed costs) of:
  1) Regional Infrastructure of coordinators to interface with the State Core Team; and
  2) ESF-8 Portal, a web-based platform for information sharing, data collection, validation, and decision-making.

- Given these unknowns, sufficient infrastructure is defined as maintaining access to disaster-responders through one-year renewable contracts. 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 the good of the community and their needs.

- **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.

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

Through the end of Fiscal Year 2024, our progress has been carried out and measured through four major commitments aimed at:

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

Emergency Preparedness Response: Progress is related to emphasizing excellence in specific areas. For the ESF-8 Network, "progress" is ensuring a sharp and crisp response for disaster events, particularly for patient movement.

Success is attributed to the investments in relationships, facilitated through the urgency of the increasing number of disaster response events.

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

Emergency Preparedness Response: Emergency Preparedness has made significant progress in contracting resources – i.e. Staff augmentation for command centers, ambulances, wrap-around services for medical operations, etc. The achievement in contracts development is primarily to make up for the growing gap in LDH employees – specifically those with medical skillsets. Despite this achievement, the progress does

not make up for the continued loss in employees attributable to budget cuts and normal attrition. Contracts do not make up for the loss of historical knowledge gained in working disasters.

- **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:

  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. During Hurricane Katrina, the issue was generators; with Hurricane Gustav, the issue was dialysis; for the catastrophic floods of August 2016, the burning issue to be solved was pharmaceuticals in shelters. For Hurricanes Laura and Ida (2020-2022) the burning issue was recovery. 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 six months or less timeframe, so as not to be repeated for the next hurricane season.

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.

   Emergency Preparedness: Lack of progress is attributable to the fact that "Response" and "Recovery" is larger than the current infrastructure for disaster response network can address by themselves.

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?

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

- **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?

  Emergency Preparedness: The ESF-8 Network's primary funding source is the Federal Hospital Preparedness Program (HPP) Grant. The grant provides some parameters for where funds can be directed. The overall strategic plan is to ensure that priorities – namely, an operational infrastructure of coordinators as well as a platform for information sharing is secured. Our Strategic Plan provides goals for achievement such as development, testing, validation and implementation of the State's Burn Plan, Chemical Response Plan, and Radiological Response Plan. To accomplish and implement these major response plans require an assessment of baseline capabilities, identification of gaps, and shortfalls.

  Overall, strategic plans will be updated department wide in July 2025.

- 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.

  In FY22, LDH revised its 5-year strategic plan. This revised plan is good through FY 2028 and will be updated in three years. Strategic plan revisions occur within each office/section on a continuous basis to address critical needs and issues within each office. Our offices continue to identify and quantify electronic processes to improve efficiencies, address needed rule revisions for consistency with processes and new statutes, and address resources needed for improved efficiencies.

  Emergency Preparedness: The draft plans are circulated with subject matter experts, regional coordinators, the various state agencies as well as LDH offices and programs for input throughout the development phase. When validating the plan, an Initial Planning Conference, Mid-Point Planning Conference and Final Planning Conference are conducted prior to a regional and/or statewide exercise.

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.)

Issue #1: Emergency Preparedness and Response efforts require contracts and acquisitions. We are experiencing an operational problem with the complexity and timeliness required to get contracts and acquisitions over the finish line.

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?
   Emergency Preparedness and Response efforts require contracts and acquisitions. An operational problem is the complexity and timeline required to get contracts and acquisitions over the finish line.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   Louisiana does not have a lack of (strategic) plans; it lacks funds and a contractual mechanism to advance executable plans.

3. What organizational unit in the department is experiencing the problem or issue?
   LDH/Contracts section is underfunded and under-resourced.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Internal and external customers are affected when the rapidity of contract development, implementation, and encumbrance is unknown or undetermined.

5. How long has the problem or issue existed?
   At least 10 years.

6. What are the causes of the problem or issue? How do you know?
   During a previous administration (Jindal), the administration swiped each agencies' contracts sections rendering all Departments, bureaus, programs, and offices in critical need for successfully maneuvering policy and acquisitions rules/regulations.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   Short and long-term performance suffers. Short-term: loss of confidence in LDH

programs and offices to address needed activities in a disaster. Long-Term: Companies do not want to provide services or do business in Louisiana due to a contract process which is often mishandled, exorbitantly lengthy in timeframe, questions and answers are revisited multiple times; too many hands in the pot identifying requirements; requirements that are not always understood of the general purpose.

B. Corrective Actions

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

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

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

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

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

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

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Peer review
☐ Accreditation review
☐ Customer/stakeholder feedback

☐ Other (please specify):

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

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

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

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

1. Title of Report or Program Evaluation:
   Administration for Strategic Preparedness and Response/ Hospital Preparedness Program (ASPR/HPP) Benchmarks and Performance Measures

2. Date completed:
   Semi-Annual and Annual

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   HPP grant requires submission of benchmarks and performance measures periodically throughout the year.

4. Methodology used for analysis or evaluation:
   Reports and performance measures are submitted to ASPR

5. Cost (allocation of in-house resources or purchase price):
   Costs are baked into the planning grant activities. HPP requires submission of performance measures throughout the year. Grant related contracts include the performance measure metrics.

6. Major Findings and Conclusions:
   The HPP Federal Project Officer (FPO) will provide technical guidance if a performance measure is not met. The HPP Grants Management Officer can also withhold funds if a performance measure is not met. The HPP grant funds awarded to Louisiana remain in good standing with no grant funds being withheld.

7. Major Recommendations:
   The HPP grant funds awarded to Louisiana remain in good standing with no grant funds being withheld.

8. Action taken in response to the report or evaluation:
   The HPP grant funds awarded to Louisiana remain in good standing with no grant funds being withheld.

9. Availability (hard copy, electronic file, website):
   Not Available.

10. Contact person for more information:
    Name & Title: Rosanne Prats, Emergency Preparedness
    Agency & Program: Emergency Preparedness
    Telephone: 225-342-3417
    E-mail: Rosanne.Prats@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

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

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

Executive Director: Kristin Bonner, MHA, BSN, RN

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

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

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: Improvements in Medications for Opioid Use Disorder Services:

A. What was achieved?

Medications for Opioid Use Disorder (MOUD) services formerly referred to as Medication-Assisted Treatment (MAT) services at South Central Louisiana Human Services Authority (SCLHSA) have been redesigned to a team approach for treatment comprised of nurses, case managers, counselors and peer support staff and led by an addictionologist. SCLHSA has modified our policies and processes to be more comprehensive and congruent with current practicing guidelines.

The SCLHSA Family Medicine physician became a Board Certified Addictionologist.

He has brought to our medical team new ideas and approaches to treating opioid addiction. Through our Louisiana State Opioid Response (LaSOR) federal funding, SCLHSA has redirected our approach from primarily preventative measures to an in-clinic treatment team. We have hired and allocated current staff members to work as a team with this population for a more comprehensive approach.

Data shows an increase of 44.9% in fiscal year 2023 of patients served by the MOUD program and a further increase of 10.3% in fiscal year 2024. The number of patient visits initially increased by 74% in Fiscal Year 2023, but decreased by 8.6% in the last FY. The decrease in services is due to a multitude of changes to the program, such as not requiring counseling as mandatory and offering immediate access to medications. In addition, many patients transitioned to injectable medication requiring less frequent visits, more medication adherence and the ability to see more individuals in need of medications for opioid use disorders.

B. Why is this success significant?

Developing MOUD services as a program instead of a service allowed for a comprehensive approach to care. Leadership has embraced the evolving treatment guidelines and regulations.

C. Who benefits and how?

The population in our catchment area has available opioid treatment at each of SCLHSA Behavioral Health clinic locations. With the "team" approach there are dedicated staff to attend to addiction patients at each site as well as access to a Board Certified physician, nurse practitioner, case manager, nurse, and peer support. With the afterhours Call Line, SCLHSA patients also have access to licensed counselors and one of the MOUD medical providers for concerns with medication, side effects, etc.

D. How was the accomplishment achieved?

One of the SCLHSA physicians has a Board Certification in Addiction Medicine. SCLHSA used current nursing staff and creating job appointments to add a case manager and peer staff to assist clients receiving MOUD services. The Clinical Director and Addictionologist have provided more education to staff and offered educational resources on MOUD treatment. Clinical leaders presented new policies and procedures to the behavioral health staff, discussed the revised approach to the MOUD program and responded to any questions presented by the staff members.

Through the Office of Behavioral Health, SCLHSA received federal LaSOR funding to expand the program. The staff members on the MOUD Team were sent to various training in order to support the program and physician.

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, medication-assisted treatment in combination with counseling and behavioral therapy is the preferred approach to treating individuals with opioid use disorder. However, American Society of Addiction Medicine (ASAM) and the addiction medical profession views medications for OUD as a life sustaining drug that should not be discontinued due to lack of counseling attendance. This team approach allows for the physician to provide medication management while the counselor, case manager and peer work to encourage therapy and recovery supports.

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

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

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

  The South Central Louisiana Human Services Authority (SCLHSA) 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.

  Specific to our improvements in Medications for Opioid Use Disorder (MOUD) Treatment and in alignment with our Strategic Linkage with the Substance Abuse Mental Health Services Administration's (SAMHSA) mission of meeting the behavioral health needs of individuals, communities, and service providers, SCLHSA improvements support Goal 1, Objective 1 as stated below.

  Goal 1: Improve service outcomes by collaborating with stakeholders to expand integrated service programs in the community and within SCLHSA's Behavioral Health Centers.

  Objective 1: Continue to provide services in the SCLHSA Behavioral Health Centers to meet and/or exceed performance indicators.

  Strategies:

  1.2 - Develop standardization of clinical processes in the behavioral health centers.

1.4 - Increase the number of persons served for Integrated Behavioral Health Primary Care services.

- **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:

  SCLHSA's initial improvements with improving the MOUD Services is great, but to claim that it is significant progress we need to collect further data to ensure increases continue to reach the individuals in our community.

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

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

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

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

  Objective 1: Develop and implement productivity benchmarks to increase efficiency and effectiveness of program tracking and to maximize time management principles in the workplace.

  Strategies:

  1.1 Benchmarks established for integrated care staff (behavioral and primary care) to include providers, counselors, case managers, nurses, pharmacy staff, dietician and clerical.

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.

Staff recruitment and retention has been an ongoing issue since the COVID Pandemic. The increasing work from home and virtual patient appointments contributed to larger caseloads for existing staff and increased burnout. Staff and patients were reluctant to return to the Behavioral Health Centers, but the increased need for mental health and addiction services was evident. SCLHSA made the management decision to relax individual productivity benchmarks for the fiscal year to reduce the staff stress and realign staffing patterns with appropriate caseloads. Productivity has continued to be monitored, but from a clinic-wide perspective.

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

The management decision was a temporary one-time event to allow time to identify potential impacts to clients and staff to determine next steps.

- **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?

Benchmarks will be re-established for individual providers, but will continue to be reported on a facility basis.

☐ 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 Board of Governance Model. The Board of Directors 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. 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).

The Executive Management Team reviews, edits, and adopts the Strategic Plan each year. The group also develops, adopts, and implements cross-divisional annual Performance Improvement Initiatives (PI) to ensure 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. The Executive Management Team delivers quarterly progress reports to the Board and Senior Management.

South Central Louisiana Human Services Authority informs employees about Strategic Plan Goals, Objectives, and Performance Indicators via monthly Manager Meetings and Directors involve staff in data collection, analysis, and reporting of Performance Indicator outcomes. Clinic Managers lead discussion about the Performance Improvement Plan during staff meetings, reporting progress, obtaining staff input, and emphasizing accountability for reaching goals and objectives. The Executive Director schedules quarterly All-Staff meetings each year at each of the Behavioral Health (BH) Centers. Performance improvement is a routine part of the agenda. Further, the Executive Director bases a significant portion of the 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.

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 SCLHSA 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 SCLHSA's Staff Development and Supervision Guidelines to review and discuss progress toward meeting expectations. Continued and open discussion is encouraged.

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

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department

management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

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

Issue #1: Filling Licensed Professional Counselor Positions

A. Problem/Issue Description

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

   In the past few years, it has become harder to fill counselor positions. The few Licensed Professional Counselors (LPC) and Licensed Clinical Social Workers (LCSW) in this region are difficult to recruit and hire. With more providers and services covered by Medicaid, Medicare and private insurance, agencies are recruiting for the same people in order to provide the full continuum of services at each level of care offered. Many of the private providers are able to offer significantly more money per hour for the level of work, making it even more difficult to recruit or retain billable professionals.

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

   Yes, the ability to provide quality core service are impacted in the Behavioral Health Centers due to large caseloads and increasing number of individuals presenting for treatment. In certain clinic locations, we are forced to refer patients away from the agency due to the lack of clinicians and/or inability to provide the service needed. Evidence-based treatment programs, specialty populations and children services all require a level of competence, commitment and training adding more challenges to recruitment and a heavier burden on retained the current clinician.

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

   The impact is to the outpatient clinical treatment services, more specifically access to care, children and evidence-based specialty certifications programs.

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

   The counselor staffing shortage is effecting SCLHSA's external customers, clients, other community social service agencies and the community as a whole. Reduced counselors, increases wait times for assessments and psychiatric evaluations and

referrals to outside agencies for children and other specialty services.

5. How long has the problem or issue existed?

   The LCSW shortage has existed for five to six years. LPC's have been increasingly harder to attract and retain over the same amount of time. Medicare reimbursement has been beneficial to providing more services to the Medicare population, however; it has increased the opportunity for LPC to enter hospital, nursing home and other setting that were not previously an option.

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

   Social workers with their master's degrees must complete 96 face-to-face supervision hours, a minimum of 3000 hours post master's degree client contact hours under supervision and pass the licensing test in order to become a LCSW. Counselors with master's degrees must complete 3000 hours with a minimum 1900 hours of direct client contact plus 1000 non-direct hours and 100 hours face-to-face supervision in addition to passing the licensing test. SCLHSA hires these individuals as Case Managers until their training hours are obtained. These positions are not billable. The field is competitive at this time. Individuals have left state employment for higher pay and several have left for positions at the Managed Care Organizations due to different working conditions, such as pay, hybrid or remote work.

   There are national reports that identify social services fields are declining in enrollment. The increased mental health need compounded by the decrease in individuals seeking social service degrees is causing a workforce shortage. Other reports have indicated that people are not wanting to dedicate that much time to work and changing fields because the reimbursement rates do not allow a clinician to maintain a healthy work life balance on a viable salary.

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

   Current employees are becoming fatigued due to heavy client loads. The time for follow-up appointments will become longer and quality care will suffer. In time, our behavior health centers will become physician and nurse practitioner medical appointments only. We will lose the ability to collect our self-generated revenue or meet requirements for federal and contractual agreements.

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 Office of Behavioral Health accomplished the suggested action, which was suggested in the AMPAR 2023, and effective September 2024. Allowing the LGEs to utilize provisionally licensed master level social workers and counselors to provide billable services under the supervision of a licensed LPC and LCSW for the Office of Behavioral Health's core services identified under the managed care contracts with the LGEs. Also providing the LGEs an advantage with state universities and graduate students who will receive a salary while obtaining the direct client contact hours needed for licensure.

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

   Yes, SCLHSA has reported staffing concerns for two years.

4. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
      - How much progress has been made and how much additional progress is needed?

      Corrective actions within SCLHSA's control are ongoing. The Civil Service Commission approved a Retention and Recruitment Premium Pay policy for LCSWs and LPCs to receive $2.00/hour. SCLHSA's Medicare population in Fiscal Year '24 was 24%. SCLHSA is actively attending university job fairs, as well as, offering extern positions for students in counselor and social work programs. Future consideration is student intern positions in 4 behavioral health centers, which at a cost of $15,600 per intern annually, equates to $62,400.

   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.

Estimated costs for Retention and Recruitment Premium Pay in Fiscal Year ’24 is $105,346.00 (includes $1,916 for staff supervision to those pursuing licensure).

b. How much has been expended so far?

$79,975.19 was spent in FY’24 on thirty-one employees. It should be noted in FY’24, the premium pay for LPCs increase from $1.50 per hour to $2.00 per hour and implemented in March 2024 when Civil Service approved the increase. LPC services are now billable to Medicare.

c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

Yes, SCLHSA submits a request during the budget process to fund the Civil Service approved premium pay. Without approval of the request, this incentive may be compromised by a budget reduction.

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?

Yes, in the FY ’25 budget document the Premium Pay is a line item.

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 (LDH) - Office of Behavioral and Office of Developmental Disabilities, Bureau of Health Licensing Standards, and the Louisiana Department of State Civil Service.

The Louisiana Medicaid State MCO's also conducts audits and reviews SCLHSA and its providers for compliance with contract standards and accountability for funds received to provide services to members.

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

The South Central Louisiana Human Services Authority's Executive Management Team provides these functions with oversight from the SCLHSA Deputy Director.

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

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

☒ **Program evaluation by in-house staff**

Performance is monitored on an ongoing basis utilizing the South Central Louisiana Human Services Authority's Strategic Plan, Operational Plan, Performance Improvement Plan, Risk Management Plan, and position-specific performance expectations. All have clearly stated expectations and performance

targets. The Executive Director, Executive Management Team, Managers and Supervisory Staff share responsibility for oversight of these functions. Outcomes are reviewed and reported to the Board, staff and stakeholders on a quarterly basis.

☒ **Program evaluation by contract**

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

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

The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies, including SCLHSA. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at the quarterly Quality Committee and reported to the Deputy Director and Executive Director. The measures, benchmarks and explanatory remarks are reported quarterly to the SCLHSA Board.

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

SCLHSA utilizes the Annual Performance Accountability & Business Functions Plan to review the annual performance measures and business functions of the agency. Executive staff and department directors collect and report on the measures described herein and are presented to either the Executive Management Team or the Quality Committee. Annually, the SCLHSA Board reviews the Annual Performance Accountability & Business Functions Plan.

☒ **Benchmarking for Best Management Practices**

Many benchmarks are set by LDH-OBH through National Outcome Measures, Telesage Outcome Measures and Office of Developmental Disabilities standards. Additionally, SCLHSA utilizes nationally recognized benchmarks from agencies such as the National Committee for Quality Assurance (NCQA) for clinical standards and performance measures.

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

The LDH contract with SCLHSA contains a description of the work to be performed based on the community core service deliverables, performance measures and monitoring plan. The OBH and OCDD conducts quarterly and semiannually audits to ensure SCLHSA is performing within the parameters of the contract benchmarks.

☒ **Peer review**

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

☒ **Accreditation review**

South Central Louisiana Human Services Authority has implemented an Authority-wide plan for re-accreditation readiness with the Commission on Accreditation of Rehabilitation Facilities (CARF). Communication between the Authority and Commission on Accreditation of Rehabilitation Facilities (CARF) is ongoing and formal application was filed. As stated previously, the SCLHSA 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 Organizations and the Louisiana Department of Health.

☒ **Customer/stakeholder feedback**

South Central Louisiana Human Services Authority participates in satisfaction surveys sponsored by the Office of Behavioral Health. Additionally, SCLHSA fields a survey within its electronic health record on a quarterly basis to gain additional information for the identification of opportunities for improvement. The SCLHSA Developmental Disabilities also collects programmatic specific surveys quarterly and both are reported to the Quality Committee and SCLHSA Board. The Authority has initiated satisfaction surveys for all contractors as part of standard contractual requirements.

☐ Other (please specify):

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

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

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

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

1. Title of Report or Program Evaluation: **CARF Accreditation**

2. Date completed: 1/26/2024

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

4. Methodology used for analysis or evaluation: Performance and Compliance with CARF standards.

5. Cost (allocation of in-house resources or purchase price): $17,460

6. Major Findings and Conclusions: Three-Year Accreditation

7. Major Recommendations: None

8. Action taken in response to the report or evaluation: Response and action to five identified recommendations.

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

10. Contact person for more information:
    Name & Title: Kristin Bonner, MHA, BSN, RN
    Agency & Program: South Central Louisiana Human Services Authority
    Telephone: (985) 876-8886
    E-mail: Kristin.bonner@la.gov

Annual Management and Program Analysis Report Fiscal Year 2023-2024

Department: Louisiana Department of Health (LDH)
09-310 Northeast Delta Human Services Authority

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

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?

By implementing the agency's Five-Year Strategic Plan and alignment with the overarching vision, mission, and tenets, Northeast Delta Human Services Authority (NEDHSA) experienced continual growth and realized numerous outstanding accomplishments during FY23-24. These accomplishments resulted from the careful and deliberate planning of new programs and services, establishment of new community partnerships, expansion of current services, and a continued focus on the specific needs of the individuals served.

In addition to the continuation of excellent care and services provided, NEDHSA has continued to set exceed our footprint in Region 8 as we extend not only services but education, resources, and a sense of community to those NEDHSA comes in contact with? Below are those achievements accomplished during FY23-24 that align with NEDHSA's Fiver Year Strategic Plan:

Accomplishment #1: Integrated Care Network and Services

A. What was achieved?

NEDHSA successfully implemented numerous special initiatives that stem from our integrative behavioral health approach. The key component of NEDHSA's innovative approach to our client-centered integrated care program involves the formal establishment of partnerships with community-based agencies and programs. The development and maintenance of a successfully integrated service network are vital to the operation and administration of the integrated approach. Ongoing relationship-building efforts and communication through regular meetings, community involvement, education, and outreach continue to be the driving forces underlying the agency's success and improved outcomes of the individual served.

In FY23-24, NEDHSA provided services to 25,648 services and of those services, 10,150 were billable services and 14,795 were non-billable services. Of these non-billable services, it should be noted these are reported to be a combination of welfare checks, therapeutic based calls (not including reminders), and/or case management calls with other healthcare professionals to discuss client treatment plan. In addition to providing these services, NEDHSA's messaging for agency awareness, resources, and services to vulnerable population's garnered 11,782,944 impressions and 172,690 engagements.

In FY 23-24, NEDHSA continued to utilize Recite Me ensuring that the agency's website is inclusive to all by supporting people who are neuro-diverse, visually impaired, speak English as a second language, or are of old age. Recite Me offers a range of on-demand accessibility solutions to help comply with ADA and WCAG standards while ensuring NEDHSA's website is user-friendly for individuals with disabilities, situational challenges, and language needs, through customization and translation options. The Recite Me cloud-based assistive toolbar makes the agency's website more inclusive by allowing visitors to customize their content so they can read and understand it in ways that work best for them.

NEDHSA Implements Community Psychiatric Supportive Treatment (CPST) Services Rollout Plan

NEDHSA has established a rollout plan for future implementation of Community Psychiatric Support and Treatment (CSPT). These services will be provided through NEDHSA's

Children and Family Services Clinic that will provide clinic-oriented components through CPST. These services further pushes the implementation of the integrated care model that NEDHSA has established to treat the whole person.

Although through these services, the family unit benefits from the services provided, the beneficiary age groups that would be provided these services are ages 6-20. Those who are 6-18 would be asses using CALOUS assessment tool and ages 19-20 are to be

assessed using the LOCUS assessment tool. These tools are to be rated by a physician or licensed mental health practitioner (LMHP).

CPST services may be provided at NEDHSA's Children and Family Services Clinic, in the community, or in the individual's place of residence as detailed in the treatment plan. The service location of these services are selected based on what is therapeutically appropriate and beneficial to the participant, hence, creating an accessible means of treatment that is conducive to the person and family receiving services and meeting them where they are.

Applied Suicide Intervention Skills Training (ASIST)

NEDHSA provided Applied Suicide Intervention Skills Training (ASIST), an evidence based two-day face-to-face workshop featuring powerful audiovisuals, discussions, and simulations. Because of this training, the Town of Farmerville and the Union Parish Office of Homeland Security and Emergency Preparedness learned how to reduce suicide by recognizing signs, learning how to provide skilled interventions, and better understand how to develop safety plans to keep people alive.

The ASIST training helps professionals learn the risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help to help individuals during a chaotic time in their lives.

Dr. Sizer added, "We must continue to be innovative in conceptualizing issues and solving problems on behalf of and with vulnerable people and communities in our region."

M&T Property Management-Lakeshore Village Memorandum of Understanding (MOU)

The intended purpose of the MOU between NEDHSA and M&T Property Management – Lakeshore Village is to continue to build stronger relationships between organizations while creating sustainable and mutually beneficial relationships in efforts to equitably serve the residents of Lakeshore Village with effective integrated care services.

Because NEDHSA views mental illness, addictive disorders, and developmental disabilities the same way our society views chronic illnesses such as diabetes or hypertension, they are health issues that can affect anyone at any time. Within this partnership, addressing social determinates of health in rule communities are a continuation of meeting people where they are.

Webinar Series Partnership with the Department of Health Foundation for Wellness: Utilizing Digital Therapeutics

NEDHSA partnership with the Louisiana Department of Health and Foundation for Wellness conducted a new webinar series on Utilizing Digital Therapeutics (DTx). This

six part series will delve into the power of Digital Therapeutics, an evidence-based software intervention that can prevent, manage, and treat various behavioral health conditions and will occur between March and August 2024.

Through the DTx webinar series, professionals will learn how to integrate DTx into practice, leverage its potential to reduce disease burdens, improve clinical outcomes, and enhance patient lives. The content learned will be submitted for continuing education and is appropriate for physicians, nurses, social workers, licensed professional counselors, and other behavioral health care professionals.

Pelican State Credit Union Financial Education and Literacy Memorandum of Understanding (MOU)

The purpose of this partnership was to plan, coordinate and execute efforts to better educate our community about financial education and financial literacy. The execution of this partnership helped to mitigate negative social determinates of health associated with financial education and financial literacy. These negative social determinates of health are often correlated with mental illness, addiction, disability, and primary healthcare challenges. The focus is on citizens having convenient access to financial education, financial literacy skills, and services. This agreement ensures financial education and financial literacy for persons employed and being serviced by either NEDHSA or Pelican State Credit Union.

Empower Your Wellness Campaign to Raise Health Literacy

This campaign is to educate individuals on their medical and psychiatric diagnoses, drug prescriptions, how to communicate with healthcare professionals successfully, and how to navigate healthcare systems. This campaign is part of NEDHSA's behavioral and primary healthcare integration model.

Health Literacy includes a broad range of abilities, such as reading, comprehending, sharing information, analyzing data, contemplating decisions, and taking action. Through the Empower Your Wellness campaign, NEDHSA offered counseling on prescriptions through its onsite pharmacy, Genoa, and host seminars at its clinics discussed topics including but not limited to nutrition, the effects of controlled substances on certain medications, and environmental risk factors. NEDHSA's staff also trained to help implement consistent messaging to ensure patients understood their role in overall health and wellness.

The Union Parish Museum of History & Art

NEDHSA and the Union Parish Museum of History & Art partnership gave individuals with mental health and addiction disorders an opportunity to realize their full human potential through mental health art on display at the Union Parish Museum of History & Art.

"Through this initiative, we commissioned seven regional creatives to develop artwork from their unique perspectives, while also focusing on mental health and addiction-related themes," Dr. Sizer said. "Through this and other agency efforts, we intend to help create an environment where dreams are realized, families are strong, bodies are healthy, community institutions are thriving, and spirits are renewed."

Mental Health Art at NELA Delta African American Heritage Museum

This exhibition is part of the agency's Art Is Medicine special initiative, an integrated health care, evidence-based prevention, communications, and treatment strategy to help serve persons with mental health, addictive disorders, and developmental disabilities.

"Through this initiative, we commissioned seven regional creative artists to create artwork that focused on mental health, addiction, and trauma-related issues," Dr. Sizer said. "Through the arts, we intend to help create an environment where dreams are realized, families are strong, bodies are healthy, community institutions are thriving, and spirits are renewed." Dr. Sizer sparked this creative expression to help address mental health issues, reduce addiction related stigma, and work to help transform the region's economy.

Second Opportunity Workforce Solutions (SOWS)

NEDHSA selected Ruth's House Resource Center to operate the Second Opportunity Workforce Solutions (SOWS) program. SOWS provided supportive employment services to citizens who are clients of NEDHSA and the integrative behavioral and primary healthcare network, including citizens who are non-violent criminal offenders and those who are being released from incarceration.

This program provided services that empowered participants by developing skills needed to live a more self-sufficient lifestyle through gainful employment, thereby enhancing recovery, promoting options, and assisting in developing opportunities to perform valued tasks and roles.

Recovery House Stipend (RHS)

NEDHSA implemented the Recovery House Stipend (RHS) to extend funding to those NEDHSA participants with a mental illness, who are actively engaged in substance abuse treatment, and their families who meet criteria that are regulated within the confines of the RHS contract. After the review of required submitted documents and the approval of the committee, these funds are mad available to the requestor no less than 10 working days for non-emergency requests, within 2 working days for emergency request. This contract was approved from a budget of $50,000.00 to meet the needs of our most vulnerable population and their families.

NEDHSA Awards Implementation and MOU Partnerships: NELA Arts Council Music Awards

Northeast Delta Human Services Authority (NEDHSA) signed a Memorandum of

Understanding with the Northeast Louisiana Arts Council (NELAAC) and the NELA Music Awards, respectively. Each MOU is an effort to recognize arts as one of its integrated health care, evidence-based prevention, communications, and treatment strategies to help serve persons with mental health, addictive disorders, and developmental disabilities.

NEDHSA Executive Director Dr. Monteic A. Sizer said, “Partnering with art-focused agencies shows NEDHSA’s commitment to non-traditional and innovative treatment solutions for persons with behavior health challenges, as well as its commitment to economic development.”

"We believe there is medicine in creative expression, and the arts can help a person come alive in ways traditional treatment options can't," Dr. Sizer said. "We intend to help create an environment where dreams are realized, families are strong, bodies are healthy, community institutions are thriving, and spirits are renewed."

According to the Americans for the Arts, 69 percent of the United States population believe the arts "lift me beyond everyday experiences," 73 percent feel the arts give them "pure pleasure to experience and participate in," and 81 percent say the arts are a "positive experience in a troubled world."

NEDHSA’s MOU with NELAAC is to support local arts in the community and create expansive health promotion and educational awareness to various populations. The NELAAC nurtures a vibrant regional arts culture through support, promotion, and education. This partnership will inform, educate, and remind our community about our agency services while providing art-sponsored events that contribute to holistic and emotional well-being.

NELAAC Director Barry Stephens said HSA's support of the Arts Council's Brown Bag concert series is “another indication of their commitment to our community and the healing arts.”

“Music is a healer and a unifier. What better way for these two organizations to partner than through this 41-year-old concert series,” Stephens said. “We're happy to have the HSA join with us as we bring music to the community through these free concerts.”

NEDHSA’s MOU with NELA Music Awards, Inc., also supports local musical artists in the community and creates expansive health promotion and educational awareness for various populations. This partnership will inform, educate, and remind our community about our agency services while providing art-sponsored events that contribute to holistic and emotional well-being.

NELA Music Awards President Myra Akers said, “The NELA Music Awards is proud to partner with the Northeast Delta Human Services Authority.”

"Music can soothe the soul, ease pain, change our mood, and remind us of many great memories," Akers said. "Thanks for giving our talented musicians another venue to showcase their talents. We have so many creatives in Northeast Louisiana."

NEDHSA has brought many art initiatives to the region, such as psychodramas, Jiggaerobics, hip hop-to-prevention efforts, and partnering with arts and communications programs at regional colleges and universities. Through this effort, NEDHSA and its partners hosted the first music mini-fest on March 19, 2024, called "Treat Yo' Self Tuesday," an event that brought local music artists and music groups to perform at no cost to the public as a treatment modality for healing.

In December 2021, NEDHSA sponsored a mural created by the University of Louisiana Monroe Honors Art Class and the Art & Entrepreneurship Class that was designed and created as a public art project to inspire ULM students to seek help, destigmatize seeking help, and provide solutions to help overcome mental health issues. Since then, the agency has displayed the mural at the Northeast Louisiana Delta African American Heritage Museum in Monroe, the Union Museum of History & Art in Farmerville, Madison Parish High School in Tallulah, and the Chennault Aviation Museum in Monroe.

Dr. Sizer said art could be that spark that further "ignites better regional population health, racial unity, economic opportunities for all, and pride in where we call home."

"It's our time to create a place we are all proud of, a place where we foster hope and opportunities for all, Dr. Sizer said." There is no better time than now. This is our now time."

Regional Award: 2024 State Transformation in Action STAR Award Finalist

NEDHSA's Innovative Approach to Behavioral Health Stigma Reduction in Rural Communities. The prestigious STAR Award recognizes impactful, creative, effective, and transferable state government solutions each year during its Southern Legislative Conference. Very competitive program submissions were accepted from a wide array of state departments operating within the executive, legislative, and judicial branches of government.

With regionally-based leadership and perspective and national-level resources, CSG South provides southern legislators and government staff with a wide variety of programs and services that facilitate regional cooperation and encourage the exchange of information. Acting as an extension of its member offices, CSG South provides policy research and analysis, leadership development, and government staff training. CSG South serves the southern legislatures of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

NEDHSA Executive Director Dr. Monteic A. Sizer and Director of Behavioral and Primary Health Analytics Dr. Dependra Bhatta represented NEDHSA and the State of Louisiana. Dr. Bhatta presented NEDHSA's groundbreaking data at CSG South's Southern Legislative Conference in West Virginia.

"We want to thank CSG South for recognizing our commitment to innovation and programmatic solutions designed to address complex problems associated with vulnerable populations in Louisiana," Dr. Sizer said. "Being selected as a finalist for such a prestigious award is a testament to our staff and Board's commitment to our agency's regional vision and mission."

Louisiana Addiction Service Provider of the Year by Louisiana Association of Substance Abuse Counselors and Trainers: Recipient – Rayville Recovery

NEDHSA is a partial funder of Rayville Recovery and their work is a testament to our efforts to collaborate with great partner to serve the vulnerable populations of Northeast Louisiana. Rayville Recovery provide affordable drug and alcohol detox and rehabilitation options to residents of Louisiana.

Research Published in The Journal of the American Medical Association's (JAMA) Network

The Journal of the American Medical Association's (JAMA) Network Open publishes Northeast Delta Human Services Authority's (NEDHSA) research entitled, "Association between telehealth and missed appointments among patients experiencing Behavioral Health Challenges." NEDHSA's cohort study is a retrospective analysis of the electronic health records of patients with behavioral health conditions who scheduled appointments in outpatient clinics in rural Louisiana from May 1, 2022, to January 31, 2023. The study sample included 9,715 appointments (3,318 in-person and 6,397 telehealth). The no-show rate was 13 percent for in-person appointments and 17 percent for telehealth appointments.

B. Why is this success significant?

These successes outline the importance of meeting the need of our citizens where they are. Ensuring they have adequate, assessable, and exceptional care no matter the existing determinants of health presenting.

C. Who benefits and how?

As seen in the integration of collaborations mentioned in NEDHSA's various partnerships and initiatives through education in prevention and understanding the increasing rate of mental health and substance use cases, NEDHSA continues to work regionally to increase awareness and decrease barriers to the access of quality healthcare that are directly linked to social determinant of health.

D. How was the accomplishment achieved?
NEDHSA continues to be innovative in creating ground-breaking programming and well placed services that directly align with the needs of the citizens serviced in Region 8.

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

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, NEDHSA utilizes and implements best management practices reflected in the agency's vision, mission, and tenets**.**

Accomplishment #2 Developmental Disabilities

A. What was achieved?
Northeast Delta Human Services Authority's (NEDHSA) continues to be committed to creating and providing innovated resources to the persons in our region to ensure each person, no matter the circumstance, reach their full human potential. The purpose of NEDHSA's Developmental Disabilities Departments is to provide person-centered supports and services to people with developmental disabilities that are flexible, meet their needs and allow for maximum independence in the home and community for their choice. NEDHSA's Executive Director, Dr. Monteic A. Sizer, continues to ensure advocacies through the Developmental Disabilities program are appropriately placed, attainable, and provided.

Under the Developmental Disabilities umbrella, there are two core specializations that continue to show significant growth and outcomes related to meeting the daily needs to this population: Waiver Services and Home and Community Based Services. Waiver Services is a Medicaid Home and Community-Based Waiver program that allows greater flexibility to choose where they want to live and to use services and support that best fit their needs. This service is provided in the home or in the community. During FY24, there were 90 Medicaid Waiver participants that were certified for waiver support services, with 53 active private provide agencies and 4 support coordination agencies. In addition, through the Flexibility Family Finds Program and Family Support, NEDHSA was able to assist with funding $1,393,675.70 to our Developmental Disabilities clients and families.

Walk around the Block for Autism
The goal of this event community together to celebrate our children and adults with disabilities, special abilities, and special needs. It is a day where friends, families, businesses, and other community stakeholders can come together to learn, teach, discuss, play and enjoy

a day of activities, exercise and fun. This was also an opportunity to bring awareness of our extraordinary of inclusion and community partnerships.

Developmental Disabilities Awareness Month

During this observation month, NEDHSA's Developmental Disabilities (DD) Departments shined a light on the laws, needs, and public awareness of all things DD. During this month a host of activities took place via NEDHSA's social media outlets and community settings:

- Reading of the Developmental Disabilities Assistance and Bill of Rights Act
- Take a Picture at the NEDHSA Developmental Disabilities Mural
- Attend Families Helping Families Training on Social Security
- Attend Families Helping Families webinar on Accommodations vs Modification
- Learn about Louisiana's Assistive Technology Access Network
- Visit SMILE's Park inclusive playground at Kiroli Park
- Wear blue to celebrate Trisomy 18 Awareness Day
- Attend "Yellow Shirt Day" at the Capitol in Baton Rouge
- 28 Kid-Friendly St. Patrick's Day sensory activities
- Share a special picture with your family members with a disability to social media
- Celebrate World Down Syndrome Day with Crazy Socks
- Learn about Statewide Independent Living resources for adults with disabilities
- Visit the LA Purchase Gardens Zoo and take a ride on their ADA compliant train

Stories of Success from NEDHSA's Developmental Disabilities Department:

Marcus Weber. He is a 23 year old with Moderate ID and Schizoaffective DO. He came to a local group home from the Baton Rouge area. He was found homeless and in a state of severe mental illness. Marcus was placed in LDH Custody due to being a danger to himself. Since that time, Marcus has been medication compliant and mentally stable for over a year. He works in a restaurant kitchen and the staff there are all fond of him. Marcus is linked to a waiver and is on track to move from the group home to his own apartment with supports. (If you need specifically why it is our success too: Our office over saw the custody, we found his group home placement, once he was stable he requested to go into waiver, we linked him to a waiver, approved FS funding for start-up costs to his own apartment, and he has found a job with the help of these services and his provider.

Melissa Marroguin. A 54 year old woman with a diagnosis of moderate ID, schizophrenia, and is legally blind. After an altercation with her sister, she was evicted from the only home that she had ever known. She had nowhere to go and needed 24 hour staff in order to live independently. Family Support provided funding assistance for her to be able to set up her own home and provided funding for the staffing supports that she needed until appropriate waiver services were established. This allowed her to immediately employ the support that she needed in order to secure her health and safety while simultaneously applying for suitable waiver supports. Melissa is now in

her own space, supported by the ROW, and is thrilled with her staff who is currently assisting her with learning to navigate her new home.

Luke Chapman. A 15 year old boy who is diagnosed with Spina Bifida, Myelomeningocele, Arnold Chiari Syndrome, and dysplastic hip paraplegias. He is wanting to get his driver's license when he turns 16. His family had a truck for him but he would not be able to drive it without the appropriate adaptions. FS funding was able to pay for the needed modifications and is now funding adaptive driver's education.

Ellie Ruth Semmes. A 3 year old who has a diagnoses of Pallister-Killian Syndrome, cerebral/cortical visual impairment, and shaken baby syndrome. She is medically fragile and has daily expenses for supplies that are required to maintain healthy care. Ellie was adopted by her current parents who reported multiple out of pocket expenses that is required on a daily basis. Elle is now receiving Flexible Family Funding that her mother expressed helps alleviate some of the financial burden of these expenses.

Bridget. Is diagnosed with Tuberous Sclerosis, which can cause tumors throughout the body. Bridget's mother reports that Bridget had 9 tumors on her brain, eight on her heart, and several more on one kidney. She is also diagnosed with Autism and Obsessive Compulsive Disorder. Bridget has had only 4 seizures in her life. Bridget lived at home all through her school years and was very social. She attended Quitman special education classes. In high school, Bridget participated in cheerleading and the homecoming court. She enjoyed good relationships with her classmates. Bridget's mother placed her in Holy Angels home in 2018. Initially, her mother felt that this was an opportunity for Bridget to be with other people her age and have more of a social life than their very small, rural community offered. Bridget suffered an illness during the COVID pandemic, when visitations were difficult. She regressed physically to the point that she had to move to a different home. She moved to a home with older ladies who also had physical limitations. This caused a downward spiral in Bridget's mood and behavior. Her mother knew it was time to get Bridget home. The family found a house for Bridget to rent that is within walking distance of family members. Utilizing Family Support Funds, My Place, and TEPA, Bridget moved back home to Hodge with waiver services. She happy to have her own place, be close to family, and to have control over her own schedule.

B. Why is this success significant?

NEDHSA continues to be a leader in advocacy and in creating programs and access to care and resources, especially to those in our community who are among our most vulnerable population. The significance of the success of NEDHSA's Developmental Disabilities Programs is noted in the amount of funding providing to ensure housing was either established or upgraded for the needs of the persons served, monthly stipends provided to families of those who met the requirements, or incontinence supplies were readily available.

C. Who benefits and how?
Those who are directly affected or families who are care takers of those who have developmental disabilities who reside within NEDHSA's location areas are beneficiaries of these services. As the single point entry into Louisiana's developmental disabilities system, NEDHSA provides funding for those individuals and families to continue to live and thrive in our community as well as provide monitoring of mandated programs under Medicare/Medicaid.

D. How was the accomplishment achieved?
NEDHSA's underline of "meeting people where they are" is a driving force of accomplishing all goals set, this achievement in particular is no different. With our compassionate Development Disability staff who prioritizes the need of the person and work with local providers via trainings, implementations of state regulations, and providing NEDHSA resources through our Integrated Care Network.

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

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, this level of support, both financially and philosophically should be shared with other executive branch departments and agencies.

Accomplishment #3: Prevention and Wellness Services

A. What was achieved?
Successfully implementation of several Prevention and Wellness programs and initiatives, which serve as an integral part of our integrative behavioral health and primary care approach. The Northeast Delta Human Services Authority's (NEDHSA) Prevention program uses research-based curriculums, environmental strategies, coalition-building, and other proactive and data-driven strategies to prevent and reduce risk-taking behaviors. NEDHSA Prevention and Wellness services include Information dissemination, formation and implementation of community coalitions, community education, and alternative activities for youth, school-based interventions, and tobacco retailer (SYNAR) compliance checks. Below is a summary of prevention activities for FY23-24:

Launch of Harm-Reduction Vending Machines

Northeast Delta Human Services Authority (NEDHSA) launched its innovative harm-reduction vending machines. These state-of-the-art machines are designed to provide critical

resources and support to individuals at risk of substance abuse, promoting harm reduction and improving public health outcomes.

With the alarming rise in substance abuse and related health issues across the region, NEDHSA has taken a proactive approach to combat this crisis. The harm-reduction vending machines are an innovative solution to bridge the gap between vulnerable populations and the necessary resources to promote safer practices. By making essential harm-reduction tools readily available, NEDHSA aims to minimize the risks associated with substance abuse and promote a healthier community.

NEDHSA Executive Director Dr. Monteic A. Sizer said, "Our harm-reduction vending machines represent a critical step forward in addressing the challenges posed by substance abuse in our community."

"We believe in meeting individuals where they are and providing them with the tools and resources they need to make healthier choices," Dr. Sizer said. "Through this innovative initiative, we hope to save lives, reduce harm, and create a pathway to recovery."

The first vending machine placement will be in the Phoenix Peer Support Center at 722 Adams Street, Monroe, LA 71201. The items placed in the machine are Narcan, Deterra, Fentanyl test strips, Rapid HIV tests, Pregnancy tests, Safe Sex Kits, Needle Cleaning Kits, Hygiene Kits, Wound Care Kits, and Period Packs.

The placement of this vending machine is in line with regional, state, and national harm reduction models. The primary goal is to save lives and protect the health of people who use drugs and those they interact with regionally. In addition to preventing drug-related deaths, NEDHSA's vending machine strategy will help facilitate access to healthcare, social services, and treatment.

There is no cost associated with accessing any of the products, and it is free and open to the public to use. Those who wish to utilize the machine will also be provided confidential 1:1 peer-to-peer support on using all items.

NEDHSA recognizes that addiction is a complex issue that requires a multifaceted approach. These harm-reduction vending machines are just one component of a comprehensive strategy that includes counseling, education, and community outreach. By combining these efforts, NEDHSA aims to reduce the transmission of blood borne infections, prevent overdose deaths, and foster a supportive environment for individuals seeking recovery.

Catch My Breath – Be Vape Free

CATCH My Breath is an evidence-based youth vaping prevention program for grades 5-12 that has been proven to reduce students' likelihood of vaping substantially. The vape education program's effectiveness was published in a peer-reviewed journal, and the program

is listed in SAMHSA's Evidence-Based Resource Guide Series. CATCH My Breath is the most-used youth nicotine vaping prevention program in the United States.

Campaign: STAY Campaign for Suicide Prevention Awareness

Northeast Delta Human Services Authority (NEDHSA) launched its suicide prevention campaign, STAY. STAY is built on a simple, pragmatic request: that people considering suicide "Stay" and reach out for help. Just that request "to Stay" infers love. It indicates value that the community wants people to stay and heal.

NEDHSA Executive Director Dr. Monteic A. Sizer said STAY is an easy request for anyone to make and understand "if you don't know what to say, start with STAY."

"So many opportunities for conversations are lost by people unsure of the right words to say when dealing with people in need," Dr. Sizer said. "STAY, as a word and a campaign, provides an easier on-ramp for conversation with a person you are seeking to help and are concerned about."

The STAY campaign targets several specific high-risk groups for suicide, including teens, military and first responders, LGBTQ+, middle-aged men and women, and older men.

The STAY campaign consists of numerous components, including TV spots, digital and social media ads, posters, and more that invite people to call the 24/7 NEDHSA Behavioral Health Crisis line or to visit the STAY website for more information and local resources at staynedelta.org.

STAY is an added effort to what NEDHSA already has in place to reduce and bring awareness to suicide in Northeast Louisiana. The agency has deployed Al's Pals and Signs of Suicide programs, distributed suicide-related information, and provided various trainings throughout the region's school districts.

To help reduce adult suicide, NEDHSA works holistically to reduce the negative social determinants of health. Specifically, NEDHSA works to combat food insecurity, high unemployment, community instability, poor education, and inadequate housing options, just to name a few.

Sponsorship of Al's Pals New Teacher Training for Regional Educators

NEDHSA sponsored Al's Pals New Teacher Training for more than 30 regional educators in the Morehouse Community Involvement Organization (MCIO) Head Starts, Ink Head Starts, Tallulah Elementary School, Tallulah Head Starts, Monroe City Schools, and Pinebelt Head Starts. NEDHSA contracted Teaching Strategies, Inc. from Charleston, South Carolina, to train the participants by examining how social-emotional learning can impact overall development and support positive child outcomes.

Al's Pals: Kids Making Healthy Choices is an early childhood curriculum designed to increase social and emotional competencies in young children. The resiliency-based curriculum provides real-life situations that introduce children to health-promoting concepts and build prosocial skills, such as understanding feelings, accepting differences, caring about others, using self-control, and managing anger. Signs of Suicide is a suicide prevention program that educates sixth, seventh, and eighth-grade students about the relationship between suicide and depression.

This full-day experience allowed for discussions and interactive experiences; participants investigated how inclusive environments can support young children's social-emotional development. Participants also was introduced to protective factors and evaluated strategies that fostered resiliency and enhanced social-emotional learning.

Opioid Summit

NEDHSA's Opioid Summit is an opportunity for behavioral health professionals, primary healthcare workers, law enforcement, federal, state, and local officials, clergy, and advocates to collaborate on how to address this complex societal issue with action. NARCAN training and distribution will also be available to all attendees. Louisiana Department of Health Secretary Ralph L. Abraham, M.D., was this year's keynote speaker.

As secretary of the Louisiana Department of Health, Dr. Abraham leads the state's largest agency with a budget of $19.8 billion and a team responsible for delivering services to millions of Louisianans. LDH protects and promotes health for Louisiana residents through services provided by Medicaid and the Offices of Public Health, Behavioral Health, Citizens with Developmental Disabilities, Aging and Adult Services, Women's Health and Community Health, and Emergency Preparedness. These programs ensure access to medical, preventative, and rehabilitative services for Louisiana's most vulnerable residents. Dr. Abraham is a practicing family medicine physician in Richland Parish and is a former three term Congressman for Louisiana's 5th Congressional District.

Other panelists and speakers included Executive Director Dr. Sizer; Dr. Avius Carroll, Director of NEDHSA's Prevention & Wellness Department; District Attorney Steve Tew – District Attorney for the 4th Judicial District serving Ouachita and Morehouse Parishes; Judge Alvin Sharpe – Judge for the 4th Judicial District, Division I in Louisiana serving Ouachita and Morehouse Parishes; Attorney Anita Tennant Mack – has worked as an Assistant District Attorney in the Sixth JDC for altogether 18 years as well as managed her private practice, The Law Office of Anita Tennant-Mack, here in Monroe, Louisiana; Senior Master Sargeant Rylan Choate – Drug Demand Reduction, Louisiana National Guard Counterdrug Program, and; Riley McEacharn – Administrator of Second Chances Addiction Recovery Center.

"Do No Harm: The Opioid Epidemic" Theater Screening Event

NEDHSA hosted a theater screening of "Do No Harm: The Opioid Epidemic," a multimedia educational series that chronicles the progression of what experts deem the "worst man-made

public health epidemic in American history. NEDHSA Executive Director Dr. Monteic A. Sizer said this theater screening and community engagement strategy will help raise public awareness "by continuing to spark regional discussions and offering sound public policy solutions to help reduce the challenges associated with our current opioid epidemic."

NEDHSA, through its Prevention and Wellness Department, provides the Opioid Misuse and Abuse Prevention Program (OMAPP), which is funded by the Louisiana State Opioid Response (LaSOR) Grant that provides services such as Narcan training and distribution, safe medication storage and disposal products, grief counseling, nursing and peer support services through the crisis mobile team and evidenced-based programs like LifeSkills and Generation Rx. All of these services are provided at no cost to all who reside in our catchment area.

JiggAerobics Health and Fitness Event

This event was part of NEDHSA's #getfitHSA initiative that supports the NEDHSA's Integrated Care model to increase access to healthy activities and inform communities about staying fit and active.

NEDHSA Executive Director Dr. Monteic A. Sizer said this event provides a fun and upbeat activity for individuals of all ages and fitness levels. He also said it exposes regional citizens to "valuable information concerning the importance of personal wellness and holistic mental, physical, and spiritual health."

Prescription Take Back Day

This event allowed NEDHSA's Opioid Misuse and Abuse Prevention Program team to educate the community about the risks of abuse of prescription and over-the-counter medications left unsecured in the home. NEDHSA accepted pills, patches, and liquids but did not accept needles, sharps, or aerosols.

"We are committed to keeping our homes and communities safe through the proper disposal of unwanted, unused, and expired medications. This initiative is just one of many ways that NEDHSA is working to break the cycle of addiction, injury, and early death in our region," Dr. Sizer said.

NEDHSA's Art Is Therapy Festival

NEDHSA Art Is Therapy Festival is an annual an event that further promotes the agency's adoption of arts as one of its integrated health care, evidence-based prevention, communications, and treatment strategies to help serve and educate the community and persons with co-occurring disorders and developmental disabilities. The Art is Therapy Festival is a free event and open to the public.

According to the Americans for the Arts, 69 percent of the United States population believe the arts "lift me beyond everyday experiences," 73 percent feel the arts give them "pure

pleasure to experience and participate in," and 81 percent say the arts are a "positive experience in a troubled world."

NEDHSA's Director of Prevention & Wellness Dr. Avius Carroll said, "Arts serve as a portal of expression and can be shared in many forms."

Project Sticker Shock Campaign: Targeting Underage Drinking

NEDHSA Project Sticker Shock Campaign is an awareness campaign that continues to educate the public and change attitudes about selling and serving alcohol to anyone under 21. The project organized youth and community members to place stickers on drink coolers where alcohol is located in local stores. The stickers contain a warning and reminder that providing alcohol to minors is illegal and dangerous.

Project Sticker Shock is not meant to discourage customers who are 21 and up from buying alcohol. It is intended to prevent criminal activity and the creation of dangerous situations for youth in our community. NEDHSA's Region 8 Student Ambassadors and sponsors have begun placing the stickers as a way to directly connect the message with the audience. Youth are about two times more likely to face addiction issues in adulthood if they start now.

Now Save 76 owner Simran Emaus said, "This unique partnership with the HSA shows that we care about our community." "We take pride in being an active and positive community advocate and partner," Emaus said. "We always want to ensure we're promoting positive messages to all who shop with us."

NEDHSA's Inaugural Recovery Day Celebration

NEDHSA's Recovery Day Celebration event created to raise awareness of mental health and substance use disorders, celebrated individuals in recovery, and acknowledged the work of prevention, treatment, and recovery support services. The Recovery Day Celebration highlights and celebrates people in recovery from substance use and mental disorders, along with treatment providers promoting that recovery is possible in all forms. This day of celebration, within Recovery Month, is part of a national observance that promotes the societal benefits of prevention, treatment, and recovery. The event will feature speakers with lived experiences, NARCAN Training, health and wellness activities, interactive games and crafts, food, and music.

"People who experience mental illness and substance use disorders must receive the support they need when they need it," Dr. Sizer said. "We know that behavioral health is essential to overall regional primary and population health outcomes. We also know that prevention works, treatment is effective, and people recover."

NEDHSA and City of Tallulah Collaboration: 1k/5k Walk/Run Race

This continued sponsorship is one facet of NEDHSA's #getfitHSA initiative that supports the NEDHSA's integrated care model to help increase access to healthy activities and inform communities about staying fit and active. Tallulah Mayor Charles Finlayson said the city is

"extremely pleased with the number of individuals who have signed up to participate in the City of Tallulah Annual Walk/Run in Tallulah honoring Bea Willis and are proud to host this event with our partners NEDHSA and Ameristar Casino."

Partnership with True Releaf: Drug Deactivation and Disposal Container

NEDHSA unveiled a Deterra Drug Deactivation and Disposal System Container to assist in increasing harm reduction efforts by ensuring additional safe spaces for disposal and fentanyl testing of products. NEDHSA purchased the Deterra® Drug Deactivation and Disposal Container for the public to access and use at no cost and with no questions asked. Drug Deactivation and Disposal System Containers provide safe, convenient, and permanent disposal of unused, expired, or unwanted medications.

Veteran's Boxing Wellness Initiative through partnership with Rodney J. Hobbs VFW Post 1809 & BoneKrusher Boxing

This partnership is one facet of NEDHSA's Operation Leave No Veteran behind Initiative to increase its service efforts toward the veteran population and meet the needs that stem from combat, training, and traumatic and stress-generating settings. Operation Leave No Veteran Behind is an effort to ensure that military veterans in Northeast Louisiana have quality and competent primary and behavioral health care. VFW Post 1809 Commander Christopher LeGuin said the partnership with the NEDHSA helps the Veterans of Foreign Wars Post 1809 by giving Veterans a local resource for mental and physical health.

A Day of Service Health Fair collaboration with Junior League of Monroe

The "A Day of Service" event is an initiative that aimed to bring together behavioral and primary health resources, services, and information from NEDHSA and other community organizations, volunteers, and individuals who seek to improve population health in Ouachita Parish.

The Junior League of Monroe President Haley Holley said, "NEDHSA's steadfast goal and dedication to building a healthier and more successful tomorrow perfectly match the purpose of The Junior League of Monroe." Holley said. "This partnership with NEDHSA represents a strong connection, bringing together two groups that have a common commitment to supporting those who require assistance."

Prevention and Wellness Community Events

NEDHSA's Prevention and Wellness Department hosted a series of events aimed at building stronger communities one person at a time. NEDHSA hosted these events to help the people of northeast Louisiana remain hopeful and informed. The events were well-attended and included the following:

- Student Ambassadors Children's Coalition Dragon Boat Festival
- Special Guest Speaker at University of Louisiana Monroe for School of Social Work
- Community Health Fair at Robinson-Williams Restoration of Community Center in Bastrop, Louisiana

- NEDHSA and Grambling State University hosted NARCAN Training ○ Prevention of opioid overdose at Grambling State University
- Community Baby Shower at Emily P. Robinson Community Center
- 32nd Annual D.A.R.E Officer's Association Training Conference
    - Prevention Coordinator Kara Etienne held three sessions on Opioid Overdose, Prevention and the importance of understanding the potential impacts to our children and schools and how to keep them safe. Narcan was provided to all attendees of each session.
- Back to School Bask at Louisiana Purchase Gardens and Zoo
    - NEDHSA participated in Ouachita Health Unit's back-to-school event sponsored by the Louisiana Department of Health. More than 300 residents in the region were served with healthcare services, free vaccinations, and community resources.

B. Why is this success significant?
The initiatives implemented through NEDHSA's Prevention & Wellness programs proves the successful implementation of NEDHSA's Integrated Behavioral Health and Primary Care Model which is vital to ensuring meeting citizens where they are to meet the need to enter them into the health care system desired. These prevention efforts are critical to providing these integrated services.

C. Who benefits and how?
As seen in the integration of collaborations mentioned in NEDHSA's Prevention & Wellness partnerships and initiatives through education in prevention and understanding the increasing rate of substance use cases within our youth population, declining in mental health solutions for youth and veterans, and physical fitness awareness, NEDHSA continues to work regionally to increase awareness and decrease barriers to the access of quality healthcare that are directly linked to social determinant of health.

D. How was the accomplishment achieved?
NEDHSA continues to be innovative in creating ground-breaking programming and well placed services that directly align with the needs of the citizens serviced in Region 8.

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

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, NEDHSA utilizes and implements best management practices reflected in the agency's vision, mission, and tenets.

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

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

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

Northeast Delta Human Services Authority's (NEDHSA) Strategic Plan goals were implemented as specified in the FY2020-2025 Strategic Plan. The continuation of monitoring and tracking the progression of agency goals have been also been implemented in the FY2022-2027 Strategic Plan. The strategies being implemented are providing positive outcomes that are integrating across departments and throughout the region as desired. The continuation and reach of services are evident of the agency's strategies, implementations, and investment in high standards of care.

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

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

NEDHSA's success is contributed to monthly and quarterly statistical data that is analyzed to provide real, tangible information to assist with providing our staff, stakeholders, and Region 8 with progressions made throughout NEDHSA's departments. Proper and effective use of grant funding is also an active supporting measure in NEDHSA's growth and operations.

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

Currently, our progress is not expecting an accelerated gain or pace. We are continuing to be focused on moderate, measurable, and sustainable gains.

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

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

  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?

  There is no lack of progress to mention at this time.

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

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

  We have submitted a Strategic Plan for 2022-2027 with no revisions, only a continuation of plans implemented in the previous Strategic Plan.

  ☐ No. If not, why not?

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

  Our strategic plan is centrally located on the agency's intranet for all employees to view. A large percentage of the performance indicators are also reported in LaPAS and through AIP reviews. 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.

Issue #1: Oversight of the Region Support Coordination Agencies:

A. Problem/Issue Description

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

Northeast Delta Human Services Authority, per contract with the Louisiana Department of Health, has been tasked with oversight of the region Support Coordination Agencies (SCA) which is contracted with the Louisiana Department of Health to provide services on behalf of the Office for Citizens with Developmental Disabilities (OCDD). This linkage has posed a disadvantage in the oversight process for NEDHSA to ensure accountability and successful outcomes. Corrective action for deficits and issues stemming from the SCAs and the private agencies contracted with them are often delayed and lack proficiency and quality to the standards to which they are held. It is also noted that various contributing factors have led to the decreased standards of care provided by these agencies along with compliance with OCDD policies and procedures, including high turnover rates of the support coordination agencies. To date, reporting numbers are continuing to get worse as this issue is not being resolved and more waiver linkages are being made. While numbers are increasing in this region, it is acknowledged that it is a statewide issue and not an isolated issue. OCDD has acknowledged this and the OCDD Support Coordination Performance are in agreement that the agency revamping to try to assist with bringing all Support Coordination agencies into

compliance is the first step in an ongoing process. However, NEDHSA is continuing to be held to the non-satisfactory resolution due to this outcome and additional staff is still needed to reach more of our population with our growing numbers to ensure the needs and advocacy efforts are still met.

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

3. What organizational unit in the department is experiencing the problem or issue?
   Developmental Disabilities Department is the department experiencing these issues.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Persons served are directly affected by the quality of services provided by the SCA's and the private care agencies.

5. How long has the problem or issue existed?
   This issues has been ongoing for 5-6 years.

6. What are the causes of the problem or issue? How do you know?
   Noted possible causes of these issues are the current policy and structure of this system, along with the reporting infrastructures in place. It is also noted that the SCA's experiences high turnover rates, which also could affect these issues.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   Failure to resolve these issues will continue to directly impact client services in consideration of the quality of services provided to our clients and the effective services rendered by care managers and staff. Not only the overall wellbeing of the client is at jeopardy, but ensuring all standards and requirements met within state contracts, governing bodies, loss in revenue to continue care, and staff turnover are all contributing factors.

B. Corrective Actions

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

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

☒ **Internal audit**

NEDHSA's Corporate Compliance Department conducts monthly, quarterly, and annual internal audits that provide fact-base and data-driven data for all NEDHSA connected departments, which are inclusive of all contracted parties as well. With information obtained and provided, we are able to pinpoint areas of needing improvements, a corrective action plan (if needed), and the fiscal status reports (if applicable). Additionally, NEDHSA tracks and documents other statistical data through our analytical department that assists with both internal and external auditing and reporting method.

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

NEDHSA is externally conducted by Louisiana Legislative Auditor (LLA). The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

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

Additionally, NEDHSA is externally audited by the Office of Risk Management (ORM) to ensure the best safety practices are being kept on an annual bases. With these reports, NEDHSA is able to ensure the safety of staff, clients, and visitors of all site facilities.

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

The Executive Director, Dr. Monteic A. Sizer has established the Corporate Compliance Department within NEDHSA as a department that updates, develops, and ensures implementation of policies throughout the agency. In addition to that, the Corporate Compliance department ensures quality assurance with involvement in peer reviews, quality assurance meetings and quarterly/annual reporting.

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

☐ Program evaluation by in-house staff

☒ Program evaluation by contract

NEDHSA's Corporate Compliance Department conducts quarterly evaluations of all clinical services contracts via record review, invoice review, critical incident reporting (with analysis reporting), and additional analysis outcomes through TeleSage Outcome Measurement System (TOMS).

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
NEDHSA Corporate Compliance Department coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for its internal departments. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

NEDHSA gathers this information internally for all required departments for reporting purposes. During this time, all information is vetted and appropriately determined for accuracy prior to submission into the LaPAS system quarterly.

☒ **In-house performance accountability system or process**
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) NEDHSA Executive Management Team and the Fiscal Department. This section reviews all objectives, performance indicators and strategies for NEDHSA.

There is an annual review of NEDHSA's budgets along with monthly review by Executive Management and the Fiscal Department. At the end of each fiscal year, NEDHSA analyzes and evaluate the performance of our agency to determine if the information has provided its intended outcomes in the strategic and operational planning set, or recommendations for improvement are needed for the next fiscal year.

☒ **Benchmarking for Best Management Practices**
NEDHSA's Executive Management Team (EMT) along with the Strategic Planning/Development Committee reviews, researches and develops objectives, performance measures and strategies to present to the Executive Director for approval that will benefit the agency and its recipients of services.

Recommendations are compared to benchmarks set from the previous fiscal year based on performance-based budgeting activities along with LDH and NEDHSA contractual guidelines and obligations. Additional recommendations are made directly to the Executive Director, if modifications or additions are needed.

☒ **Performance-based contracting (including contract monitoring)**
All NEDHSA contracts are required to contain a Statement of Work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

☒ **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

☐ Other (please specify):

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department:	Louisiana Department of Health (LDH) 09-320 Office of Aging and Adult Services
Department Head:	Michael Harrington, MBA, MA LDH Secretary
Undersecretary:	Drew Maranto
Assistant Secretary:	Gearry Williams

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: Maintained and increased access to home and community based services (HCBS)

A. What was achieved?
The Office of Aging and Adult Services (OAAS) implemented several initiatives aimed at ensuring current home and community-based services (HCBS) participants receive appropriate services and at increasing access to HCBS. Additionally, OAAS staff worked to ensure participants maintained access to existing services and to add additional covered waiver services.

In FY24, OAAS requested and received an additional 500 Community Choice Waiver (CCW) slots. OAAS Program Operations staff worked collaboratively with other OAAS Divisions and Support Coordination Agencies to certify 773 participants, including the 500 additional waiver slots and waiver slots made available via attrition. New providers and services were also added in SFY24 including a new Program of All-Inclusive Care for the Elderly (PACE) Center in Alexandria and six new Support Coordination Agencies in Regions 2, 4, 5, 6 and 7. OAAS staff in the Money Follows the Person and My Choice Louisiana (MCL) programs worked to transition 237 participants out of nursing facilities and back into the community with appropriate waiver supports and services, 21% of which transitioned with the support of the Permanent Supportive Housing program.

OAAS worked with Medicaid to complete outreach calls to waiver participants who had failed to respond to the Medicaid renewal notices as part of the unwind process over the course of the year, resulting in 94% of those participants maintaining their Medicaid coverage. OAAS added four new covered services to Adult Health Care (ADHC) waiver programs (home delivered meals, personal emergency response system, health status monitoring, and activity sensory monitoring). Finally, OAAS staff worked to ensure compliance with CMS Maintenance of Effort requirements by developing reports and following up on data generated to ensure participant services were maintained at the level at which they were approved.

B. Why is this success significant?
These services and initiatives allow OAAS to continue to enhance and improve access to quality long-term services and supports for the elderly and people with adult-onset disabilities to live with dignity and independence in a safe and holistic environment.

C. Who benefits and how?
OAAS participants benefit from having additional long-term care options that allow them to access services in a manner that supports choice, informal caregiving, and effective use of public resources as is in line with OAAS's mission.

D. How was the accomplishment achieved?
OAAS analyzed program data, collaborated with internal and external stakeholders on legislative initiatives, waiver and policy updates, and outreach efforts to maintain and increase access to HCBS.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, these initiatives contribute to improving access, quality, and outcomes for populations receiving and at-risk of needed long-term supports and services which are in direct alignment with goals I and IV of the OAAS FY 2023 – 2028 strategic plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, analyzing program data to identify and implement strategies to efficiently certify

individuals into waivers and to streamline other processes is a best practice that should be shared with others agencies and replicated where applicable.

Accomplishment #2: Increased stakeholder engagement to inform participant choice, streamline policies and procedures, and enhance quality of care

A. What was achieved?
The Office of Aging and Adult Services (OAAS) made concerted efforts to improve communication, outreach, and training to both internal and external stakeholders. OAAS implemented several outreach campaigns, including letters, phone calls, and community events to inform participants and families of the services offered through OAAS programs.

In FY24, OAAS reinstated several stakeholder meetings with providers and support coordination agencies in an effort to provide them with accurate and up-to-date information on program and rule changes, program successes and opportunities, and to obtain their feedback on OAAS processes and procedures. As a result of this collaboration, OAAS implemented 29 initiatives at the request of providers, including streamlining assessment and plan of care processes, allowing for electronic signatures, and updating OAAS training and the certification process for provider staff. OAAS was also able to leverage stakeholder support to ensure its legislative initiatives in FY24 were passed, including a bill to create a PACE single license signed into law June 3, 2024 and a bill to arrange for administrative changes to the Traumatic Head and Spinal Cord Injury (THSCI) program to more accurately define the population served signed into law on May 28, 2024.

OAAS received approval from CMS to use American Rescue Plan Act funds to support training for Direct Service Workers (DSW) on dementia and person centered thinking in FY24 for FY25. Planning efforts are underway with trainings scheduled to begin in the first quarter of FY25.

OAAS's Nursing Home Resident Trust Fund (NHRTF) staff received CMS approval for all projects submitted in FY24 after a 7 month pause in approvals while CMS restructured the Civil Monetary Penalties program. Louisiana was the first state in CMS Region 6 to receive approval on new projects submitted after programmatic changes were implemented. As a result, NHRTH staff provided assistance to several states who have reached out with questions related to best practices.

B. Why is this success significant?
OAAS programs are complex and our populations and their families must navigate eligibility requirements and the provision of services via multiple LDH agencies and external providers. Access to easy-to-read, accurate, and accessible program information is crucial to ensuring participants receive the services they need in the settings they wish. Additionally, alignment of OAAS policies and procedures and state rules with federal requirements led to streamlined program procedures which decreases duplication of efforts and program confusion as well as improves program *compliance*.

C. Who benefits and how?
OAAS staff, participants, and providers benefit from having clear, concise, easy-to-understand information on program services and requirements.

D. How was the accomplishment achieved?
OAAS staff engaged in regular stakeholder and legislative partnership meetings in order to achieve these successes. Staff conducted regular HEAT meetings to review, update, and disseminate revised program information and notices using plain language and accessibility standards. Additionally, staff performed outreach at 15 community events and collaborated with the Live at Home Coalition, ADHCs, and Support Coordination Executive Directors to schedule quarterly or biannual meetings with a goal of sharing information on best practices, policy and procedure updates, and program status updates.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, streamlining OAAS policies, procedures, and processes, aligning them to federal requirements, and ensuring stakeholders are represented in decision making aligns to decreases, duplication of efforts, improves program compliance, and improves access, quality, and outcomes for populations served which are in direct alignment with goals I and IV of the OAAS FY 2023 – 2028 strategic plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, all state agencies should have a vested interested in ensuring stakeholders have access to accurate program information in the manner and form most appropriate to them.

Accomplishment #3: Villa Feliciana Medical Complex (VFMC) Record Low Vacancy Rate for Fiscal Year 2024

A. What was achieved?
Villa Feliciana Medical Complex reduced vacancy rates from over 20% in FY23 to less than 10% in FY24.

B. Why is this success significant?
This success is significant as maintaining a low vacancy rate is essential for VFMC to provide consistent and quality care to its clients. A minimum number of vacancies ensures that all clients receive adequate attention and care from qualified staff.

C. Who benefits and how?
Lower vacancy rates benefit various stakeholders:
- Clients: Receive better continuity of care with familiar staff, enhancing their overall experience and well-being.
- Staff: Reduces reliance on staffing agencies, which can lead to better workload

distribution, less overtime, and lower staff burnout, ultimately contributing to higher job satisfaction.

- Facility: Improved retention rates and recruitment efforts lead to a more stable workforce, enhancing team cohesion and operational efficiency.

D. How was the accomplishment achieved?
The achievement was made possible through strategic initiatives:
- Increased Recruiting Efforts: Expanding outreach and recruitment strategies to attract more candidates.
- Implementation of Alternative Schedules: Introducing flexible scheduling options such as a 4-day workweek, telework arrangements, and custom clinical scheduling to accommodate staff needs and improve work-life balance.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, this accomplishment is integral to the strategic plan as it aligns with financial viability goals. Reduced vacancy rates directly correlate with improved staff morale and operational efficiency, making it sustainable for the facility which are in direct alignment with goals III and IV of the OAAS FY 2023 –2028 strategic plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, the methodologies employed contribute to a Best Management Practice framework. The external factors, including new and relaxed COVID-19 guidelines, have also played a significant role in alleviating staffing challenges. Sharing these strategies could aid other facilities facing similar challenges and promote effective staffing solutions in the healthcare sector.

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

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

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

The Office of Aging and Adult Services (OAAS) aims to provide a system where adults in need of long-term services and supports can live with dignity and independence in a safe and holistic environment. OAAS has made progress toward this goal over FY24 by:

1. Promoting and developing health and Long Term Support and Services (LTSS) delivery systems that improve care and outcomes for high risk, high cost

population served by OAAS and achieve LTSS rebalancing consistent with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's decision in Olmsted vs L.C.
2. Timely completion of investigations of abuse, neglect, exploitation, and extortion of vulnerable adults.
3. Administering and operating OAAS programs in a cost-effective manner while achieving high quality outcomes.

The commitment, achievements, and work towards this vision and goals are evident by the achievements outlined in Section I of this report.

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

Significant progress has been made in all areas of OAAS:

- Utilizing data driven dashboards to visualize and manage performance and processes. Program Operations were able to set a record in certification and My Choice Louisiana (MCL) was able to greatly increase the success with milestones required for transitions, thereby driving forward progress to ending the Department of Justice (DOJ) Settlement Agreement. Training management in the skills needed to use data and dashboards to make operational decisions is the most significant accomplishment in this activity, as it represents a best practice for managing processes.

- Policy secured additional financial resources to increase the infrastructure of our service delivery system. Additional services were added (see Part I, Accomplishment 1), a new PACE center was opened, and OAAS secured an increase in PACE provider rates.

1. **To what do you attribute this success?**
   This success is attributable to hard work and dedication of all OAAS staff; LDH Executive Management; collaborative work with other offices within LDH and partners within governmental agencies outside of LDH; elected Louisiana Congressional Members; and several external stakeholders. While OAAS led efforts specifically related to its own office's initiatives, it also worked in a support role in areas where needed. Each of the accomplishments represent an internal ability to review current practices and look for opportunities to improve. The self-examination was the first step in each successful endeavor by our agency.

2. **Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?**
   Some of OAAS's progresses produced one-time gains, such as updates in policy and procedures. Several of OAAS's progresses are expected to continue and accelerate, such

as the practice of using data and visually charting process metrics through dashboards; outreach and education when partnerships require it; and internal review and field visits to give a comprehensive assessment of policies, procedures and staff satisfaction.

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

None. The Office of Aging and Adult Services (OAAS) has been able to promote and develop and Long Term Support and Services (LTSS), investigate abuse and neglect, and operate the office in a cost-effective manner.

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

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

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

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

☒ No. If not, why not?

OAAS is currently operating on a five-year strategic plan that covers FY23 to FY28. While OAAS has made progress toward and achieved success in the goals mentioned above, updates are not needed at this time as OAAS continues to make advancements in these areas. The five-year strategic plan is evaluated annually to determine if updates are 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.

The Office of Aging and Adult Services (OAAS) strategic goals and objectives are clear and have been consistent over time, administrative changes, and understood by all OAAS staff. OAAS has been fortunate in having access to data that allows management and staff to monitor program outcomes, often against national goals and benchmarks. This allows OAAS to adjust strategies as needed to attain office objectives. Because OAAS administers Medicaid funded programs, OAAS works very closely with that agency and

other LDH offices to assure strategies and goals are aligned.

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

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

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

Issue #1: <u>Waitlist Reduction and Service Alignment</u>

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   While the Office of Aging and Adult Services (OAAS) has made significant efforts to reduce the waitlist, ultimately there continues to be more people requesting services than there are available slots. Additionally, current waiver, policy, and procedure documents do not support a comprehensive continuum of care model for participants currently enrolled in OAAS programs or for those waiting for services. The updates needed to develop a comprehensive continuum of care model will likely require additional funding and significant time to develop as waiver and rule documents will need to be modified with support and feedback from internal and external stakeholders.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   Yes. OAAS's mission is to provide access to quality long-term services and supports for the elderly and people with adult-onset disabilities in a manner that supports choice, informal caregiving, and effective use of public resources. While we are able to offer services, the Office is unable to reach all of the population requesting services. While this is in part due to availability of slots, it is also greatly affected by the Support Coordination Agencies' (SCAs) ability to maintain workforce and capacity to handle caseloads which will be discussed in greater detail in the next section of Part III.

3. What organizational unit in the department is experiencing the problem or issue?
   Home and Community-Based Services (HCBS) Waiver Operations, Permanent Supportive Housing, Traumatic Head and Spinal Cord Injury (THSCI), State Personal Assistance Services (SPAS) and Policy.

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

5. How long has the problem or issue existed?
   Waitlist numbers decreased during the COVID Public Health Emergency (PHE), reaching an all-time low in December 2022, but have steadily increased since January 2023. The issue with a continuum of care and alignment of services exists due to the structure and content of current waiver requirements which have been in effect since January 1, 2011.

6. What are the causes of the problem or issue? How do you know?
   The growing elderly population translates to a greater need for services. Additionally, changes to existing HCBS waiver delivery systems require consistent, incremental work that will take years to fully implement.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   As more people request additional services, waitlist numbers continue to increase and the amount of time from service request to service receipt continues to increase.

B. Corrective Actions: <u>Waitlist Reduction and Service Alignment</u>

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?

Issue #2: <u>HCBS Service Infrastructure Issues</u>

A. Problem/Issue Description:

1. What is the nature of the problem or issue?
   Even if the Office of Aging and Adult Services (OAAS) were to receive funding to accommodate requests for services for all eligible participants, current provider and workforce infrastructure issues would make it near impossible to provide the necessary services they need in the settings they wish. SCAs and providers frequently report issues with pay, hiring, and retention. While OAAS is currently working with an external partner on a Support Coordination gap analysis, the deliverables of this project will only provide specific insight into this issue and recommendations for next steps. The most comprehensive of these activities will not be actionable without out support for LDH leadership and increased funding. Additionally, there are areas of the state in which there are few or no providers for various program services. OAAS is also impacted by workforce issues as we have received increased funding for waiver offers for the last 3 State Fiscal Years with no corresponding increase to staff to support the work that must

be done to ensure those offers are successful. Additionally, the lack of available safe, affordable, and accessible housing affects our ability to transition eligible participants from a nursing facility into the community.

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

   Yes, OAAS is unable to fill existing waiver slots due to SCA and DSW infrastructure issues. OAAS is unable to transition eligible participants into the community with supports and services due to the lack of appropriate housing.

3. What organizational unit in the department is experiencing the problem or issue?
   All organizational units within OAAS are experiencing the problem.

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

5. How long has the problem or issue existed?
   Workforce issues became apparent during the COVID PHE, and have steadily become more apparent over time. Housing issues have been present since 2009.

6. What are the causes of the problem or issue? How do you know?
   Workforce issues, pay issues, increased workload with no corresponding increase in workers, pay, or other supports. Affordable housing availability is exacerbated by disasters in Louisiana.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   OAAS participants will have to wait longer for services even once linked to a waiver. For MCL, inability to transition participants out of nursing facilities puts LDH in jeopardy of not meeting the requirements of the DOJ Agreement. A lack of workers, housing, and consistent and stable in-home supports puts our participants at risk.

B. Corrective Actions: <u>HCBS Service Infrastructure Issues</u>

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?

Issue #3: <u>Change Management Complications</u>

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   Leadership changes and changes to internal processes and procedures have created knowledge gaps and process delays, affecting our ability to problem solve and perform the day-to-day operations necessary for program success. There have been several changes in leadership within LDH and OAAS within the past year resulting in loss of significant institutional knowledge and delays in implementing program initiatives as new staff were on-boarded. Additionally, internal OAAS and LDH processes are often convoluted and lengthy resulting in delays and re-work.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   Yes, in order for OAAS to accomplish its goal of promoting and developing health and Long Term Supports and Services, it must be able to respond quickly to changing priorities and meet the needs of its participants in a timely manner.

3. What organizational unit in the department is experiencing the problem or issue?
   All organizational units within OAAS are experiencing the problem.

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

5. How long has the problem or issue existed?
   OAAS flagged issues with contracts and other LDH processes in the FY23 AMPAR report – those problems still exist. OAAS has had 100% turnover in its top executive leadership positions (Assistant Secretary and two Deputy Assistant Secretaries) in the past year.

6. What are the causes of the problem or issue? How do you know?
   Administrative changes are inevitable as is the nature of Government at all levels. Leadership and staff changes are natural and to be expected; however, there is often a lack of accurate and up-to-date program reports and transition documents as well as a lack of a comprehensive onboarding process for new staff at all levels. Lack of clear, transparent procedures to complete administrative tasks (such as contracts) add delays.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   Stalled initiatives and delays in hiring impact program performance. Contract issues and changes to other internal LDH process impact our relationship with vendors and providers, causing delays in implementing initiatives (if we are able to implement at all), and create duplicative and unnecessary work for program staff. Ultimately this impacts the ability of OAAS to best meet the needs of participants.

B. Corrective Actions: <u>Change Management Complications</u>

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

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

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

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

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

5. Do corrective actions carry a cost?

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

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

A. Check all that apply.

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

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste and abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to

management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

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

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

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

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

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

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

programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

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

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

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

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department: Louisiana Department of Health (LDH)
09-324 Louisiana Emergency Response Network

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

Executive Director: Paige Hargrove

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

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

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

Accomplishment #1: State Trauma System Consultation by the American College of Surgeons

A. What was achieved?
The Louisiana Emergency Response Network (LERN) contracted with the American College of Surgeons Committee on Trauma (ACS-COT) for an evaluation of Louisiana's trauma system. The ACS is recognized across the nation and around the world as the leader in trauma care, in the verification of trauma centers, and in the development of trauma systems. The ACS COT assesses and evaluates trauma systems and provides consultative guidance for future trauma system development. Using the

public health approach, the ACS COT provides expertise in the areas of regionalization of care, healthcare system development, and disaster preparedness through system enhancement.

B. Why is this success significant?
Louisiana's only previous consultation of the state's trauma system was conducted by the ACS-COT in 2009. At the time, there were only two trauma centers in Louisiana. The LERN board used the recommendations from the 2009 consultation as a blueprint to build the Louisiana Trauma System – which today consists of 14 ACS verified trauma centers. Due to this growth, the LERN Board once again engaged the ACS-COT to evaluate the progress and provide expert recommendations for the next 10 years.

C. Who benefits and how?
The citizens of Louisiana benefit and any visitors in Louisiana experiencing injury benefit from a robust trauma system. Trauma Systems increase the chances of survival by strengthening the relationships between local health departments as injury prevention advocates, trained community bystanders, Emergency Medical Services (EMS), trauma centers, and rehabilitation services.

D. How was the accomplishment achieved?
LERN Board's process of evaluating system growth, strategic plans and recognizing the value of external review to assist in defining the path forward. Specifically, as LERN is closing out on our 3-year plan and preparing the blueprint for the next phase of the trauma system, LERN administration had to evaluate the budget and plan appropriately to fund this endeavor. We also had to work with LDH, the Division of Administration and the Legislature to appropriate funding. Additionally, the LERN Executive Director worked with system partners to complete an exhaustive pre-review questionnaire to provide the required information for a successful evaluation.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes, it contributes to Goal I – Decrease risk adjusted trauma-related deaths and incidents of morbidity and mortality due to trauma 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 – when designing and implementing a statewide system of care, it is best practice to obtain guidance from experts in the industry.

Accomplishment #2: Forty Percent Increase in Education from FY 2023

A. What was achieved?
There was a 40% increase in education from FY23. LERN taught 198 classes reaching 4,328 students in FY23.

B. Why is this success significant?
Education is a key component of any system of care. LERN is responsible for implementing systems of care for trauma, burn, stroke, ST-Elevation Myocardial Infarction (STEMI) and disaster response – all time sensitive, requiring swift evaluation, diagnosis, treatment or transfer. Much of LERN's education is targeted to small rural hospitals.

C. Who benefits and how?
Louisiana citizens or any visitor suffering one of these time sensitive conditions. Doctors, nurses, EMS, ancillary staff and lay citizens benefit – depending on the target audience. LERN teaches or coordinates education for: trauma nurse core curriculum (TNCC), Emergency Nurse Pediatric Course (ENPC), Pre-Hospital Trauma Life Support (PHTLS), 12 Lead ECG Course, Stroke Recognition and Response, Basic Stroke Course, Rural Trauma Team Development Course (RTDDC), Stop the Bleed and Mass Casualty Training (MCI).

D. How was the accomplishment achieved?
The three LERN Regional Coordinators and the Statewide Education Coordinator coordinate with providers at the local level to identify needs. Education is a standing item on LERN Regional Commission agendas. Through these networks, LERN coordinates education for trauma, stroke, burn, STEMI and MCI. The addition of the statewide education coordinator position has expanded our capability to meet regional needs. Collaborating with GOHSEP in the implementation of the Safe Schools Act has facilitated increased scheduling of Stop the Bleed classes.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes – Goal I: Decrease the risk adjusted trauma-related deaths and incidents of mortality due to trauma in Louisiana:
1.5 – Provide trauma nursing education in each LDH region.
1.6 – Support dissemination of RTTDC to rural areas of the state.
1.7 – Teach Stop the Bleed courses in every region.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Utilizing regional networks to identify needs and implement programs is a good practice but one I believe other departments already utilize.

Accomplishment #3: New Stroke Pre-Hospital Destination Protocol

A. What was achieved?
Louisiana Emergency Response Network Board (LERN) adopted and implemented new stroke pre-hospital destination protocol.

B. Why is this success significant?
The new guideline provides direction on transport of patients with wake-up stroke or unknown symptom onset. About 20% of strokes are detected upon awakening. Historically, these patients were excluded from treatment with IV lytic "clot busting medication" due to being "out of the window" from last seen normal. Radiographic studies of patients with wake-up strokes support the onset is likely shortly upon awakening. A randomized controlled study demonstrated efficacy of IV lytic in improving the odds of an independent outcome when selected by MRI of the brain, performed within 4.5 hours of symptom detection. The number needed to treat was nine. The symptomatic hemorrhage rate was only 2.4%. Since 2019, our AHA/ASA Guidelines for the Emergency Management of Acute Ischemic Stroke issued a Class 11a, level of evidence B recommendation for IV alteplase within 4.5 hours of symptom detection for patients who have MRI confirmation of DWI lesion less than one-third of the MCA territory and no visible signal change on FLAIR. This applies to patients who are found with stroke symptoms whose last seen normal is more than 4.5 hours prior. Due to these outcomes, it was imperative for LERN to implement this best practice, industry standard within our stroke system of care.

C. Who benefits and how?
Stroke patients with wake-up or unknown symptom onset benefit from this new protocol. They benefit by now being included in the patient population considered for treatment with IV lytic, when previously excluded. One in nine patients treated will have an independent outcome, meaning they will not have stroke deficits after treatment with IV lytic.

D. How was the accomplishment achieved?
LERN's stroke medical director updated the stroke pre-hospital destination protocol based on updated research and national guidelines. LERN vetted the draft versions with the state stroke workgroup, the regional physician champions and LERN Regional Commissions. LERN considered stakeholder feedback and incorporated changes where appropriate. The LERN Board ultimately adopted the protocol and promulgated it in rule. Additionally, the Stroke Medical Director conducted a recorded video to educate both EMS and hospitals on the new protocol. This is available on the LERN Website for continuous learning. https://vimeo.com/891113638?share=copy

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. Objective III.2: Develop a statewide system of stroke care to improve outcomes for Louisiana citizens regardless of where they live in the state.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
It is a best practice to include regional stakeholders in any process impacting their practice. Making partners part of the process engages them in the process and helps for successful implementation. It is also best practice to have a subject matter expert lead related initiatives.

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

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

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

  Yes, Louisiana Emergency Response Network Board (LERN) is progressing towards meeting the goals and objectives set forth by our strategic priorities. Returns on investment are being met, as evidence by the 40% increase in education/outreach, less than 5% secondary transfer rate for patients directed by the LERN Communication Center (LCC) and expansion is networks for trauma, stroke, STEMI and Burn.

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

- Fourteen Louisiana Trauma Centers are participating in the Trauma Quality Improvement Program (TQIP). The collaborative allows us to look at benchmark risk-adjusted outcomes as a state system against all nationally participating TQIP centers. It facilitates system-level trauma center quality improvement and identification and sharing of best practices among collaborative participants. Based on the TQIP data the collaborative developed a hip fracture guideline to help formalize an approach to hip fracture care to improve postoperative outcomes and reduce mortality. We are in the final phases of adopting this guideline.
- We do not have a comprehensive trauma registry. We have 14 hospitals submitting data to the state trauma registry. This is up from seven in CY 16. Hospitals are now submitting data quarterly. Annual reports are posted to the LERN Website. https://lern.la.gov/trauma/trauma-registry/ Based on data from the 14 hospitals submitting data in 2023, the highest cause of injury is falls, followed by motor vehicle crashes and then firearm discharge. The highest cause of mortality is firearm discharge, then falls, followed by motor vehicle crashes.

- We now have fourteen designated trauma centers in the state.
  - Ochsner LSU Health Shreveport – Level I Trauma Center
  - Ochsner LSU Health Shreveport – Level II Pediatric Trauma Center
  - University Medical Center New Orleans – Level I Trauma Center
  - Children's Hospital New Orleans – Level II Pediatric Trauma Center
  - Rapides Regional Medical Center – Level 2 Trauma Center
  - Our Lady of the Lake Regional Medical Center – Level 2 Trauma Center
  - Our Lady of the Lake Children's Hospital - Level II Pediatric Trauma Center
  - North Oaks Medical Center – Level 2 Trauma Center

- Ochsner Lafayette General Medical Center – Level 2 Trauma Center
- Lakeview Regional Medical Center – Level 2 Trauma Center
- St. Tammany Parish Health System – Level 3 Trauma Center
- Lake Charles Memorial Hospital – Level 3 Trauma Center
- Ochsner LSU Health Monroe
- St. Francis Medical Center

- Hospitals are updating the burn screen in the ESF-8 portal daily, providing transparency in burn bed availability statewide. Children's Hospital New Orleans is working to become a burn center. Additionally, the LERN Board updated all burn educational materials to reflect American Burn Association guidelines for burn care and resuscitation.
- All of these efforts are improving morbidity and mortality, but we need a comprehensive registry and an upgraded state trauma registry in order to provide valid data. Based on the state trauma registry, consisting of 14 trauma centers/programs, the number of injured patients in the registry increased by 39%over a five-year span and the death rate decreased by 7%.
- LERN continues to teach trauma specific courses statewide. In CY 2022, LERN taught or facilitated 120 courses, reaching 2,553 students. In CY 2023, we exceeded the 2022 effort. LERN taught 170 trauma classes, reaching 2,826 students.
- The ACS-COT Trauma Systems Consultation will help inform strategic planning going forward.

Goal 2: Maximize the return on investment (ROI) of state dollars and supplement of general fund dollars with alternative funding sources.

- The LERN Call Center tracks secondary transfers as part of its performance metrics. The LERN benchmark is less than 5%. Secondary transfers, especially for time-sensitive illnesses such as trauma, stroke and STEMI, are detrimental to patient outcomes. A considerable number of these transferred patients undergo potentially preventable, repeated CT scans adding radiation dose to patients and costs to the healthcare system. Patients directed by the LERN Call Center (LCC) have a 5% secondary transfer rate as compared to 55% of patients requiring a secondary transfer when not directed by LERN. Cutting down on secondary transfer's saves money. We are not able to attribute a dollar amount to this efficiency. We continue to depend on the state general fund for LERN Operations.
- We received $40,000 in grant funding to support the EMS Registry.
- Anticipated returns on investment are being realized in terms of efficient use of resources.
- Moving to a state owned building has reduced annual rent significantly and cost of ancillary services.
- We continue to look for grant funds.
- $25,000 grant funds from Living Well Foundation for Pre-Hospital Trauma Life Support classes and for stroke education in northeast Louisiana.
- $30,000 grant funds from for AIS-15 injury scoring class for the state trauma registrars.
- Funding bill for LERN presented in 2019 Regular Session. The bill did not pass.

Goal 3: Ensure that all citizens gain access to the statewide networks for trauma and time sensitive related illnesses.

- LERN has participation agreements with 98.3% of the Tier 3 hospitals in the state.
- The expansion of the number of trauma centers from two in 2011 to 14 in 2024 provides 90% of the population with access to a trauma center within a 60-minute drive time. This is up from 40% in 2011.
- LERN developed a Trauma Program status for those hospitals working towards trauma center designation. This expands access to high-level trauma care. Ten hospitals have taken advantage of this process and subsequently passed verification by the American College of Surgeons (ACS):
    - North Oaks Medical Center
    - Lakeview Regional Medical Center
    - Lake Charles Memorial Hospital
    - St. Tammany Parish Hospital
    - Lafayette General Medical Center
    - Ochsner LSU Health Shreveport Pediatric Trauma Center
    - Our Lady of the Lake Children's Hospital
    - Children's Hospital New Orleans
    - Ochsner LSU Health Monroe
    - St. Francis Medical Center

- When considering the fourteen Verified Trauma Centers, 90% of the population have access to a trauma center within a 60-minute drive time.
- When the LERN Board's vision of a verified trauma center in each of the LDH regions is achieved, 97% of the population will have access to a trauma center within a 60-minute drive time. The LERN Trauma Medical Director provides consultative services to all centers to help them achieve and maintain verification. LERN has a 100% success rate in ACS verification and re-verification.
- In CY 2023, the LERN Board implemented the updated pre-hospital trauma destination protocol. This update was necessary to incorporate national CDC field triage guidelines. Based on regional concerns, the board committed to tracking over triage to trauma centers and this proved not to be a valid concern. The protocol was successfully implemented.
- 100% of the population has access to the LERN Call Center for assistance with direction to the most appropriate resourced hospital for trauma, burn stroke or STEMI.
- LERN's targeted trauma, stroke and STEMI education to rural hospitals helps increase their readiness to treat patients with these time-sensitive conditions who present to their facility via private vehicle. LERN increased education and outreach by 40% in FY 23 as compared to FY22.
- LERN tracks trauma transfer denials and shares a daily report with all trauma centers. This transparency helps each center to evaluate, in close to real time, processes related to transfer acceptance. This result in a higher acceptance rate and decreases cross-region or state transfers, allowing patients to receive care closer to home.
- LERN established criteria for six levels of stroke hospitals. The LERN Levels are: Comprehensive Stroke Center (CSC= formerly Level I), Thrombectomy Capable Stroke Center (TSC= new), Primary Stroke Center (PSC = formerly Level II), Primary Stroke Center with Endovascular (PSC-E = new), Acute Stroke Ready Hospital (ASRH = formerly Level III), and Stroke Bypass Hospital (formerly Level IV). A stroke bypass

hospital does NOT have the capability of taking care of stroke patients. LERN has built a network of stroke centers that provides the public access to either a CSC, TSC, PSC/PSC-e, or an ASRH to 99.3% of the population. Hospitals attest to their level every two years.

- Performance metrics for stroke meet or exceed national benchmarks:
  - Door to Needle for Acute Stroke Ready Hospitals = 47 minutes with 75.8% of treated patients receiving alteplase within 60 minutes, 45.8% within 45 minutes and 15% within 30 minutes. National benchmark is 60 minutes.
  - Door to Needle for CSC, TSC and PSC = 41 minutes.

- LERN established criteria for STEMI Receiving centers which require 24/7/365 access to a cardiac catheterization lab. There are 35 STEMI Receiving Centers in the state. These 35 hospitals provide 97.6% of the population with access to a STEMI Receiving Center within a 60-minute drive time. LERN continues to successfully collect this data from all 35 Receiving Centers and two Referral Centers (and from two referral centers).
- The LERN STEMI Medical Director provides individualized quarterly feedback reports to each receiving center. LERN continues to distribute feedback reports to the referral centers. The reports provide them with the time it takes them to transfer STEMI patients out of the ED to the Receiving Center where they can receive emergent PCI. The state median for Door to PCI is 58 minutes, far better than the national benchmark of 90 minutes. The median transfer time for referral centers is 58 minutes, much longer than the national benchmark of 30 minutes. LERNs strategic plan focuses on improving this metric. Additionally, LERN will continue to teach 12 Lead ECG classes statewide. In CY 2023, LERN taught 17 classes reaching 369 students.
- LERN continues to meet with the LERN Burn workgroup to implement and evaluate the state burn system. LERN planned and executed three mass notification/resource update drills with the American Burn Association, statewide burn centers and the Southern Regional Burn Consortium. 97% response rate to burn bed query.
- Fully implemented Stroke Recognition and Response (SRR) class. LERN taught 25 classes, reaching 296 students. Additionally, we taught 19 basic stroke classes, reaching 317 students.
- EMS Registry continues to be developed. We now have 48 EMS agencies participating in the registry. In December 2012, we only had 13 providers submitting data to the state registry. We are sharing data from the EMS Registry with LDH for an opioid surveillance project. We submitted data to NEMESIS again this year and are working to transition all EMS agencies from NEMSIS 3.4 to the new national standard – NEMSIS 3.5 requirements. At the end of CY 2023, LERN successfully transitioned 33/48 agencies to NEMSIS 3.5.

Goal 4: Establish and codify protocols that specify the role of LERN in ESF-8 activities

- Continue LERN's role in the ESF-8 to include manager of the EMS Tactical Operations Center during a disaster.
- LERN involvement in disaster drills throughout the state. Statewide Disaster Preparedness Manager integrated with 9 regional Healthcare Coalitions and Office of

Homeland Security Emergency Preparedness operations. Working on finalizing continuity of operations plan. Provided updated Mass Casualty Incident (MCI) training to partners in all regions related to how the LCC functions and collaborates with EMS during an incident.

- Established core-planning teams for LERN Continuity of Operations Plan (COOP) and Emergency Operations Plan (EOP). LERN COOP ensures the continuity of essential functions during a crisis while the EOP is a response plan for a wide spread disaster.
- Participated in multiple regional exercises, specifically related to active shooter. The LERN Disaster Response Manager actively seeks to be part of a community planning teams as well as informing stakeholders of the importance of whole-community approach to MCI response and management. LERN has provided MCI training, EMS Boot Camp, casualty cards, assisted in developing SitMan and MESL, evaluated capabilities, and led other exercise efforts. These efforts ensures the whole community understand the process of continuity of care from point of injury to definitive care during an MCI event.

- **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?

A 40% increase in LERN Education and Outreach. This progress is attributable to the LERN Board's directive to identify educational needs statewide utilize LERN Regional Coordinators to target these areas. Several reasons contribute to these increases:

- Hiring a statewide education coordinator – although this position was added in 2022, the benefits continue as LERN can better accommodate educational requests.

- Filled the region 2, 4, 5 Regional Coordinator with a nurse skilled in providing trauma, stroke and STEMI education.

- LERN also partnered with GHOSEP to target education to comply with the Safe Schools Act passed in the 2023 regular legislative session.

    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

The increase in educational services provided by LERN is attributable to LERN actions. We did not reallocate resources, but strategically hired a nurse with the skillset needed to expand education in regions previously underserved.

Additionally, the LERN Disaster Response Manager has successfully integrated into the regional healthcare coalitions and regional Office of Homeland Security and Emergency Preparedness networks. This results in LERN being included or helping lead mass casualty incident drills statewide.

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

The success in increasing education and outreach is not due to multiple departments or agencies. It is due to LERN's development of regional networks, which facilitate lines of communication between LERN, hospitals, EMS and community partners. Through these networks, we are able to identify and provide educational needs.

- 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 growth will plateau over time.

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

1. To what do you attribute this lack of progress? For example:
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?

The major area we are experiencing a significant lack of progress on is, lessening the dependence on the state general fund for LERN funding. I do not feel like this is a management issue. Many State Trauma Systems funding comes from sin taxes (tobacco, speeding violations, DUI,) or via receiving a portion of driver license or vehicle registration fees. On two occasions, LERN has been unsuccessful in getting legislation passed for this type of funding.

LERN also needs a comprehensive trauma registry. Currently only the 14 trauma centers/programs contribute injury data to the registry. Without a comprehensive registry, it is difficult to measure system improvement and to target injury patterns.

- Is the lack of progress due to budget or other constraint?
  Lack of progress is due to the legislature not having an appetite to increase taxes, fee/fines on citizens, which would help reduce LERNs reliance on the state general fund.

The registry is a funding issue for hospitals. It is difficult for smaller community hospitals to identify staff to input trauma registry data. In the past, the Louisiana Hospital Association pushed back on mandatory data collection.

- Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
  See above.
- Other? Please specify.

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

   The reliance on the state general fund will continue until we can pass legislation to create a dedicated funding source outside of the State General Fund to fund the system. The registry will continue to be an issue until as a state we legislate mandated participation and purchase a registry capable of integrating EMS registry data with trauma registry data. State trauma systems funded via fees or fines use this revenue to fund the state trauma registry.

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

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

  The LERN Strategic Priorities are set for a 3-year interval. Each year the LERN Board reviews the strategic priorities and adjusts 12-month goals and the action items to achieve goals. In November 2021, we developed new strategic priorities for 2022-2024. We consulted with the American College of Surgeons Committee on Trauma to evaluate Louisiana's Trauma System. We will use recommendations from this report when developing the 2025 – 2027 three year strategic plan.

  ☐ No. If not, why not?

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

  The LERN Board adopts a 3-year strategic plan. The Executive Director provides a report to the LERN Board of Directors (BOD) at least quarterly. This report includes progress to goals for each strategic priority. The strategic goals for each priority is completely re-evaluated annually by the LERN BOD and annual goals are updated to help advance each priority. The LERN Regional Commissions are informed through the Tri-Regional Coordinators, the LERN Administration and Medical Directors. The Tri-Regional

Coordinators also submit quarterly Commission Activity Reports (CAR) that provide information on what is being done at the regional level to achieve strategic priorities. The strategic plan is posted to the LERN website.

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

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

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

Issue #1: Reliance on State General Funds

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   The Louisiana Emergency Response Network Board (LERN) relies on State General Fund (SGF) in order to run the network. This is a concern due to the anticipated fiscal shortfall related to the expiring .45 cent sales tax. LERN operations are at risk if budget cuts are implemented due to this anticipated fiscal shortfall.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   This problem is not currently affecting progress of LERNs strategic plan because our planning accounts for existing appropriation. The strategic plan will be affected if cuts are implemented to LERN in the future.

3. What organizational unit in the department is experiencing the problem or issue?
   LERN only has one department and our mission covers four core components (Trauma, Stroke, STEMI, and Disaster Response).

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Our external public, hospital and EMS providers will be impacted by reductions in

education and support provided.

5. How long has the problem or issue existed?
   LERNs reliance on the state general fund has existed since LERN was first funded in 2006. LERN has twice unsuccessfully attempted to pass legislation for dedicated funding – separate from the state general fund.

6. What are the causes of the problem or issue? How do you know?
   As previously stated, expiration of the .45 cents sales tax impacts the state general fund. The LERN Board will consider this when establishing the next 3-year strategic plan. LERN is almost 10% funded by the SGF.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   Impact and consequences will depend on the extent of budget reduction required by the legislature. Impacts may range from maintaining LERN Call Center operations to decreasing education opportunities provided to EMS, hospitals, and to lay public.

B. Corrective Actions

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

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

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
   The board is waiting on the final report from the ACS-COT for recommendations related to financial stability for the trauma system. Establishing a dedicated funding source (ex: portion of vehicle registration fee/ or driver license fee dedicated to LERN) would reduce LERN's dependence on SGF.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   Yes – 2017, 2019, 2022 report.

4. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
      - How much progress has been made and how much additional progress is needed?
   b. If not:

- Why has no action been taken regarding this recommendation?

The LERN Board will discuss the possibility seeking dedicated funding at the August board meeting. LERN sought to pass HB 360 in the 2019 Regular Session without success. This bill added $2.75 cents to driver's license or renewal.

- What are the obstacles preventing or delaying corrective actions?

When pursued in a previous session, there was resistance by the legislature to adding this fee. Concerns were related to the burden placed on the end user.

- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

Any dedicated funding source requires legislation. The earliest any funding could be directed to LERN would be one year from the conclusion of the 2025 Regular Legislative Session. ? July 2026.

5. Do corrective actions carry a cost?

☒ No. If not, please explain.

Establishing a dedicated funding source would be done via the legislative process. Most trauma systems are funded via a tax or fee dedicated to operating the system. The goal would be to lessen LERN's dependence on the state general fund leaving those dollars available for federal match.

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

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

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

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

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

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

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

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

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

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets.

Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

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

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

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

☐ Peer review
☐ Accreditation review
☐ Customer/stakeholder feedback
☐ Other (please specify): Case review process. All reviews tracked in Access Data Base.

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department:	**Louisiana Department of Health (LDH)** 09-325 Acadiana Area Human Services District
Department Head:	Michael Harrington, MBA, MA LDH Secretary
Undersecretary:	Drew Maranto
Executive Director:	Brad Farmer

I. What outstanding accomplishments did your department achieve during the previous fiscal year? For each accomplishment, please discuss and explain each item below.

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

Accomplishment #1: CCBHC PDI Grant

A. What was achieved?
Acadiana Area Human Services District (AAHSD) was awarded a Certified Community Behavioral Health Clinic Planning, Development, and Implementation (CCBHC-PDI) grant from SAMHSA effective October 1, 2022; this is a $3.8million four-year award. AAHSD has been working closely with an external consulting group; the University of Louisiana; and the Office of Behavioral Health during this development phase. Our program attestation was reviewed and accepted by SAMHSA effective January 1, 2024. This means that AAHSD has gained Federal recognition as a CCBHC.

Additionally, AAHSD was surveyed by CARF International in October 2023 and earned a Three- Year Accreditation for the CCBHC program. AAHSD was the first

organization in the country to earn this designation.

B. Why is this success significant?
This model of care will improve the quality of services provided to our community by providing a framework for best practices and aligning services with community needs. The requirements (performance standards) are 'above and beyond' State licensure standards and current contractual indicators. It will assist AAHSD in expanding services and will provide a structure to sustain operations.

C. Who benefits and how**?**
AAHSD benefits from technical assistance, training, and consultation; along with external funding. The entire service population benefits from expanded services and professional collaborations. This program will also ensure AAHSD adequately addresses the needs of Veterans seeking services.

D. How was the accomplishment achieved?
As part of the ongoing process, AAHSD has appointed an internal Project Director to oversee all efforts with this program. AAHSD has contracted with an external consulting group for ongoing technical assistance and with the University of Louisiana to serve as the project evaluator. Additionally, conducts regular project meetings with both of these groups and has invited the Office of Behavioral Health to participate as well as a way to enhance communication with State officials. AAHSD also has monthly calls with the identified Grants Project Officer
(GPO) from SAMHSA.

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

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

Accomplishment #2: Same Day Access Grant

A. What was achieved?
Acadiana Area Human Services District (AAHSD) participated in a technical assistance project and implemented the Same Day Access model. This project went 'live' on January 8, 2024. From January 8 – June 30, 2024, AAHSD conducted over 1100 comprehensive assessments for persons seeking services. These were provided 'on demand' and were not scheduled appointments. Of those assessments, over 90% were admitted to AAHSD for services; others either declined care or were referred to more appropriate providers.

B. Why is this success significant?
This project will work in tandem with our CCBHC efforts and will greatly increase service accessibility. This is recognized as a 'best practice'. A secondary benefit is increased service capacity for ongoing non-intake appointments.

C. Who benefits and how**?**
All persons seeking services from AAHSD. This has eliminated a traditional 'waiting list' for services.

D. How was the accomplishment achieved?
AAHSD worked with MTM Services to complete a gap analysis of our systems and to implement necessary changes. AAHSD appointed a Same Day Access Team to guide implementation and this Team continues to meet and monitor our progress and makes recommends changes as needed.

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

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

Accomplishment #3: Just In Time Grant

A. What was achieved?
Very similar to the Same Day Access program last year, AAHSD has been invited to participate in a technical assistance project to implement a 'Just in Time' program (JIT). The JIT project focuses on revamping the scheduling process for prescribers so that persons served have more timely access to those staff members. AAHSD has only had one planning session and two follow-up sessions to date. The project has an implementation target date of prior to the end of calendar year 2024.

B. Why is this success significant?
This will increase accessibility to evaluation and medication services for persons served. This will increase overall efficiency of clinical operations as well. And as noted above, this is considered a best practice.

C. Who benefits and how?
All persons being served by AAHSD. This will provide more timely access to prescribers for medically-necessary care. For the organization itself, this standard of care will allow us to demonstrate conformance/compliance with licensure and accreditation standards.

D. How was the accomplishment achieved**?**
Utilization of a nationally-recognized consulting firm to help set-up the system and an internal team for ongoing monitoring and revisions.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
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: Partnership with Families Helping Families to provide a Easter baskets for children with developmental disabilities and/or dealing with mental health issues in the community

A. What was achieved?
Acadiana Area Human Services District (AAHSD) partnered with Families Helping Families to give Easter Baskets to kids with DD and/or Mental Health issues.

B. Why is this success significant?
It allowed the community and children with developmental disabilities and/or mental health issues to interact and receive an Easter basket. Also provided children with DD and/or dealing with Mental Health issues the same opportunities available to all.

C. Who benefits and how**?**
Children with developmental disabilities and/or dealing with Mental Health issues and their families and the community. It helped build relationships and showed the community the abilities of people with DD and/or dealing with Mental Health issues.

D. How was the accomplishment achieved?
AAHSD collaborated with Families Helping Families. Easter baskets were collected through their networks and all assisted with delivery of the baskets to the children.

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

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

Accomplishment #5: Continued Partnership with OCDD regarding the tiered waiver system

A. What was achieved?
Partnered with the Office for Citizens with Developmental Disabilities (OCDD) for the continued administering of the tiered waiver system.

B. Why is this success significant?
It changed the way the request for waiver services registry (waiting list) is implemented. It has gone from a first come first serve registry to as needs based screening process.

C. Who benefits and how?
Individuals with developmental disabilities and their families. It will allow quicker access to home and community based services.

D. How was the accomplishment achieved**?**
OCDD partnered with the district and authorities throughout the state to screen all of the individuals on the registry. Once done, the needs of those individuals were established. Priority was given to those with the highest, most urgent need.

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

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

Accomplishment #6: Partnership with the City of Lafayette Parks and Recreation Department to provide a Christmas Extravaganza for people with developmental disabilities and all kids within the community

A. What was achieved?
Acadiana Area Human Services District (AAHSD) partnered with City of Lafayette Parks and Recreation Department to give a Christmas party for people with developmental disabilities and all kids within the community.

B. Why is this success significant?
It allowed the community and children with developmental disabilities to interact to break down barriers and stereotypes. It provided a safe environment people could celebrate Christmas, participate in dancing, arts and crafts and be allowed to visit Santa.

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

D. How was the accomplishment achieved?
Collaboration with the City of Lafayette Parks and Recreation Department. Many community providers assisted in providing various activities to the individuals.

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

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 #7: Partnership with the Aetna to provide inclusion event for trick or treating (Treats at the Village) for individuals with developmental disabilities in the community

A. What was achieved?
Acadiana Area Human Services District (**AAHSD) partnered with the Aetna to give have an inclusive trick or treating experience in the community.**

B. Why is this success significant?
It allowed the community and individuals with developmental disabilities to interact with the community to participate in trick or treating. Also provided individuals with DD the same opportunities available to all.

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

D. How was the accomplishment achieved?
AAHSD collaborated with Aetna.

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

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.

Acadiana Area Human Services District (AAHSD) submitted our initial five-year Strategic Plan in June 2025. Thus far, our goals and objectives are being met and the plan is on target for successful completion.

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

AAHSD is progressing towards accomplishing goals and objectives, such as: developing clear policy objectives; providing behavioral health treatment services as part of the State's continuum of care; improving accessibility; increasing stakeholders' involvement; and, providing quality services and supports. These strategies are effective in ensuring

persons served receive the highest quality care.

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

  1. To what do you attribute this success? For example:
     - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
     - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new 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.

  Acadiana Area Human Services District (AAHSD) is on target for making the progress that was projected in the five-year Strategic Plan. Progress is due largely to reorganizing our internal structure, developing new policies and procedures, utilizing the expertise of the Governing Board, conducting staff training, and implementing a team structure and approach to management. We are continually working to improve policies/systems and making necessary changes to become more effective and efficient.

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

  Progress is expected to continue on an 'on-target pace' as we conduct regular ongoing meetings of teams (Accreditation, Health/Safety, Quality Improvement, and Senior Management), participate in ongoing external reviews, and conduct ongoing internal reviews. Our efforts so far have not been 'one-time events' but the building of infrastructure and operating systems to ensure ongoing success.

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

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

so, please describe the problem and any recommended corrective actions in Section III below.
- Other? Please specify.

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

None.

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

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

☒ No. If not, why not?

The Acadiana Area Human Services District (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.

There is no significant management or operational problem issue 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**
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)**
Office of the Legislative Auditor every two years.

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

☐ Policy, research, planning, and/or quality assurance functions 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)**
LaPAS Reports

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

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

☒ **Peer review**
Medical Doctors and OCDD peer review process

☒ **Accreditation review**

CARF Accreditation—AAHSD received a 3-year accreditation

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

☒ Other (please specify):

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

☒ Yes. Proceed to Section C below.

☐ No. Skip Section C below.

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

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

1. **Title of Report or Program Evaluation: <u>AAHSD Management Report</u>**
2. Date completed: June 2024
3. Subject or purpose and reason for initiation of the analysis or evaluation: The AAHSD Management Report is offered as partial fulfillment of the standards set forth by CARF and is designed to summarize the results of the program plans; quality assessment; goals and objectives; the data collected in the areas of effectiveness, efficiency, service access, and consumer satisfaction; and from other operating systems and to provide a synopsis of ‘significant events’.
4. Methodology used for analysis or evaluation:
   Review of AAHSD systems including: Corporate Compliance, Health and Safety (including Accessibility), Human Resources, Information Management, Outcomes Management System, Quality Improvement, and Risk Management.

5. Cost (allocation of in-house resources or purchase price): In house resources
6. Major Findings and Conclusions:
   - AAHSD developed and signed a contract with LDH for services in Acadiana.
   - AAHSD clinical and administrative policies and procedures were reviewed by Civil Service, Office of Risk Management, and LDH.
   - AAHSD received successful reviews from the MCOs, State licensure, and State contract performance indicators.
   - 2024/2025 budget submitted and approved. AAHSD maintained operations within budgetary guidelines.
   - AAHSD realized an increase in collections for self-generated revenue. AAHSD has doubled its self-generated collections in the past three years.
   - Professional and service contracts maintained and monitored by AAHSD. Monitoring was increased to at least quarterly for all contracts (some monitored monthly). The monitoring process has received positive comments from two separate regulatory reviews.
   - Employees completed Civil Service PES as required.
   - AAHSD continued its employee training program/schedule and utilized two online training programs – LEO and Relias Learning. Targets and timeframes were met.
   - All Senior Managers have maintained a succession plan for their respective areas.
   - AAHSD did implement a new pay/performance structure as outlined by State Civil Service.
   - AAHSD maintained credentialing by all five MCOs within the State plan.
   - AAHSD conducted and/or participated in numerous public events, health fairs, community forums, and other professional forums. This is reflected by the increase in number of stakeholder surveys.

   - AAHSD was monitored by: ORM, LDH/OBH and OCDD, LDH/Bureau of Health Standards, State Civil Service, and the Fire Marshal. All reviews were successful.
   - AAHSD assumed operation of services, including the provision of crisis services within our designated area.
   - AAHSD was trained and participated in OPH/Emergency Preparedness exercises/activities.

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

7. Major Recommendations: None
8. Action taken in response to the report or evaluation: None
9. Availability (hard copy, electronic file, website): Located in the policy and procedure manual and website

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

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department: Louisiana Department of Health (LDH)
09-326 Office of Public Health

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto, MPA

Assistant Secretary: Tonya Joiner, JD

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

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

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

Accomplishment #1: Implementation of Act 98 of the 2021 Regular Session -- Issuance of first letter grades for community water systems

A. What was achieved?

In accordance with the Community Drinking Water Infrastructure Sustainability Act (Act 98 2021 Legislative Session), LDH issued letter grades for community water systems on May 1, 2024.

B. Why is this success significant?

Louisiana is the first to develop a grading scale and issue letter grades for public water systems that covers more than just water quality violations. The water system grades provide relevant information and an accountability process to support drinking water sustainability for citizens of Louisiana. The grades encompass more than just federal drinking water violations and are based on water quality violations, state violations, financial sustainability, operation and maintenance performance, infrastructure violations, customer satisfaction and unregulated contaminants that cause aesthetic issues.

C. Who benefits and how?

The public (i.e., customers of the community water systems) benefit by being better informed and having a better understanding of the public water system that provides their drinking water. Public water systems benefit by being held accountable for more than just federal and state violations, which do not include financial and customer satisfaction accountability. OPH benefits by being able to compile, track and report on financial sustainability, customer satisfaction and unregulated contaminants (aesthetic) issues in addition to the normal water quality violations, state violations, operation and maintenance performance and infrastructure violations. Overall benefit includes holding the entity that owns/operates a public water system with a Grade of ***D*** or ***F*** accountable. Public water systems with a Grade of ***D*** or ***F*** may be subject to 1) enforcement action as provided for in R.S. 40:5.9 including Receivership; and 2) oversight of all federal or state funding by an auditor approved by the legislative auditor and with the authority to make decisions regarding the expenditure of funding.

D. How was the accomplishment achieved?

This accomplishment was achieved by significant Bureau of Engineering staff effort. Engineering staff have developed a letter grade schedule and performed rulemaking to adopt the letter grade schedule and requirements. Each year staff compile data, vet all data and grades, develop and generate report cards.

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

This accomplishment will contribute to the success of the strategic plan to provide Safe Drinking Water.

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

This accomplishment indeed represented best management practices and has been shared with other states' Safe Drinking Water Programs, Region 6 USEPA and Association of State Drinking Water Administrators (ASDWA). Other states have expressed interest in creating this for their state. Effective communication, quality assurance, collaboration, and staff development strategies led this work to an accomplishment.

Accomplishment #2: Creation, implementation, and continuation of the Louisiana Heat Dashboard

A. What was achieved?

On August 11, 2023, following a record number of days with a heat index in the 100s and drought conditions throughout the state, Louisiana declared a State of Emergency. Within ten days, the Bureau of Health Informatics (BHI), in collaboration with the State Epidemiologist and the Bureau of Infectious Diseases Section for Environmental and Epidemiology and Toxicology (SEET), launched the Louisiana Heat Illnesses and Deaths Dashboard. Updated weekly, the dashboard provided detailed breakdowns of heat-related emergency department visits by day, parish, LDH region, age, sex, and race. It also published heat-related deaths by month, region, sex, age group, ethnicity, and race. The dashboard further provided guidance on recognizing heat-related illness, precautions for avoiding heat-related illness, and prevention resources.

LDH tracked 88 heat-related deaths and 6,142 emergency department visits for heat-related illness in 2023.

LDH leveraged last year's processes and findings to improve the dashboard and to shape its public health preventive measures and practices. In June 2024, anticipating another record-setting high-temperature, minimal-rainfall summer, the dashboard and associated processes were updated and relaunched.

B. Why is this success significant?

Surveillance data is a critical effort in the planning, implementation, communication, and evaluation of public health programs and services. Multiple sources of data are integrated and used to select, improve, and build capacity for prevention activities. Surveillance data further identifies priority populations, areas of concern, and populations at disproportionate risk. BHI also leveraged current assets and staff to produce this data product at zero additional cost to the agency.

C. Who benefits and how?

Many stakeholders benefit from this project. The public benefits from seeing that LDH is responsive to the health and safety needs of the people of Louisiana, and gain a better understanding of the risks associated with exposure to high environmental temperatures. Sharing demographic information (who and where) and time-based information is helpful for individuals to protect themselves from the effects of extreme heat. Leadership benefits from having this information available for decision-making and prevention purposes. Finally, researchers benefit from having accessible, updated information upon which to base scientific studies.

D. How was the accomplishment achieved?

The dashboard represents the collaborative efforts of several different entities within LDH. The BHI is responsible for (1) extraction and validation of weekly deaths recorded

in the state vital records database; (2) implementation of the visualization and customization of the dashboard; and (3) for both death and syndromic surveillance data, integration and processing, including automation. The SEET is responsible for extraction and validation of emergency department data and subject matter expertise informing public facing materials. BHI, Infectious Disease Epidemiology, and SEET collaborated on the case definition and validation methodology for heat-related illnesses and deaths to ensure consistency across data sources. The State Epidemiologist is responsible for subject matter expertise, data collection and quality, and public guidance. The LDH Bureau of Media and Communications is responsible for public-facing written materials and graphics. Iterative design and review processes ensured that development was achieved in a timely manner.

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

The heat dashboard contributes to the Community Safety priorities outlined in the 2024 State Health Improvement Plan. Engaging the public with quantitative data on the environmental hazards of excessive heat supports the SHIP goals of promoting healthy and safe environments and supporting community readiness and resilience. This accomplishment advances the OPH BHI mission, vision, and strategic priorities, but is not connected to a specific LDH Business Plan outcome.

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

This accomplishment represents a practice of collaboration with stakeholders and partners in efforts to turn data in actionable, informed decision-making that positively affects communities, improves health outcomes, and saves lives.

Accomplishment #3: The Bureau of Family Health Integrated the Louisiana Mental Health Perinatal Partnership (LAMHPP) Services with the Bureau's Provider-to-Provider Consultation Line (PPCL)

A. What was achieved?

The Bureau of Family Health (BFH) integrated the Louisiana Mental Health Perinatal Partnership (LAMHPP) services with the Bureau's Provider-to-Provider Consultation Line (PPCL). This expansion enabled PPCL to extend its mental health consultation, training, and resource and referral support services to serve both pediatric and perinatal providers statewide. The Bureau also applied for and was granted another five-year grant from Health Resources and Services Administration (HRSA) to sustain perinatal consultation and training.

B. Why is this success significant?

This success is significant because Louisiana now has one comprehensive program, the PPCL, that can support frontline healthcare providers in recognizing and responding to the mental and behavioral health needs of children, youth, and pregnant and postpartum persons. Louisiana has a shortage of mental health professionals, resulting in frontline

providers being called upon to be the first line of care and treatment for children, youth, and pregnant and postpartum women with mental health and substance use concerns. Unfortunately, providers often lack the training, confidence, and time needed to address the behavioral health needs of their patients. By providing training, mental health consultation, and resource and referral support to pediatric and perinatal providers, the PPCL supports the integration of behavioral health services into the pediatric and perinatal primary care settings, thereby increasing the access of children and youth as well as pregnant individuals to comprehensive care. The five-year grant award from HRSA not only sustains the work with perinatal providers, but also provides additional resources to assist providers in treating pregnant and postpartum women with substance use disorder.

C. Who benefits and how?

All perinatal and pediatric providers and their patients with behavioral health conditions and concerns potentially benefit from integrating the perinatal program under the PPCL. The merging of the programs has had multiple benefits, including increased efficiencies and greater impact related to marketing and outreach activities resulting in an increase of providers registering for the program, reduced confusion among providers and stakeholders on how to access services, and increased sustainability of the program. The new award from HRSA has also led to increased support for providers who are working with pregnant and postpartum persons with substance use disorder, an area of workforce capacity building that is greatly needed given that overdose is one of the leading causes of pregnancy-associated deaths in Louisiana.

D. How was the accomplishment achieved?

The Office of Public Health (OPH) worked with its partner, Tulane University, to transition the perinatal program to PPCL, and PPCL staff diligently built the infrastructure needed to successfully integrate the programs. OPH submitted a competitive proposal for the award from HRSA. Louisiana's successfully funded project reflects extensive historical expertise and a commitment to innovation.

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

This accomplishment advances the BFH strategic priorities, but is not connected to a specific agency strategic plan.

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

This project applies health improvement science in its work with providers and clinics to develop and improve practices for identifying, diagnosing, treating, and referring patients with mental health and/or substance use concerns, increasing the integration of mental and behavioral health into primary care settings.

Accomplishment #4: Reduction in WIC Vendor Authorization Process Times

A. What was achieved?

The Louisiana Women, Infants, and Children (WIC) Vendor Operations staff, within the Bureau of Nutrition Services (BONS), are responsible for the oversight of the 425+ WIC-authorized grocery stores (vendors) throughout the state of Louisiana. The WIC-authorized grocery stores provide access to the WIC-approved food items that WIC participants can buy with their benefits via the WIC electronic benefits transfer (EBT) card. In FY24, the WIC Vendor Operations staff streamlined the processing time for new vendor (grocery store) initial authorization, resulting in reduced application review and approval times. The time elapsed from when the vendor application was received to final approval and authorization decreased from an average of 138 days in FY23 to an average of 84 days in FY24. This represents a 39% decrease in the time it takes to review, approve, and authorize new vendors on the WIC Program and offer more shopping options for families on WIC.

B. Why is this success significant?

WIC participation has steadily increased in Louisiana over the past three years. In June 2024, there were 99,283 participants with access to WIC EBT benefits to use at WIC-authorized grocery stores in Louisiana, compared to 87,678 in June 2021. WIC grocery stores are necessary to provide specific WIC-approved food items to WIC participants. The faster a grocery store can be authorized to accept WIC transactions, the sooner participants can redeem their WIC EBT benefits there, thereby increasing their access to nutritious foods. Reduced vendor authorization process times also leads to increased grocery store satisfaction with the Program. Reducing administrative burden and processing time increases the likelihood that potential applicants will apply for WIC authorization and subsequently choose to remain a WIC-authorized grocery store.

C. Who benefits and how?

More than 99,000 low-income women, infants and children participating in the Louisiana WIC Program benefit by having more WIC-authorized grocery store access points to redeem their WIC benefits. WIC vendor applicants benefit by being able to transact WIC EBT cards sooner, drawing in more business from customers who participate in WIC.

D. How was the accomplishment achieved?

A working committee within the Bureau of Nutrition Services was formed to review the vendor authorization process and identify opportunities for improvements. Data analysis was performed to measure the average length of time each step in the process took to complete. Inefficiencies were identified and several process steps were combined and/or reordered. A streamlined and standardized process management and data tracking solution was implemented through Monday.com. Specific personnel were assigned to perform the functions of the process and were provided specific training, thereby promoting expertise and efficiency. An increased emphasis was placed across all staff on prioritizing the vendor authorization process and working efficiently to complete the required tasks.

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

Yes, WIC participants having increased access to redeem their WIC benefits ensures that BONS is meeting its overall mission of improving health outcomes, reducing disparities, and supporting nutrition security in Louisiana by providing healthy foods, nutrition education, breastfeeding support, and referrals to support services all through coordinated efforts across the landscape of stakeholders.

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

Yes, the methodology of analyzing data, identifying inefficiencies, piloting and evaluating new processes, and standardizing the new process to reduce administrative burden and implement efficient and effective practices is a best management practice and should be a priority for every agency in the state.

Accomplishment #5: Title of significant accomplishment: Syphilis Home Observed Therapy (SHOT Program)

A. What was achieved?

Four patient encounters have been held through the OPH Clinical Network and eight referrals have been made for the Syphilis Home Observed Therapy Program.

B. Why is this success significant?

Louisiana ranked seventh in the United States in the 2022 Centers for Disease Control and Prevention National Sexually Transmitted Infection (STI) Surveillance Report. Congenital syphilis (CS) occurs when pregnant individuals pass syphilis to their babies during pregnancy. Syphilis is an STI that can cause serious health problems without treatment. The SHOT at Home Program harnesses the fundamental public health concept of meeting people where they are by administering syphilis treatment for pregnant women during home visiting. The treatment protocol also addresses blood pressure screenings, which addresses crosscutting maternal health issues by capturing potentially life-threatening events that may otherwise be undetected.

C. Who benefits and how?

Pregnant individuals in Louisiana and their babies benefit from their program, as well as any future sexual partners of the persons receiving treatment. If left untreated, congenital syphilis can cause miscarriage, stillbirth, prematurity, low birth weight, and death shortly after birth in affected babies. Furthermore, babies born with congenital syphilis can have deformed bones, severe anemia, enlarged liver and spleen, jaundice, brain and nerve problems, like blindness or deafness, meningitis and skin rashes.

D. How was the accomplishment achieved?

For the SHOT Program, CS cases are reviewed to determine recurring barriers and identify lack of access to timely Bicillin treatment, persons who are unable to access treatment for syphilis at a medical treatment facility or their local parish health unit. Pregnant women and their partners were referred from a prenatal care provider, public health unit nurse, Disease Intervention Specialist or Perinatal Case Manger after one failed attempt. The decision to treat in the home is made in consultation with the regional medical director. SHOT was piloted in Regions 4, 7, and 7 with the goal of increasing access to appropriate treatment. Regions where the pilot was conducted have the highest rates of CS. Home visits are conducted by OPH nurses who are accompanied by disease intervention specialists ("buddy system"). The perinatal case manager may also conduct home visits.

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

Yes, this accomplishment contributes to Objective VII.7.5 of the strategic plan "Evaluate the effectiveness, accessibility, and quality of HIV, Hepatitis and STD, prevention, identification, and treatment." General performance indicators for this metric include the following:

a. Percentage of primary and secondary syphilis cases treated within 14 days of specimen collection
b. Number of primary and secondary syphilis cases

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

While the execution of the SHOT Program includes direct services of teams including nurses and disease intervention specialists, the design phase wherein the concept was developed represents Best Management Practices through the following:

a. Multidisciplinary teams provided a preliminary protocol for dissemination
b. A broader team provided input, with spearheading by our Regional Medical Directors who provided perspectives from specialty care areas including Obstetrics and Gynecology, Emergency Medicine, Family Medicine, and Pediatrics
c. Refining the final protocol was arrived by a statewide leader in infectious disease medicine with input from our OPH Clinical Lead.

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

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

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

Overall, the Office of Public Health (OPH) has been making remarkable progress towards its agency goals as outlined in the 2023-2028 Strategic Plan for OPH. The State Health Improvement Plan development illustrated a collaborative effort between many Bureaus and local partners, and a dashboard platform was used for the first time to ensure the Plan would be updated in real-time and contain relevant, real-time information for the people of Louisiana. The Strategic Priorities of OPH (maternal and child health, infectious disease and chronic disease) also align very closely with the four priority areas selected through the consensus-driven SHIP prioritization process (maternal and child health, behavioral health, chronic disease and community safety). As the examples in the prior section show, our work is resulting in measureable improvements in health-related behaviors and outcomes for the people of Louisiana. Additionally, the CDC-funded Public Health Infrastructure Grant created many opportunities for Bureaus to collaborate on new advances addressing Data Modernization efforts, workforce strengthening and capacity building efforts, and more.

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

  We are making significant progress in facilitating partnerships to increase our impact on health and wellness of individuals and communities through the development of the State Health Improvement Plan and in Data Modernization efforts funded by the CDC PHIG. Additionally, as part of Public Health Accreditation Board reaccreditation, we are implementing activities to increase the culture of Quality Improvement (QI) throughout OPH and thus improve existing processes that will strengthen our work. These strategies are reflected in the accomplishments described in Section 1.

  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.

     This progress is due to the collaborative nature of cross-Bureau efforts such as implementation of PHIG-funded activities in Bureaus and the SHIP. The success

builds on efforts of previous years with a renewed focus on community partnerships and data modernization.

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

   Should the required resources remain available, this work will continue to result in significant progress over the coming years.

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

  None.

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

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

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

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

  The new Assistant Secretary has strategic priorities (maternal and child health, chronic disease and infectious disease), which align with the SHIP priorities (maternal and child health, behavioral health, community safety and chronic disease) that were developed by a consensus-driven process between OPH Bureaus, community partners and community leaders.

  ☐ 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.

  Regular leadership meetings and town halls are held across the agency to review, update, and ensure implementation of plans.

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

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

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

There is no significant management or operational problem.

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 Louisiana Department of Health (LDH) Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Title of Report or Program Evaluation:
2. Date completed:
3. Subject or purpose and reason for initiation of the analysis or evaluation:
4. Methodology used for analysis or evaluation:

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

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department: Louisiana Department of Health (LDH)
09-330 Office of Behavioral Health

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

Assistant Secretary: Karen Stubbs Church, JD

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: Louisiana Crisis Response System (LA-CRS) Expansion to Youth

A. What was achieved?
The Louisiana Crisis Response System (LA-CRS) offers an alternative to crisis treatment traditionally delivered in an Emergency Department or with the involvement of law enforcement. Since 2022, the Mobile Crisis Response (MCR) and Behavioral Health Crisis Care (BHCC) have been available through a network of providers for Medicaid members 21 and older to access help during a mental health crisis and continues to expand. In early 2024, LDH Office of Behavioral Health (OBH) implemented updates to the crisis services definitions with the dual purpose of

improving service delivery and supporting providers of these services.

In the regions with an initial service, Community Brief Crisis Support (CBCS) is available to supplement the crisis interventions, if needed. CBCS is an ongoing crisis intervention response rendered to provide relief, resolution and intervention through maintaining individuals at home in the community, engaging in de-escalation to reduce the intensity of behavioral health symptoms, referring for treatment needs, and coordinating with local providers. LDH/OBH, with input from the Managed Care Organizations (MCOs) and providers revised the CBCS service definition to expand the use of CBCS to individuals discharging from emergency departments who have presented for a reason related to emotional distress. MCOs may now directly refer these individuals to CBCS services for support in the community.

LDH/OBH spent fall 2023 working closely with the LSUHSC Center for Evidence to Practice adapting both policy and training to offer MCR and CBCS to youth in Louisiana. A provider recruitment and selection process resulted in the identification of providers in eight (8) of the 10 LDH regions. Providers are still being sought in Regions 7 and 8 in the northern part of the state.

Mobile Crisis Response and Community Brief Crisis Support will be available to those 20 years of age and under through these providers. Selected providers began training in March, concurrent with applying for licensing and credentialing with the six (6) MCOs and Magellan. Providers are in varying stages of implementation with the first cohort beginning services in July/August 2024.

B. Why is this success significant?
Historically, when a youth has experienced a mental health crisis, the sources for timely response include presenting at an emergency room or engaging law enforcement. Neither of these types of emergency responses are most appropriate to provide actual therapeutic relief to the youth's urgent feelings of distress. Moreover, these historically used responses may be experienced as coercive and involuntary by youth and end up reducing a youth's willingness to seek help in the future. Mobile Crisis Response uses teams of highly trained staff, whose goals are to provide relief of distress, and teams also use trained Family Peers to engage with parents and family members and help the family resolve their experience of crisis as well. Delivery of MCR services to youth is anticipated to reduce unnecessary emergency room visits and involvement with law enforcement, and increase the timely provision of help to youth and families when and where they need it most.

C. Who benefits and how?
Youth and families will benefit from the ability to receive community-based, therapeutic crisis response services in their homes and communities, without needing to travel to the emergency room or contact law enforcement when it is not necessary to do so. Schools will benefit from being able to call mobile crisis teams when a student is in crisis, helping the school to resolve the crisis right on campus, while also being able to ensure that follow-up supports are provided to the family in the family home after

school hours are over. Department of Child and Family Services (DCFS) -involved youth will benefit because when a youth arrives to a foster home for the first time, the DCFS worker or foster parent can call for a visit from the MCR team to help the youth cope with the trauma of being moved to a new home. Further, the trained professional can help the youth remain stable in the new home thus preventing the repeat trauma of being moved multiple times through multiple placements.

D. How was the accomplishment achieved?

LDH/OBH partners with the LSUHSC Center for Evidence to Practice; throughout FY24 OBH worked with LSUHSC to develop and refine the selection process for providers, as well as refining and implementing the comprehensive training program for those providers.

Once providers were selected, starting in the spring of 2024 LDH/OBH has been meeting with providers regularly 1:1 and in group meetings to support their pre-implementation activities.
LDH/OBH has also been promoting collaboration with key partners such as:

- Department of Child and Family Services (DCFS) – Recognizing that out of home placement such as foster care is a crisis for the child involved, OBH is working with DCFS state level employees to develop a protocol for the delivery of MCR to any child who DCFS identifies as experiencing an abrupt change in living situation, such as removal from the family home and placement into a foster home. DCFS also collaborated on a video to include in crisis provider training. Locally, providers are also coordinating with their regional DCFS counterparts as they develop services.
- Office of Juvenile Justice (OJJ) – Much like DCFS, OBH has been communicating with OJJ on a state level and encouraging providers to reach out locally to probation and parole offices.
- Department of Education (LDOE) – LDH/OBH has been working with LDOE to identify opportunities to inform local school districts and educators on the implementation of these crisis services. Recognizing the most impactful collaboration is going to happen at a local level between school districts and providers, providers are also coordinating with school districts. LDH/OBH has developed a Frequently Asked Question flyer for schools.
- Texas Health and Human Services Commission (THHSC) - The expansion of crisis services to youth also included the development of a new Family Peer Training curriculum and recognition. LDH/OBH collaborated with THHSC, who has an existing Family Peer Program to contract with their subject matter experts to support LDH/OBH with developing a Louisiana specific Family Peer Specialist Training Program. As LDH/OBH has operated a Peer Training Program for adults since 2008, to ensure properly trained peers are supporting the youth and their families in crisis, OBH committed to the development of a Family Peer Specialist Training Program to ensure appropriate services to this new target population.

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

II below.)
Yes, expanding the LA-CRS to serve youth is directly linked to the goal of continuing to increase access to behavioral health services.

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

Accomplishment #2: 988 and Suicide Prevention

A. What was achieved?
988 is available statewide 24/7 to Louisiana Residents.
OBH responds to 988 calls 24-hours per day, seven days a week with live coverage. When someone contacts 988, they will be connected to a trained helpline specialists. Louisiana has 100% statewide primary and back up coverage for calls. Both centers are in routing for chats and texts 7pm until 1am 7 days per week. If a contact is not answered by a Louisiana crisis center, the national operator of 988, Vibrant Emotional Health, routes the caller to a national backup center.

OBH contracts with two certified Lifeline centers. VIA LINK is in routing for area codes 504, 985, and 225. Louisiana Association on Compulsive Gambling (LACG) is in routing for area codes 318 and 337. VIA LINK and LACG provide backup coverage for each other.

During FY 24, The Office of Behavioral Health (OBH) accomplished the following:
1. OBH continued to expand the state's capacity to respond to 988 calls statewide 24/7 to Louisiana residents and responded to chats and texts from 7:00pm to 1:00am 7 days a week.
2. OBH was awarded funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) to ramp up our 988 response.
3. OBH was awarded a grant from the National Association of State Mental Health Program Directors (NASMHPD) to improve 988 and 911 interoperability.
4. OBH expanded the 988 public awareness campaign to inform the public about 988.
5. OBH maintained a statewide dashboard.

In FY 24, the centers answered a total of 37,189 calls, texts, and chats. Below are the number of calls, texts and chats answered.

Calls	32,242
Texts	3,513
Chat	1,252

Since the launch of 988 in July 2022, call volume has consistently increased. By June 2024, Louisiana centers answered over 65,000 calls, 5,600 texts, and 2,500 chats since the launch of 988. The average monthly in-state answer rate during FY24 was 88%, which is a significant increase from 64% prior to the launch of 988 in July 2022.

OBH has established and accomplished the following goals in FY24:

a. The Lifeline crisis centers maintained and expanded their workforce to respond to calls, chats, and texts originating in the state.
b. Developed and implemented a comprehensive statewide 988 communication strategy with input from the community.
c. Enhanced statewide data collection and analysis with specific focus on high-risk populations and populations with high numbers of suicide deaths and attempts while safeguarding individual information consistent with applicable Federal and State privacy laws.
d. Evaluated the state's current mobile crisis service options which identified any current integration with 988 Lifeline crisis centers.
e. Evaluated the current 988 and 911 structures and collaborations across the state.
f. Developed a plan to engage and support all Tribes and Tribal Organizations within the state.
g. Enhanced the state's capacity to ensure referral connections post-988 contact, including all referrals for those at imminent danger or referred for mobile crisis support or crisis stabilization services.
h. Engaged with the state's substance use policy team and 988 Lifeline crisis centers to develop appropriate protocols and referral resources for 988 contacts.
i. Implemented data collection and a quality evaluation and improvement process. OBH will continuously assess progress toward meeting the established goals.

OBH was awarded additional capacity building funds.

OBH was awarded funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) to ramp up our 988 response. Priority areas include the following:

- Improving answer rates for calls
- Expanding hours for chat and text response
- Improving follow-up rates
- Improving coordination with 911
- Improving collaboration with state and federally recognized tribes

OBH launched a project to expand 988 and 911 Interoperability

OBH and the crisis centers developed a plan to improve 988 and 911 interoperability. It is critical that both systems work together to save lives. Through the Transformation Transfer Initiative awarded by NASMHPD OBH began to establish a process to improve 911 and 988 interoperability. OBH collaborated with a national expert to develop a training and facilitated discussion between the crisis centers and the 911 administrators, police, sheriffs, and local decision makers on the parish level.

This effort is a significant step forward to bring both systems together to share information and to discuss policies, technology, procedures, training needs, and the staffing needs of the Public Safety Answering Points (PSAPs) and the 988 centers. The long-term goal is to establish an MOU or agreement between the PSAPs and the crisis centers to work together. The MOU may include a process for warm transfers from the

PSAPs to 988.

OBH expanded the 988 public awareness campaign to inform the public about 988.

In collaboration with both crisis centers, community stakeholders, and a public awareness vendor, OBH developed a comprehensive plan to implement a local 988 campaign using a wide range of strategies including billboards, television, radio, social media and geo-targeting. The research based campaign reaches Louisiana residents throughout the state with a focus on outreach efforts to reach high-risk groups including youth, rural residents, veterans, and LGBTQ+.

OBH and its partners provide 988 presentations, and participate in local health and wellness events. OBH is conducting outreach to students who attend a HBCU. For example, OBH implemented a targeted outreach effort during the last Bayou Classic. OBH and its partners deployed several different strategies before, during and after the rival football game. This successful effort was done in collaboration with Southern University and Grambling University. This outreach event gained national attention.

OBH launched a new 988 micro-site with key information for the public to understand 988. The site includes a materials generator to allow our partners to created and co-brand 988 outreach material. The site is www.Louisiana988.org.

The awareness campaign expands knowledge of 988, reduces stigma, and encourages residents to call, chat or text 988 for mental health and substance use support. From January to March 2024, the outreach efforts resulted in over 15 million impressions through YouTube, Meta, radio streaming, billboard, cable/streaming television, website, podcasts, and digital ads.

OBH maintains a statewide dashboard.

In May 2023, LDH launched an online 988 Dashboard providing transparency on key metrics of crisis call data from Louisiana's two 988 crisis centers. The dashboard, which is updated monthly, contains metrics on accessibility, referral source, reason for the call, and outcomes. The dashboard is also a resource for the Local Governing Entities (LGEs), behavioral health and crisis providers to access parish-level data regarding the location of calls. The dashboard is important for providers to track utilization of 988 in their areas and can also support marketing and communication efforts. The 988 Dashboard can be reached at www.ldh.la.gov/988.

B. Why is this success significant?

988 is the first step to make a fundamental shift in how people in crisis are engaged and connected to services in our communities. 988 is an important entry point to a broader Crisis Care Continuum Response System that is being built to connect callers to community-based providers who can deliver a full range of crisis care services (such as mobile crisis and crisis stabilization centers). The transformation of this system means that more individuals will be served by the least restrictive intervention.

OBH continues to collaborate with the local crisis centers to build a sustainable infrastructure to answer Louisiana based calls to intervene as early as possible to divert from higher levels of care when possible and provide the most appropriate level of response offering a more person-centered approach. The Lifeline is the nation's public safety net for all American residents in emotional distress or suicidal crisis. Specifically, Louisianans will benefit by being served by their local crisis centers.

There are many reasons why people connect with the 988 Lifeline. Some examples in addition to thoughts of suicide including: feeling overwhelmed with anxiety, sexual orientation worries, drinking too much, drug use, feeling depressed, mental and physical illness, loneliness, trauma, relationships, and economic worries.

The additional funding from SAMHSA and NASMHPD, supports OBH and the crisis centers to continue building upon the work that was accomplished since the launch of 988. The 988 funding supports the expansion of the crisis center workforce.

C. Who benefits and how?
Lifeline callers benefit from this free, confidential service that allows them to connect with a trained crisis counselor that will collaborate with them on ways to feel better and connect them to local resources. Specifically, it allows more Louisiana callers to reach a locally based crisis center that is familiar with the local culture, stressors specific to the geographical location and familiar with local resources to best serve the caller.

The 988 Lifeline was established to improve both accessibility of crisis services and to meet the nation's growing suicide and mental health-related crisis care needs. The 988 Lifeline provides easier access to mental health crisis care through a 200+ network of crisis call, text, and chat centers, separate from the public safety purposes of 911, where the focus is on dispatching emergency medical services, fire, and police, as needed.

A 988 Crisis line that is effectively resourced and promoted will be able to:

- Connect a person in a mental health crisis to a trained specialist who can address their immediate needs and help connect them to ongoing care.
- Reduce healthcare spending with more cost-effective early intervention.
- Reduce use of law enforcement, public health, and other safety resources.
- Meet the growing need for crisis intervention at scale.
- Help end stigma toward those seeking or accessing mental healthcare.

D. How was the accomplishment achieved?
OBH developed a 988 Implementation Plan in collaboration with a multi-stakeholder coalition which represented a wide range of stakeholders including Lifeline contact center staff, providers, advocates, peers, and representatives from the state 911 administrators.

OBH implemented the plan by contracting with two Louisiana based certified lifeline centers to respond to calls, chats, and texts. OBH increased funding for both centers to

expand their capacity to respond to calls, chats and texts. OBH and the crisis centers meet weekly to discuss program and system updates, to share weekly contact data, staffing updates, and training updates. This close collaboration allows OBH and the crisis centers to share information and to work through challenges. OBH meets with the SAMHSA grant project officer and the Vibrant center engagement staff at least monthly to ensure effective and timely communication with our national partners.

OBH developed and implemented a statewide 988 data hub to collect key metrics from both centers including the number of calls, chats, and texts answered weekly. The 988 hub will be expanded to collect demographic information, crisis center staffing information, outreach efforts, and other key implementation data. The hub will allow OBH to effectively track and trend data.

OBH contracted with a research based marketing firm, Marketing for Change, to develop and implement a local 988 awareness campaign. “Help and Hope are Here” has been used to increase awareness with a Louisiana logo to reach residents.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Access to 988 through calls, chats, and texts allows someone in a crisis, big or small, to reach out to a trained helpline specialist. Specialists assess each individual for suicide risk, provide support, and referrals to community resources. 988 is an intervention. Since the launch nationally, nearly 10 million individuals contacted 988 for help, including 71,000 contacts routed to Louisiana. Crisis centers in Louisiana are trained to do warm transfers to mobile crisis or implement an active rescue for individuals at high risk of self-harm or harm to others, approximately 2% of contacts. Crisis centers can resolve approximately 80-90% of crisis contacts without the need of escalating the call to a higher level of response such as an active rescue or dispatch of mobile crisis.

Numerous studies have shown that most Lifeline callers are significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful after speaking to a Lifeline crisis counselor. People in crisis can easily use hotlines to access help when other mental health, substance use, and social services have eligibility restrictions, are unavailable in rural areas, are inaccessible during late-night hours, or no longer operate because of budget cuts. The new 3-digit dialing code to reach the Lifeline provides an easy to remember number, which makes for easier access to life-saving resources for individuals in crisis. Increasing the number of calls answered in state by local crisis centers, helps to connect individuals in crisis to the most appropriate resources and provide a more person-centered, community based response, which can defer from higher levels of response such as emergency departments and a criminal justice response.

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

Accomplishment #3: LOUISIANA STATEWIDE OPIOID RESPONSE 3.0 & OPIOID PREVENTION EFFORTS

A. What was achieved?

Treatment Services

Through the Louisiana State Opioid Response (LaSOR) grant, the "Hub and Spoke" model approach is being used to provide opioid use disorder (OUD) treatment. A "Hub and Spoke" network is a multi-faceted, collaborative mechanism with the purpose of enhancing and expanding capacity of OUD treatment providers to provide a full array of comprehensive services, including: screening, assessment, orientation, urine drug screens, methadone management and other forms of Medications for Opioid Use Disorder (MOUD), counseling (individual, group, and/or family), case coordination, recovery support services, etc. Opioid Treatment Programs (OTPs) serve as the Hubs and Office-Based Treatment Providers (OBOTs) serve as Spokes.

As a Hub, and a specialty treatment center, Louisiana's eleven (11) OTPs are responsible for coordinating the care of individuals with complex substance use disorders and co-occurring disorders. OTPs provide comprehensive medical and psychological evaluation and screening, group and individual counseling, care coordination, and recovery support services to persons with high/severe levels of OUD. Each OTP has the capacity to provide all FDA approved medications for opioid use disorder, including methadone, and are tasked with referring clients to the Spokes once they are stabilized or have mild to moderate levels of OUD severity.

OBOTs, which serve as Spokes, are physicians that offer MOUD, with the exception of methadone, to those individuals with less severe OUD. OBOTs can be Primary Care Physicians, outpatient substance abuse treatment providers, Federally Qualified Health Centers (FQHC), Local Governing Entities (LGE), nurse practitioners, and/or independent psychiatrists. As Spokes, OBOTs offer the ability to expand capacity within each area of the state, with a focus on rural areas where treatment is more difficult to access. Presently, there are 36 spokes with executed contracts statewide.

Nine (9) spoke care teams (SCTs) operate across the state to support Spoke providers and serve as liaisons with the Hubs. Each SCT is comprised of a registered nurse (RN) and a licensed mental health professional (LMHP). SCTs provide assistance that includes screening, brief intervention, and referral to treatment (SBIRT), assessments, care coordination, recovery support services, and data collection.

In addition to the Hub and Spoke model, the LaSOR program partnered with the Department of Public Safety and Corrections (DPSC) to provide individuals in both state and local correctional facilities with opioid use and/or stimulant use disorder treatment that is individualized and includes MOUD via oral and/or injectable naltrexone. In addition to MOUD, evidence-based practices are used during the pre-release phase (beginning typically nine months prior to release), which includes intensive cognitive behavioral therapies. Peer Support Specialists (PSS) are also an integral part of treatment and are utilized to deliver group meetings and individual

sessions. All program participants receive naloxone kits and other resources needed upon release.

During the 2023-2024 state fiscal year, 2,239 individuals received treatment services through these initiatives.

Prevention of Substance Use Disorders – Evidence-Based/Evidence-Informed Programs

The Office of Behavioral Health (OBH) oversees the implementation of evidence-based/evidence-informed programs to include Life Skills Training and Generation Rx.

Life Skills Training is an evidenced-based, school-based curriculum developed for elementary, middle and high school students, the program focuses on resiliency and social skills to reduce risky behaviors, such as drug use and violence. The Life Skills Training model aligns with the Risk and Protective Factors theoretical framework, which posits that developmentally appropriate "pro-social" skills and behaviors can act as a buffer against pro-drug influences.

Generation Rx is a research-validated substance abuse prevention program proven to educate individuals about the risks of using and abusing prescription medication. The focus was on the collegiate and older adult populations. This comprehensive program provides individuals of all ages with the information necessary to reduce the risks of prescription medication abuse.

During the 2023-2024 state fiscal year, a total of 22,728 individuals participated in these evidence-based/evidence-informed prevention programs. More specifically, 20,338 individuals participated in Life Skills and 2,390 individuals participated in Generation RX.

Harm Reduction Distribution Hub

The Office of Behavioral Health (OBH), in partnership with the Office of Public Health (OPH), developed and utilizes a centralized harm reduction distribution "hub". Employing technology through a published website, organizations across the state can request to become distribution sites ("spokes") to disseminate harm reduction products throughout their regions. Items such naloxone, fentanyl testing strips, wound care kits, and proper drug disposal products are presently offered with vending machines, naloxone boxes, safe storage items, and additional products planned to be available in the future. As the Hub, OPH is responsible for outreach to the community partners to create local distribution sites statewide. All requesting organizations are required to complete training as part of the agreement to distribute naloxone on behalf of the project. This Hub has been instrumental in maximizing naloxone distribution while the spokes distribute needed harm reduction items to those individuals with the highest need.

During the reporting period, there were 71 registered distribution sites across the state, which distributed the following:

- 72,751 Naloxone kits
- 62,622 fentanyl test strips
- 3,150 wound care kits
- 2,255 sharps containers

Also during the reporting period, 13,975 overdose reversals were reported to the distribution sites, 5,019 of which were the result of grant-funded naloxone.

B. Why is this success significant?
Research shows that Medications for Opioid Use Disorder (MOU) coupled with counseling is the most effective treatment for those with Opioid Use Disorder. However, due to stigma and costs, these services are not readily available, especially to those without insurance. The treatment provided through the LaSOR grant is ensuring access to OUD treatment is available to all individuals with OUD, regardless of insurance status, throughout the state. This support increases the likelihood of individuals entering long-term recovery, gaining and/or maintaining employment, reducing criminal behavior, and preventing overdose deaths that have contributed to the opioid epidemic.

The significance of the success of the Harm Reduction Hub is evident in the number of overdose reversals reported. Close to 14,000 lives were saved because of using naloxone and 5,000 can be directly attributed to the naloxone provided through the hub.

C. Who benefits and how?
Individuals with OUD benefit from increased access to evidence-based OUD treatment and life-saving naloxone.

D. How was the accomplishment achieved?
These accomplishments were achieved through State Opioid Response (SOR) funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as collaborative efforts with LDH/OBH leadership, partners, stakeholders and contractors.

E. Does this accomplishment contribute to the success of your strategic plan?
Yes, the number of individuals treated with MOUD directly contributes to the objective of increasing individuals enrolled in Medication Assisted Treatment (MAT).

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

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

To answer this question, you must determine whether your anticipated

outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

  The Office of Behavioral Health (OBH) is on target. OBH is committed to the most effective use of the state's scarce behavioral health resources to adequately provide for the overall safety and health of the public. OBH will continue to develop goals and objectives that prioritize the creation of innovative programs to promote and improve the behavioral health of the citizens of the state. In addition, OBH is continuously seeking to achieve increased access to services for underserved populations, while increasing the quality of services for better outcomes at a cost-effective level. This is being accomplished by initiating and implementing services and programs, including interagency collaboration, and promoting evidence-based best practices. Overall, OBH's strategies appear to be effective and are rooted in evidence-based techniques and practices.

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

  Continually increasing access to Behavioral Health services through substance use disorder system enhancements

  As collaboration with LA-CRS partners, barriers to full implementation are being recognized and strategies are being implemented to address any barriers. Progress towards expanding the network has continued into FY 2025. OBH is engaged in a media and public outreach campaigns to advertise crisis services including the nationally recognized 988 hotline, as well as expansion of treatment options to engage the public around these services. Additionally, OBH is collaborating with Louisiana State University Health Sciences Center (LSUHSC) to support the MCR and CBCS services for youth. Regarding SUD enhancements there was an increase in the number of providers serving as an office based opioid treatment (OBOTs) locations through the OBH specific state opioid response (SOR) initiative. The current number of OBOTs with executed contracts is 36.

  1. To what do you attribute this success? For example:
     - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
     - Is progress directly related to specific department actions? (For example:

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

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

The Office of Behavioral Health (OBH) will continue to lead efforts to increase access to behavioral health services by promoting early identification of behavioral health concerns. Examples of some strategies that OBH is still employing are efforts in supporting behavioral health providers by collaborating with local and state partners to develop a framework regarding Community Behavioral Health Clinics (CCBHCs). Also, efforts are still ongoing regarding primary care physicians through behavioral health consultation, as well as increasing access to high-quality evidence-based behavioral therapies for young children such as programming specific to assist women with children or those currently expecting. Additional strategies employed to address the increased volume on the behavioral health system with Medicaid Expansion and long-term effects of the COVID-19 pandemic have been the integration of Peer Support throughout the system of care. The use of trained, credentialed peers is a critical component to a recovery-oriented system of care and results in improvements in client engagement, treatment outcomes, and recovery. As an enhancement to traditional treatment services, peer support services allow for more effective and targeted interventions resulting in improved care and an increased capacity of the system to serve a broader array of individuals. To increase access to effective behavioral health supports and services, OBH will work with Medicaid, advocates, providers, and Healthy Louisiana managed care partners to implement strategies to retain and increase the behavioral health workforce. Workforce development efforts will include training and support for providers of evidence-based therapies addressing issues emerging in early childhood, trauma exposure, and other psychiatric and addictive service needs. OBH will lead efforts to provide training and support for providers of peer recovery supports, including mentoring and coaching opportunities. Expanding the workforce of providers of behavioral healthcare now includes utilization of provisionally licensed provider types such as provisionally licensed social workers, professional counselors, and marriage and family therapists. Finally, all of the aforementioned will assist the strengthening of the Louisiana Crisis Response System (LA-CRS) that will ensure that the behavioral health system of care is evolving and meeting the needs of the citizens of Louisiana.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress will continue; OBH's progress is ongoing and expected to continuously increase.

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

Progress is ongoing. There is a national shortage of behavioral health professionals and a slow growth of providers entering the behavioral health workforce. OBH is perpetually researching and working on additional measures and methods to combat these problem areas. Therefore, OBH attempted to highlight this problem by utilizing various methods, which included introducing students to the endless education and career opportunities associated with behavioral health. As collaboration with LA-CRS partners, barriers to full implementation are being recognized and strategies developed to address these barriers. The two main barriers identified are limited workforce and low utilization of services. Progress towards expanding the network has continued into FY2025. The LA-CRS OBH team meets regularly with crisis providers and MCO partners to both discuss workforce development and increasing awareness of services through local coalition building. Therefore, OBH is diligently working to increase the number of interventions and prevention mechanisms that are in place to ease the occurrences of crisis.

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

The Office of Behavioral Health (OBH) is not significantly behind on any individual component related to the goals and objectives highlighted in the five year plan. However, the slow growth of providers does impact the time it takes to employ providers for various services. As indicated earlier, multiple initiatives are being researched to provide innovative methods to increase in the prevalence of behavioral health professionals.

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

No.

- **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?

Initiatives to address areas of progress are ongoing as part implementation and allow flexibility to address barriers is incorporated in the implementation and ongoing improvement of initiatives.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly**

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

OBH continuously reviews the strategic plan, and meets regularly to discuss the implementation progress and any remaining needs around the specific 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.

Issue #1: The Contracting Process

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   The complex and time-consuming nature of, both within LDH and in conjunction with the Division of Administration's protocols, continues to hinder the timely and efficient implementation of services and initiatives. Although the Office of Behavioral Health (OBH) acknowledges the need for thorough review, communication, and approval, these delays highlight inefficiencies and issues with operational coordination and communication throughout the contracting process. The involvement of multiple parties in the development, submission, review, and approval of State contracts—now managed through the Office of Management and Finance's (OMF) Contracts and Procurement unit, with the additional requirement for routing to Legal and Office of State Procurement (OSP) to occur through OMF—has not led to any noticeable improvements in efficiency. OBH is concerned about the stagnation in modernizing and streamlining the contracting process. OBH could also use additional internal resources in this area given the increased number of grants which in turn require an increased number of agreements with other parties.

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

The obstacles that OBH encounters in order to secure contracts in a timely manner impacts the ability of OBH to achieve our mission and goals. The contract process is already preceded by the need for receipt of federal grant award notifications, the attainment of Legislative approval for Budget Authority for the receipt of federal funds which may require the submission of a BA-7 that may require approved by the Joint Legislative Committee on the Budget. Formal Agreements are required between the State (OBH) to simply flow out funds to our regional Local Governing Entities, but in order to contract directly with non-government providers, this process is even more tedious. Therefore, the delays in the State's ability to secure Interagency Transfers (IATs) and contracts in a timely manner, inhibits our ability to promptly initiate the goals and objectives we pursue with the grant funding and Legislatively approved State funding afforded to our Office.

3. What organizational unit in the department is experiencing the problem or issue?
   All units within OBH have been affected by the inefficiencies caused by these obstacles. Administration must prioritize the submission of contracts to OS/OMF, Legal, Civil Service, and the Division of Administration to minimize the impact on individuals requiring behavioral health services. Although direct care often takes precedence, daily requests for prioritization of contracts, amendments, Request for Information (RFIs), Request for Application (RFAs), Request for Proposals (RFPs), and Cooperative Endeavor Agreements (CEAs) are based on current needs and political considerations. This situation complicates the implementation of the goals and objectives outlined in the grants and initiatives supported by OBH.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   This issue impacts not only our staff and all of the Louisiana Department of Health staff, but also the recipients of our efforts, the providers of behavioral health services, and our contractors and managed care entities working to provide the essential behavioral healthcare services needed by the residents of Louisiana.

5. How long has the problem or issue existed?
   This impact has been ongoing at a minimum since contract processing was centralized, therefore more than ten years, if not prior. However, has since been exacerbated with the influx of federals funds and grants requiring more contracting to implement initiatives.

6. What are the causes of the problem or issue? How do you know?
   Inefficient processes compounded by voluminous, outdated and user-unfriendly forms, and overly cumbersome and duplicative routing procedures contribute to the problem. Additionally, there is no comprehensive, transparent tracking system or prioritization methodology across the Department.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   Consequences include staff being unable to complete the goals and objectives of

initiatives, grants, programs, or strategic plan tasks, and OBH's inability to effectively advance its initiatives and goals.

B. Corrective Actions

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

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

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
Internally, OBH has been working toward streamlining internal procedures. We have developed new training to help ensure that contract monitors have the tools needed to submit accurate and comprehensive contract packages. We have also developed a tracking system through Monday.com in order to more effectively and transparently allow for the tracking of our contract documents, internally. OBH continues to expand the capacity and functionality of Monday.com, as well as expanding and revising trainings in order to better meet the needs of staff.

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

4. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
        Trainings occurred in FY24, and will continue into FY25. We maintain a single entry email for all contract related documents and we have fully implemented the use of monday.com to track all contracts, amendments, CEAs and RFI/A/Ps. We reorganized our shared drive in an effort to increase the ease and completeness of the use and availability of contract documents and training guides necessary for the submission of contracts, amendments, RFIs, RFAs, RFPs and CEAs.
      - How much progress has been made and how much additional progress is needed?
        The single entry email and OBH tracking system are both in full implementation. In person training opportunities continue to be consistently offered on not only contract development, but also invoicing related to these contracts. If FY24, we also implemented just-in-time training and Q&A opportunities related to contracting, invoicing and other financial matters via weekly “office hours” sessions which occur every Friday, and are open to all staff. The

newly revamped shared drive resources are continuously updated in order to account for ongoing modifications to forms and processes.

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

5. Do corrective actions carry a cost?

☒ No. If not, please explain.

We're using existing resources and licenses at this point, in order to achieve our objectives.

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

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

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

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

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

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud,

waste and abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

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

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

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

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

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

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

made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

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

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

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

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

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

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

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

Agency & Program:
Telephone:
E-mail:

There are three (3) reports listed below for the Office of Behavioral Health:

1. Title of Report or Program Evaluation:
   SAMHSA Block Grant Annual Reporting (SUPTRS and CMHS)

2. Date completed: In progress
   Louisiana's CMHS and SUPTRS Behavioral Grant reports must be submitted to SAMHSA no later than December 1st of each year. Some components of reporting are completed quarterly with an annual review prior December 1. If OBH misses the statutory date for submitting the reports, it will not receive any federal Block Grant funds for that federal fiscal year.

3. Subject/purpose and reason for initiation of the analysis or evaluation:
   Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. 300x-52(a)) requires SAMHSA to determine the extent to which States and Jurisdictions have implemented the State plan for the preceding fiscal year. States and Jurisdictions are required to prepare annual reporting for submission that consists of multiple components which include data submissions, performance indicators and fiscal tables. The annual reporting needs to include the purposes for which the CMHS and SUPTRS funds were expended, recipients of grant funds, authorized activities funded, and services purchased with such funds. CMHS and SUPTRS reports are not combined.

4. Methodology used for analysis or evaluation:
   OBH Quality staff work in collaboration with OBH analytics, program and fiscal staff and LGEs in the development of the annual reports. Some data is submitted quarterly; annual reporting submissions require several months of preparation and typically begin in 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' Electronic Health Record (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. Additionally, it is posted on the LBHAC webpage.

10. Contact Person:
    Name: Catherine Peay
    Title: Block Grant State Planner
    Agency & Program: LA Department of Health, Office of Behavioral Health
    Telephone: 225.342.7945
    Email: Catherine.peay@la.gov

1. Title of Report or Program Evaluation:
   Prevention Management Information System Reporting on Prevention Services (Quarterly and Annual)

2. Date completed:
   July 1, 2023 – June 30, 2024. Data for this report was pulled on July 19, 2024.

3. Subject / purpose and reason for initiation of the analysis or evaluation:
   The Office of Behavioral Health (OBH) is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the Substance Abuse, Prevention and Treatment (SAPT) grant, which is the primary funding source for prevention services. It requires 20% of the grant be set aside for primary prevention services. An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report is a continuing process to measure the number of services we provide and the populations that are served.

4. Methodology used for analysis or evaluation:
   The data in this report is from the Prevention Management Information System (PMIS), the primary reporting system for the SAPT for prevention services. PMIS reports are generated quarterly and captures demographic information such as age, gender, race and ethnicity. Data and information outlined in this report are also used to meet the requirements for the Prevention National Outcome Measures (NOMS).

5. Cost (allocation of in-house resources or purchase price):
   There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from PMIS to generate this document. Data is entered into PMIS by the Local Governing Entity (LGE) prevention staff, their contract providers statewide and OBH staff.

6. Major Findings and Conclusions:
   During FY 2024, Prevention Services provided evidence-based services to 86,261 enrollees. In addition, during FY 2024, block grant funded one-time services were provided to the general population and reached 17.7 million people. This number reflects the number of individuals that are impacted by PSAs, billboards, and other media campaigns. This number included the combined services provided by Prevention Staff and Prevention Contract Providers.

7. Major Recommendations:
   The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.

8. Action taken in response to the report or evaluation:
   No actions other than the recommended (above) were pertinent.

9. Availability (hard copy, electronic file, website):
   The report is distributed via e-mail and is available by hard copy upon request.

10. Contact Person:
    Name: Dr. Leslie Brougham Freeman
    Title: Director of Prevention, Wellness and Workplace Development
    Agency & Program: LA Department of Health, Office of Behavioral Health
    Telephone: 225.342.5705
    Email: Leslie.BroughamFreeman@la.gov

1. Title of Report or Program Evaluation
   Synar Report: Youth Access to Tobacco in Louisiana

2. Date Completed:
   December 27, 2023

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 $107,800 ($100.00 per compliance check x 1078 checks). The total cost to prepare and complete the Annual Synar Report was $97,331.00.

6. Major Findings and Conclusions:
   The objective of this study was to estimate the non-compliance rate for tobacco sales in Louisiana among youth under age 21. Annual targets were established to decrease the state's non-compliance rate to 20% by FFY 2002. However, Louisiana achieved 20.3% non-compliance in FFY 1999, only two years after the start of the Louisiana Synar Initiative, and three years ahead of the scheduled target date. The current rate of tobacco sales to minors in FFY 2024 is 8.6%.

7. Major Recommendations:
   OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2024 report and will adhere to any future recommendations, as warranted.

8. Action taken in response to the report or evaluation:
   An annual report is generated by SAMHSA including a Table listing the Synar Retailer Violations (RVRs). According to the most recent FFY 2018 on file, Louisiana was below the national average in regards to compliance. The SAMHSA report can be viewed at https://www.samhsa.gov/sites/default/files/synar_program_rvr_table_1997-2018_dec_11_2018.pdf. Our goal is to continue implementing current strategies since they've proven to be successful.

9. Availability (hard copy, electronic file, website):
   The FFY 2024 Annual Synar Report is available by hardcopy, and may be accessed online at

http://ldh.la.gov/index.cfm/newsroom/detail/1390

10. Contact Person:
    Name: Dr. Leslie Brougham Freeman
    Title: Director of Prevention, Wellness and Workplace Development
    Agency & Program: LA Department of Health, Office of Behavioral Health
    Telephone: 225.342.5705
    Email: Leslie.BroughamFreeman@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department: Louisiana Department of Health (LDH)
09-340 Office for Citizens with Developmental Disabilities

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

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: Redesign of Day and Employment Services to Promote Integrated Community Settings

A. What was achieved?

The Office for Citizens with Developmental Disabilities (OCDD) finalized the redesign and alignment of the day and employment service array across the New Opportunities Waiver, Residential Options Waiver, and the Supports Waiver on April 1, 2024. The redesign included the addition of new community services for day habilitation and prevocational services as well as a virtual delivery component. OCDD also unbundled

the Individual Supported Employment service from one service into five separate services. OCDD gave rate increases and alignments for existing services, onsite day habilitation, onsite prevocational; group employment and the new community services also received a rate to match the services.

Day Habilitation now includes a new separate community component entitled **Community Life Engagement (CLE)**. This service is specifically designed to create a more individualized experience in the community alongside everyone else and not just people with disabilities. In this service, individuals and others who have similar interests can participate in activities they like in the community. Instead of the typical onsite day habilitation ratio of 1:5-8, CLE allows for a ratio of 1:2-4 or a 1:1. In this service, individuals are supported in the community in activities and events of their choosing, which also may include opportunities for volunteering.

Prevocational services now include a new separate community component entitled **Community Career Planning (CCP).** This service is specifically designed to give individuals the ability to participate in job and career readiness activities in the community in practical situations such as internships, mentoring programs, and volunteering experiences. These programs help them gain valuable information that furthers their knowledge and skills about working in typical jobs in the community. The end goal of this service is to determine the job area or position for which the individual is interested in obtaining a job in the community. Instead of the typical onsite prevocational ratio of 1:5-8, this service is provided in a 1:2-4 or a 1:1 ratio.

The **Individual Supported Employment service** has been unbundled into the following five separate services: Work-Based Assessment, Job Development and Job Placement, Initial Job Support, Extended Job Support, and Ongoing Follow-Along Support. Individual Supported Employment services help support an individual in determining their job interests, finding a job, learning the job tasks, and maintaining employment. These services are provided to those individuals who want to find individual employment in the community in typical businesses and industries.

B. Why is this success significant?

This redesign enriches the lives of individuals who are supported in these services. OCDD developed these services to help individuals become more integrated into their communities, providing opportunities to participate in everyday activities and support for working in typical community businesses. In the past, individuals only received support at a facility that served those with intellectual and developmental disabilities and experienced very little, if any, community activities. When these individuals did things in the community, they were in large groups of eight or more and everyone did the same activity; the activities were typically designed just for people with disabilities. If they worked, it was usually in sheltered employment at a provider agency's building and they earned a subminimum wage with no growth opportunities. Even though OCDD had offered individual supported employment services, there was not a complete service array that could support someone in individual jobs in the community. With this successful redesign, individuals have new opportunities for community involvement and

experiences. They will also have the support they need to work, which will allow them to purchase items they would like to buy, but previously were unable to due to limited funds.

C. Who benefits and how?

Individuals in the New Opportunities Waiver, Residential Options Waiver, and the Supports Waiver who choose to participate in the day and employment services will benefit.

D. How was the accomplishment achieved?

A workgroup of providers from across the state met for several years to discuss the Individual Supported Employment services and to ensure they were going to allow the individual to receive the necessary support to obtain and maintain employment in the community. OCDD has been working with Louisiana Rehabilitation Services (LRS) to align changes in its waiver service delivery with LRS services, ensuring a seamless support system for individuals entering the workforce. OCDD is a member of the State Employment Leadership Network, which provides technical assistance and guidance on employment and community engagement; they provided guidance as OCDD developed the revised service definitions and implemented the services.

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

Yes, OCDD's strategic plan specifically states several goals including:

- 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; and
- To increase the capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings.

This accomplishment, and the array of services OCDD developed, helps ensure that people within the system have increased opportunities to live, work, and learn in the community. It also allows people greater choice in their activities, which in turn has a positive effect on their quality of life.

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

This accomplishment aligns with nationwide best practices of Employment First as well as the Home- and Community-Based Services (HCBS) Settings Rule, which was issued by Centers for Medicaid and Medicare (CMS) in 2014. Individuals now have a choice of how they spend their day and where day and employment services are delivered.

Accomplishment #2: Training Modules for Direct Support Workers

A. What was achieved?

The OCDD Programmatic Unit (PU) implemented core training modules for direct support workers. The OCDD PU successfully launched an annual schedule of trainings with a formal registration platform and tracking. In fiscal year (FY) 2023-2024, the OCDD PU completed training with hundreds of provider staff across all provider types. Here are the specific numbers for each module:

- Preparedness = 821 provider staff
- Person-Centered Thinking = 340 provider staff
- Emotional Wellness Supports = 192 provider staff
- Recognizing Signs and Symptoms of Illness = 189 provider staff
- Supporting Individuals Medical Needs = 182 provider staff
- Supporting Staff with Medication Administration = 45 provider nurses
- Supporting Staff with Delegating Non-Complex Medical Tasks = 54 provider nurses

All participating staff and nurses successfully completed training and passed the competency check for each module. Providers report satisfaction with the module offerings and ease of access. Annual offerings will continue.

B. Why is this success significant?

Providers have consistently requested support in the access to and completion of annual required training to meet the Health Standards requirements and to improve quality of services. OCDD, Health Standards, and providers have all acknowledged that finding available quality training content has been a challenge. This effort allows for statewide access and tracking because modules are available virtually.

C. Who benefits and how?

This effort benefits several groups of people. First, OCDD benefits from the completion of annual trainings in areas of importance to the services and programs. Next, providers and their staff benefit by having easier access to high-quality content. Finally, individuals with intellectual/developmental disabilities (I/DD) and their families benefit because their staff have access to improved training content.

D. How was the accomplishment achieved?

Last fiscal year, OCDD's PU collaborated with OCDD's Resource Center to develop the content. The PU then worked with Health Standards and waiver staff to review and approve content. Next, the PU developed a registration format and offered trainings via a calendar of events. The platform tracks registration, attendance, and online completion of the competency checks.

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

Yes. OCDD's strategic plan has goals focused on assuring access to person-centered and effective supports. All modules are linked to knowledge and skills to ensure individual needs are met.

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 developed modules and competency checks consistent with federal regulatory requirements and best practice standards for competency-based training. OCDD also incorporated adult learning principles into modules with use of visual aids, role-playing, and multiple modes of learning.

Accomplishment #3: Stand-up of Self-Direction Advisory Group

A. What was achieved?

OCDD created a self-direction advisory group and a quarterly self-direction meeting to hear directly from those in the self-direction program. The self-direction program allows participants and family members to act as their own employer, rather than use a traditional employer agency. This offers greater flexibility for the family to hire the person of their choice, and to pay them a higher rate. However, it also requires the participant or family to keep additional documentation and formally supervise (including hiring and firing) staff. The self-direction advisory group and the self-direction quarterly meeting give OCDD direct access to those participating in the program.

B. Why is this success significant?

This success will help OCDD evaluate the documents and outreach that we do with participants in the self-direction program. OCDD can leverage the self-direction groups to workshop documents while also learning about issues within the program before they become larger issues. Additionally, there have been several federal rule changes over the last six months. One of these rule changes, the Access Rule, will create widespread changes in how OCDD delivers home and community-based services. Accessibility and transparency are two hallmarks of that rule. This achievement helps OCDD move towards greater accessibility by allowing OCDD staff to hear directly from the participants about the documents and if they are accessible. This achievement also helps further the goal of transparency by giving participants a direct line to OCDD to talk about issues within the program.

C. Who benefits and how?

Self-direction participants benefit by giving them direct input into OCDD's documents. This will create clearer instructions on how to participate in the Self-Direction program

and increase accessibility in the program. OCDD, local governing entities (LGEs), and fiscal employer agents (FEAs) benefit because they get to hear about current problems in the self-direction program, and can help mitigate those before they become larger issues. OCDD also benefits by using the lessons learned through the self-direction advisory group and applying them across the service delivery system to make all documents more accessible to participants and families.

D. How was the accomplishment achieved?

OCDD sent out a general call in December 2023 for people in the self-direction who wanted to participate in a self-direction advisory group. The group meets monthly to discuss what topics are most important to those in the self-direction program. OCDD selected a broad cross-section of participants, including those enrolled in the self-direction program, support coordinators, local governing entities, and the fiscal employer agents. After selecting the group participants, OCDD gave the group an opportunity to set their own priorities and determine what the group would be working on. Overwhelmingly, the group voted that the first priority was to update the Self-Direction Handbook and the accompanying forms and attachments. OCDD has met monthly with the self-direction group, working through the handbook to update the information and to make sure the information was easier to understand and more accessible.

Though only the selected workgroup members are able to provide input during the monthly meetings, OCDD made sure that the meetings are available to anyone who wanted to listen. OCDD wanted to ensure that everyone in self-direction had the opportunity to participate in some capacity. OCDD set up quarterly self-direction meetings to include not only the small work-group members, but also anyone who wants to participate. During these quarterly meetings, OCDD and the small work-group share the work they have been doing in the monthly meetings, and get additional feedback from the larger group.

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

Yes, one of OCDD's goals is to afford people access to information about what services and supports are available and how to access that information. This accomplishment ensures that people within the self-direction service have access to information about supports and services in a way that is accessible to them. This accomplishment will also help OCDD create more user-friendly, accessible, and plain-language documents in the self-direction program and across the service delivery 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. CMS considers community partner engagement a best practice. OCDD developed a core community-partner group to give direct input on OCDD's documents for self-direction. OCDD also created a quarterly meeting to offer all self-direction participants

the chance to give their input on the projects the core group will be working on. CMS also considers plain language documents as a best practice; this accomplishment will help OCDD work towards getting accessible plain language documents in the self-direction program and across the service delivery system.

Accomplishment #4: Training for Dental Service Providers

A. What was achieved?

Comprehensive dental services were added as billable services for adults with intellectual/developmental disabilities (I/DD) receiving home and community based waiver services and residing in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) in previous years. OCDD partnered with Louisiana Dental Association, LSU Dental School, and Special Care Advocates in Dentistry (SAID) to offer five regional and three statewide training and continuing education opportunities to dental practitioners. These activities focused on helping dentists to understand how to best support individuals with special needs in their practices. The training was provided by a dentist with expertise in providing services to people with special needs.

B. Why is this success significant?

This success is significant because individuals with I/DD often have difficulty participating in routine dental cleanings and examinations, leading to poor oral hygiene and increased risk for illness. These trainings will help to improve access to comprehensive dental services for this population by having more informed dental practitioners across the state.

C. Who benefits and how?

Individuals with intellectual/developmental disabilities benefit because there is greater access to dental services with providers who are able to effectively provide these services. The overall health system benefits because it helps to reduce the risk of future illness when people have good oral hygiene.

D. How was the accomplishment achieved?

OCDD used Section 9817 American Rescue Plan Act dollars to assist with funding of these training activities. Collaboration with state partners allowed for identification of dentists interested in this subject matter and setting up venues to offer these opportunities.

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

Yes, it contributes to increasing access to services for individuals served through OCDD.

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 has been recognized for being one of the first states to offer comprehensive dental services to adult Medicaid recipients. It is a known best management practice to engage in comprehensive dental services to assist with good oral hygiene practices.

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

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

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

OCDD is making timely progress in its current five-year Strategic Plan, particularly with those initiatives that support the following strategic plan goals:

- To provide a Developmental Disabilities Services System that affords people access to information about what services and supports are available and how to access the services;
- To provide a person-centered system that supports person-centered thinking and planning approaches such that supports identified via needs-based assessments are provided in a manner that focuses on the person's goals and desires and addresses quality of life;
- To increase the capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings;
- To increase the capacity of the Developmental Disabilities Services System to support people with complex behavioral, mental health, and/or medical needs in all service settings;
- To implement an integrated, full-scale data-driven quality enhancement system; and
- To rebalance the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs.

These initiatives also support OCDD's priorities, which relate to system transformation, as well as effective and efficient service delivery. OCDD's effective use of available CARES Act and American Rescue Plan Act funding allowed OCDD's progress on objectives to remain steady despite setbacks posed by the COVID-19 Public Health Emergency. OCDD continues to build on successes in the areas of customer responsiveness, waiver reform, person-centered thinking, early intervention, and

supports for people with complex behavioral needs, and employment. The success of these initiatives in FY 2023-2024, and the continued success in 2024-2025 will help move OCDD toward the goals and objectives outlined in OCDD's Strategic Plan.

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

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

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

Supporting Individuals with Complex Behavioral Health Needs to Live in their Community

The OCDD Resource Center has continued to support individuals with the most complex behavioral needs, and currently acts as a service of last resort. The primary reasons for high-cost institutionalization within the OCDD system are the presentation of behavioral health needs and legal involvement. A performance indicator (#24259) is included in OCDD's Strategic Plan and Operational Plan to monitor the success of this initiative. This year, the Resource Center's behavioral health staff provided consultation or direct services as a last resort to 470-750 individuals each month across the state, including continued operation both in person and virtually of a medical psych clinic for individuals unable to secure a prescriber for psychotropic medications. This support resulted in more than 98% of the individuals maintaining community living. These results represent significant positive outcomes for these individuals, and speak to the success and importance of this OCDD effort.

1. To what do you attribute this success?

    The OCDD Resource Center employs clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral/ medical support needs. The OCDD Resource Center uses a multi-disciplinary approach to providing consultation, training, and services that improves the

ability of caregivers and providers to achieve positive outcomes for persons with complex needs.

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

   Progress is expected to continue. The Resource Center staff implemented triage initiatives and have been able to provide services to a greater number of individuals and provider agencies. In collaboration with the LGEs, Resource Center professionals have implemented crisis/diversion initiatives; these allow professionals to initiate a consultation prior to escalation of a crisis to ensure one's community connection is maintained, or within a timeframe, that increases the likelihood of diversion to the most integrated setting. The Resource Center staff have also implemented formal liaison partnerships with all managed care organizations (MCOs) and the two state-operated psychiatric hospitals to assure collaboration and access to appropriate services.

Enhanced Training for Community Professionals and Providers to Improve Capacity to Support Individuals with Complex Needs

The OCDD Resource Center uses the staff's professional expertise to develop and conduct training and technical assistance activities with community providers and professionals. These activities enhance the ability of these providers and professionals to support individuals with complex medical and behavioral support needs; they are initiated by the office and by provider/professional request. A performance indicator (#24692) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative.

The Resource Center conducted more than 400 training activities in FY 2024 and continued *Operation House Call* activities in both New Orleans and Shreveport locations. A partnership with LSU Medical School and Ochsner Health in Shreveport focuses on training psychiatric residents and psychology interns. Training within university systems continue with Southeastern Louisiana University, Louisiana College and LSU Health Sciences Center as well. With regard to dental needs, OCDD continued formal outreach and coordination with Medicaid health plans and stakeholder groups and served as a member of the dental task force.

Furthermore, OCDD's clinical director and associate clinical director partnered with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and a sister state to develop mini-module recordings for clinicians as part of educational options. The OCDD clinical director and deputy assistance secretary for programs presented at the National Association on Dual Diagnosis. Additionally, the OCDD registered nurse manager and several nurses presented at the state American Association on Intellectual and Developmental Disabilities (AAIDD) conference.

1. To what do you attribute this success?

   OCDD employs clinicians with expertise in supporting and treating individuals

with developmental disabilities and complex behavioral and medical support needs. OCDD and the Office of Behavioral Health (OBH) have developed more formal partnership approaches to address the needs of individuals with co-occurring needs.

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

   Progress is expected to continue. The OCDD Resource Center and clinical staff have expanded trainings by offering virtual alternatives to in-person training. These hybrid approaches help maximize the providers and professionals that the Resource Center can reach and affect. OCDD obtains feedback from customers during each training event, which helps OCDD be more responsive to customers' training needs. Professional continuing education and discipline-specific outreach events will continue, with planning done each fiscal year.

Ongoing Training and Technical Assistance for Case Managers on Person-Centered Tools

OCDD initiated a Value-Based Payment (VBP) project for support coordination agencies based upon previous pilot activities from last fiscal year. Executed through the Money Follows the Person (MFP) My Place Capacity Building program, the VBP project provides structured training and certification for support coordinators and supervisors to develop and implement person-focused support plans. It also focuses on tailoring support to meet the specific needs and preferences of each individual.

Four phases are included: support coordinator certification in person-centered tools, support coordinator certification in person-centered plan development, supervisor certification in person-centered tools, and plan review in house agency capacity to implement as part of new support coordination and supervisor onboarding. The following five agencies are actively participating in this initiative: Blossom Support Coordination, LLC, Quality Support Coordination, INC, Medical Resources & Guidance, Easter Seals, and Cadence of Acadiana. Together, these organizations serve nearly 12,600 participants across the state of Louisiana.

1. To what do you attribute this success?

   OCDD proposed the initiative as part of the expansion of its My Place program. OCDD's MFP, clinical services, and waiver divisions collaborated to implement the initiative and complete needed reviews and certifications for interested support coordination agencies. By encouraging support coordination agencies to invest in staff training, the initiative ensures the effective use of tools for developing personalized support plans. Financial incentives are provided to build agencies' capacity for training and certifying coordinators and supervisors, ultimately improving the quality of support provided.

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

   The initiative is currently progressing through its defined phases and meeting specific milestones and targets as outlined in the project work plan. It is on track to meet its goals, with ongoing efforts to address challenges and support agencies in achieving certification milestones. The continued commitment to training and technical assistance will ensure that support coordinators and supervisors are well-equipped to develop and implement person-centered support plans effectively.

Management of State-Wide Incident Management System

1. To what do you attribute this success?

   In September 2023, OCDD identified 919 abandoned critical incident reports (CIRS) within the System Incident Management System (SIMS). To address this critical backlog, the Quality Enhancement (QE) section took the lead in organizing a dedicated SIMS group. This team was tasked with working through the abandoned pending incidents to ensure participant health and safety and to effectively close each incident. Today, there are zero abandoned CIRs. The QE team's dedication and commitment to improving health outcomes for the participants that we serve is what motivated us to be successful with this initiative.

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

   The QE section has also worked diligently with the incident management vendor, WellSky, to address the manual workarounds that SIMS users must use to ensure critical incidents pass through their intended workflow. However, progress has been slow because WellSky has provided an off-the-shelf system, limiting opportunities for necessary customizations and edits. WellSky has also shared that they have been short-staffed and there is a noticeable turnover in their staff; this has negatively affected progress for OCDD's management of critical incidents. Eliminating the backlog was indeed a significant gain, but moving forward, our team is dedicated to daily monitoring of the SIMS database to continue addressing abandoned critical incidents as they are entered into SIMS.

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

  1. To what do you attribute this lack of progress? For example:
     - Is the lack of progress related to a management decision (perhaps

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

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

Development of an Integrated, Full-Scale Data-Driven Process

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

   OCDD is in the process of obtaining a full-scale data-driven quality database since it lacks the resources to develop a process. OCDD must resolve many issues before the database is complete. However, LDH has been able to secure funding through the American Rescue Plan Act (ARPA) for possible system upgrades and the opportunity for OCDD to obtain the desired system. The plan also presents a funding opportunity to secure additional human resources to support the one available programmer who, to this point, has had the full time responsibility for modernizing all of OCDD's databases. OCDD is currently in the pilot and testing phase of finalizing the electronic Individual Support Plan (eISP), which will be key to the effectiveness and operability of any system OCDD will use.

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

   The lack of progress on a quality-integrated database was due to a lack of resources, both in terms of funding to create the singular data system and infrastructure (i.e. concerns for server space, web-based capabilities) and adequate personnel to develop and administer the system. In addition to the barriers, modernization of all IT infrastructure has had a significant impact on progress. However, OCDD has completed the initial phases of the system's upgrades.

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

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

☐ No. If not, why not?

Yes. OCDD has updated its Strategic Plan for FY 2023 through 2028. Updates included revisions to office goals, program objectives, strategies and indicators to reflect OCDD direction, to build on successes, to provide strategies in areas where success has not been as substantial or where changes in program direction indicate such, and to improve

performance assessment.

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

  The LDH Division of Planning and Budget coordinates performance-based budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) on a department-wide level. This section reviews objectives, performance indicators, and strategies for programs within the Office of the Secretary, other LDH agencies, and for some LGEs. Each agency and LGE, with input from executive management, develops its own operational plan and strategic plan. Plans are then submitted to the Office of the Secretary for review and feedback. If modifications or additions are needed, recommendations are made directly to the assistant secretaries or the secretary. In addition, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

  OCDD assigns objectives to specific staff members who are responsible for management and oversight of the accomplishment of each objective and related performance indicators. A variety of management tools (i.e., databases, project charters, etc.) and initiative-specific workgroups/committees are used to track, review, and provide feedback for use in decision-making and resource allocation. Progress, or lack of progress, (along with support/resources needed to achieve assigned objective) is reported to OCDD Executive Management. Performance data is also reported in Louisiana Performance Accountability System (LaPAS), and is available for both management and stakeholder review.

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

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

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

Issue #1: Community settings lack adequately trained professionals and direct support staff to deliver needed (1) behavioral services, including qualified persons to deliver applied behavior analysis to people with autism, and (2) services and supports, including skilled nursing service and community nursing service, to individuals who are medically fragile

A. Problem/Issue Description

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

   There continues to be a lack of adequately trained professionals and direct support staff to deliver needed behavioral and medical/nursing services to individuals with complex needs in community settings; this includes a lack of qualified professionals to deliver applied behavior analytic therapies to persons with autism. There is also a shortage of trained staff to provide services and supports for individuals with significant medical needs, including a shortage in skilled nursing services, and a shortage of trained nurses who work either full-time, part-time, and contract for the provider for individuals who are medically fragile and reside in community settings.

   Adequate behavioral health supports can be very effective in improving quality of life and reducing behavioral symptoms/challenges for individuals with I/DD. Applied behavior analysis can significantly alter the course of autism for many individuals. Complex medical support needs, particularly those requiring nursing supports throughout significant periods of the day, can be managed in community settings; however, it is very difficult to locate and secure trained staff to meet these needs. Continued challenges in this area contribute to institutional admissions, hospital admissions, emergency room use, increased illnesses, increased medication usage and costs, and other negative health outcomes.

   There have been specific departmental and OCDD initiatives introduced during this fiscal year to continue addressing this barrier and improvements have occurred in some areas; however, the general problem still exists. A multi-faceted and multi-year approach is likely required to resolve the problem.

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

   Yes. Lack of professional supports in community settings has continued to be the primary contributor to admissions to the supports and service center and other more restrictive settings. Requests for admissions happen when community providers are unable to meet behavioral and psychiatric needs of people whom they are serving in community settings and (in smaller numbers) those with complex medical needs. The lack of trained autism professionals negatively affects the ability to develop new autism services, which could prevent more severe negative developmental outcomes. The inability to adequately teach functional behavioral skills detracts from community participation objectives (i.e., that individuals with disabilities are

participating fully in communities). The continued movement from Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) settings to community-based living arrangements is also hampered due to the challenges in securing needed behavioral and medical/nursing supports for individuals with complex needs.

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

   The lack of professional support in the community has affected OCDD and LGEs for many years. OBH and Medicaid are also becoming impacted.

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

   Supported individuals and their families, support coordinators, and private providers who serve people with I/DD in community homes, family homes, and supported independent living settings are all impacted by this problem. Hospitals are impacted when individuals with co-occurring needs come to the emergency room due to difficulty accessing other needed services. Behavioral health professionals and agencies are impacted because they are now receiving referrals for individuals with co-occurring needs for whom they may not feel adequately trained to deliver treatment. MCOs 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 I/DD. National reports continue to indicate that there is a general shortage of behavioral health professionals in many areas of the country, with access for those with co-occurring developmental disabilities and behavioral health needs even more challenging. The cost of providing nursing services in individual settings—and challenges in terms of isolation in these arrangements—negatively affect the access to needed medical/nursing supports. Both the increasing number of persons with I/DD now being served in the community and the downsizing of institutional services (generally considered positive and progressive developments in developmental disabilities services) have contributed to an increased need for medical/nursing and behavioral/psychiatric supports in the community. In addition, private Supported Independent Living (SIL) providers serving persons in waiver settings and private community home providers generally do not conduct, and are

not required to conduct, training with direct support staff on positive behavior supports and medical/nursing needs.

Impacts from COVID-19, major hurricanes disrupting services in the state, and historically significant workforce challenges within Louisiana continue to further affect this challenge. These public health disasters and workforce challenges continue to affect the provision of community-based services. Many entry-level jobs are reimbursing new hires at rates significantly higher than Direct Service Professional (DSPs). Therefore, we may have a shrinking workforce of qualified DSPs to support people in the community, resulting in increased usage of more restrictive, high-cost alternative.

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

   Consequences include:
   - A significant number of people with I/DD having unmet needs
   - A continued need for costly institutional admissions to the higher treatment cost supports and service center
   - Continued high usage of high-cost acute services
   - 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 work to implement the inclusion of behavioral and medical therapeutic respite options via the OCDD consolidated waiver, and research development of specialized shared living waiver models for individuals with complex medical and behavioral needs.
   - Continue to create opportunities to partner with university programs that provide training as well as individual clinicians to help grow the service provider pool.
   - Continue OCDD's developed and sponsored professional continuing education opportunities.

- Continue to evaluate other states' practices, which may offer opportunities for new and expanded services.
- Continue to enhance nursing and dental outreach efforts to improve outcomes for individuals with complex medical/dental needs.
- Continue working with OBH to develop a crisis framework and services, and explore other partnership opportunities with shared stakeholders.
- Review the systems analysis recommendations with the Center for START Services to address the needs of individuals with I/DD and co-occurring behavioral health issues. Continue working with the Center for START Services to develop a pilot program for Louisiana.
- Implement the other activities of the study groups in House Concurrent Resolution (HCRs) passed in FY 2022 related to DSP workforce, nursing services within agencies, and the needs of individuals with dual diagnoses (I/DD and co-occurring behavioral health needs).

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

   Yes. OCDD has included a recommendation in this annual report since FY 2007-2008. Some recommendations have been implemented, and new recommendations are included. Many of these recommendations require sustained implementation over a period of time to affect needed systems issues and improve outcomes.

4. Are corrective actions underway?

   Yes. The following actions are underway:
   - OCDD continues implementation of the complex care supplemental option within the waiver services and implementation of an Emotional Wellness Guide in its HCBS program.
   - OCDD has developed and deployed core training for DSPs on supporting emotional wellness and meeting complex medical needs.
   - OCDD continues its statewide offering of Medical/Nursing DSP training via Money Follows the Person (MFP) Rebalancing Demonstration.
   - OCDD continues to offer board certified behavior analysts (BCBA) continuing education opportunities, as well as other behavioral and psychological continuing education options.
   - OCDD has continued professional continuing education across disciplinary areas.
   - OCDD continues to provide consultation and technical assistance via the OCDD Resource Center.
   - OCDD has implemented routine outreach to full-time, part-time, and contract nurses for HCBS providers via the OCDD Resource Center.
   - OCDD continues to work with Medicaid to support Applied Behavior Analysis (ABA) services via the State Plan and has increased routine coordination with OBH related to mental health needs for individuals with I/DD.

- OCDD continued efforts to contract with the Center for START services.
- OCDD continues to partner with the statewide Dental Taskforce and providing dental coverage has occurred in the last two fiscal years.
- OCDD continues collaborating with OBH, Coordinated System of Care (CSoC), and the Managed Care Organizations (MCOs) to address the co-occurring I/DD and behavioral health needs of recipients who access services across systems.
- OCDD Resource Center staff continue implementation of a liaison program with the two state-operated psychiatric facilities and each MCO.
- OCDD continues to collaborate with Missouri and NASDDDS to develop additional training and educational materials for clinicians.
- OCDD participates in the Arc of Louisiana's dual diagnosis grant workgroup and continues to work with the group to develop a clinician's guide to accessible behavioral health treatment for individuals with I/DD and co-occurring behavioral health needs.

5. Do corrective actions carry a cost?

☒ No. If not, please explain.

Most of these actions do not carry a cost. The training and capacity building efforts approved in the MFP Rebalancing Demonstration (My Place Louisiana) Operational Protocol are funded with federal demonstration dollars. While other corrective actions could carry a cost insofar as additional clinicians and/or technical assistance staff are recruited into state service systems, they do not carry a cost as most new positions in OCDD are existing positions diverted from institutional services. They do not incur a cost when the focus is on community, non-public capacity building. Costs are associated with new services such as ABA, START, and enhanced waiver services. However, those costs are likely offset by costs associated with failure to implement corrective actions such as: 1) failure to intervene at the community level can result in extensive additional institutional treatment costs, and 2) failure to intervene with persons with autism at an early age does result in extensive lifelong service costs that are estimated at over one million dollars per person and incurred by families and the taxpayer. Additionally, the initial funding for the START contract will occur through federal ARPA dollars.

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

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

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

Issue #2: Information Technology (IT) Upgrades/Modernization Project

A. Problem/Issue Description

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

   OCDD's Information Technology (IT) software and equipment are out-of-date and need a system upgrade and modernization. Many applications and databases need a redesign or major revisions; equipment needs to be updated. Modernization is necessary to allow for automation of processes requiring access by multiple internal and external users. OCDD's system transformation efforts are being seriously thwarted by the lack of up-to-date IT equipment and programming.

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

   Yes. In some way, all of the six goals are negatively impacted by OCDD's outdated IT system since OCDD needs better resources to make improvements. Goal V (To implement an integrated, full-scale data-driven quality enhancement system) is especially hampered by this problem.

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

   This problem affects all OCDD units to varying degrees. IT upgrades and modernization would improve the efficiency of all work units within OCDD.

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

   The people supported by OCDD and their families, providers, support coordination agencies, and other stakeholders are indirectly affected. OCDD is unable to 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 IT Upgrades/Modernization projection has been significantly hampered by the lack of funding. Although OCDD requested funding during the state budgeting process, the project was not chosen as one of LDH's priorities.

7. What are the consequences, including impacts on performance, of failure to resolve

the problem or issue?

Development and implementation of person-centered software such as OCDD's electronic Individual Support Plan (eISP) and OCDD'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?

OCDD needs funding to implement, test, correct, and maintain the data infrastructure necessary to implement the eISP, build a proposed electronic developmental disability health record, and redesign the current quality enhancement integrated database. OCDD needs a full-time programmer and additional funding to replace older equipment. 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 HCBS waivers.

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

Yes.

4. Are corrective actions underway?

OCDD requested funding in the FY 2023-2024 budget. LDH has allocated money from the American Rescue Plan Act (ARPA) to provide OCDD with necessary resources to begin the process of building or obtaining the desired system and technology. OCDD might also need resources to help make the move to new systematic program coding to make existing OCDD systems compatible with the new IT system upgrades.

5. Do corrective actions carry a cost?

☐ No. If not, please explain.

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

Yes. To resolve the issue, OCDD must have salary for another full-time programmer. Funding for equipment upgrades and system modernization are also required. This cannot be managed with the current TO and budget.

Issue #3: Ongoing cost associated with facilities that have been closed, vacated, or privatized

A. Problem/Issue Description

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

   Over the last 18 years, eight former state-operated supports and services centers for people with developmental disabilities have either privatized their operations or closed in ongoing efforts to serve people in the least restrictive settings in their communities. OCDD continues to bear responsibility for the ongoing costs associated with four of these eight facilities. These costs generally include the following: acquisitions and major repairs, the payment of risk management premiums, building and grounds maintenance, utilities, and/or loss prevention/ security, and ongoing, or legacy costs, including the employer share of group insurance benefits for retirees.

   As of FY 2023, these expenditures require a state general fund appropriation to the OCDD budget to maintain.

2. Is the problem or issue affecting the progress of your strategic plan?

   No, OCDD noted direct impact to the strategic plan to the extent that these costs are billed at the appropriated level. Should billing exceed the amount set aside for these costs, services would be impacted if funds must be moved from other areas to meet these mandated costs.

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

   Not applicable.

4. Who else is affected by the problem?

   The OCDD budget is impacted.

5. How long has the problem or issue existed?

   OCDD identified this issue in 2010.

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

   The issue results from the mandatory expenditures mainly associated with duties and costs for state-owned property insured by Office of Risk Management (ORM), mandated group insurance costs for retirees from now closed institutions.

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

   The consequence of this issue is the continued expenditure of funds to maintain properties that OCDD no longer uses. These expenditures may cause cash flow shortfalls in future fiscal years to the extent that billing for these costs exceeds the

appropriated funding.

B. Corrective Actions

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

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

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

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

LDH should pursue an alternative use for the facilities, such as the 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 usage of state-owned property as revenue generating property. If not, the state may propose to sell the properties. Note that sections of all facilities contain asbestos that will require abatement. All such actions above may require an amendment to rule or law.

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

Yes. Similar recommendations have been made in this annual report since FY 2009-2010.

4. Are corrective actions underway?

Yes. Corrective actions are underway.

- Closed Facilities. With respect to ongoing facility maintenance and upkeep at closed facilities, in accordance with the ORM guidelines, OCDD is working to identify potential alternate uses for all properties not occupied or those planning to be vacated due to ongoing downsizing efforts. The Opelousas property is in process of sale. The Arc of Acadiana property is in process of surplus. The Hammond/North Lake property is in process of demolition following major repairs associated with Hurricane Ida.

5. Legacy Costs. Regarding ongoing legacy costs associated with mandated group insurance premiums for employees who retired from now closed institutions, Act 119 of the 2021 Regular Session appropriated less than full funding from the State General Fund, placing a greater burden on the revenue stream at the state-operated facilities. Do corrective actions carry a cost?

☒ No. If not, please explain.

No. There are no anticipated direct costs related to researching and existing staff would complete developing amendments to existing legislation, as these actions. Failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings and facilities. Additional resources are necessary to the extent that the revenue stream at Pinecrest is unable to fund the costs over and above the State General Fund appropriation.

☐ Yes. If so, what investment is required to resolve the problem or issue? (For

example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:

a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.

b. How much has been expended so far?

c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

d. Will additional personnel or funds be required to implement the recommended actions? If so:

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

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

A. Check all that apply.

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

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

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

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
LDH has a designated audit coordinator who serves as the 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.

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

☒ **In-house performance accountability system or process**
LDH's Division of Planning and Budget coordinates performance-based budgeting activities (such as strategic planning, operational planning, and the Louisiana Performance Accountability System). This section reviews all objectives, performance indicators, and strategies for the Office of the Secretary and each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or LDH's undersecretary, if modifications or additions are needed. At the close of a fiscal year, agencies and programs also review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

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

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

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

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

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

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

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

1. Title of the Report or Program Evaluation:

   ***National Core Indicators Survey*. NASDDDS and the Human Services Research Institute (HSRI) co-sponsor the National Core Indicators (NCI) project. Forty-eight states and the District of Columbia contribute survey data on individualized cycles for each NCI annual survey period.**

2. Date completed: August 8, 2024

   HSRI and NASDDDS made the final reports for the survey cycle that ended on June 30, 2023 available to Louisiana in January 2024.

   The new 2023/2024 survey cycle began in October 2023. Pre-survey work activities involved pulling samples, cleaning up samples, and updating survey tools.

   During May 2024, OCDD mailed Child Family Survey packets to the families of children from ages birth to 18 for the parents or guardian to complete; 7,424 family members of children receiving OCDD services received these packets.

In addition to the Child Family Survey, OCDD sent electronic invitations via the NCI portal to provider agencies for the NCI Workforce Survey (Previously called the Staff Stability Survey) in March 2024. NCI also extended the final response entries for the State of the Workforce Survey from June 30, 2024 to July 31, 2024.

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

   For the Child Family Survey, the core indicators are standard measures used across states to assess service outcomes provided to individuals and their families. Indicators address key areas of concern including employment, rights, support planning, community inclusion, choice, and health and safety. Surveys were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. Survey questions concerned satisfaction, quality of care, and quality of life. Analyses compared Louisiana statewide results with results of other states participating in the NCI Project. During the 2023/2024 survey cycle, OCDD chose to conduct the Child Family survey and the NCI Workforce Survey.

   The Adult Family Survey, Family Guardian Survey, and the In-Person Interview Survey were not conducted for this cycle.

   This year, 2023/2024 marks the seventh consecutive year that OCDD participated in NCI State of the Workforce Survey. NCI instituted this survey to address the concerns that surfaced in HSRI and NASDDDS about the instability of the direct care service workforce across the United States. Concerns center on wages, benefits, career opportunities, work environment, and educational opportunities for the workforce of caregivers. The NCI State of the Workforce Survey is an online survey through an NCI portal that is accessed by licensed service provider administrators of agencies supporting adults with I/DD in residential, employment, day services, and other in-home or community inclusion programs. The survey captures information about wages, benefits, and turnover of the direct support staff hired by the agencies. Respondents participate on a voluntary basis, but are strongly encouraged by OCDD leadership to complete the survey in order to obtain the most comprehensive data about the conditions that exist in Louisiana. OCDD only has access to the aggregate data collected and reported by NCI.

4. Methodology used for analysis or evaluation:

   OCDD used the Adult Family Survey as the primary tool to measure the service participant satisfaction for the 2022/2023 cycle (prior year). The analysis reports both the number and percentage of responses to each question. The NCI averages contained in the national report are “weighted,” which means their calculations reflect the relative population sizes of all participating states, as well as the sample size. NCI developed the weights using each participating state’s number of survey respondents and its total survey-eligible population. NCI tests for statistical significance as well as effect sizes. Effect sizes are used in addition to statistical significance because statistical significance of a state’s result depends in part on the size of the state’s sample. NCI compiles comparisons in the NCI national report that includes all of the participating states who submit a minimum

of 400 surveys. It then produces state reports for each participating state. If a state is not eligible to be included in the national report, that state will still have a state report available. NCI offers a web-based survey response site that provides families who were participating in one of the family surveys the opportunity to respond via direct entry into the NCI database. OCDD provides a unique survey code on each survey for respondents to use to anonymously access the database. In previous years, OCDD experienced a diminishing rate of return of surveys, which has resulted in pulling larger samples and mailing more survey invitations in order to achieve the target of a minimum of 400 completed Family Surveys per targeted population. OCDD did not conduct the In-Person Survey that directly interviews adults with a developmental disability participating in services through OCDD-managed programs. In addition, OCDD did not conduct the Child Family nor the Family Guardian Survey this cycle. Final reports from NCI on the aggregated 2022/2023 data were available in January 2024.

HSRI and NASDDDS prepared the reports and delivered them to OCDD in January 2024.

National Core Indicators Louisiana Child Family Survey 2023 Final Report: This report provides an aggregated summary of the survey results. This report, which was mailed to families of adult individuals living and receiving developmental disability services in the family home, provides comparisons between Louisiana and the national average of other participating states.

OCDD concluded the Adult Family Survey on July 31, 2023 and met the projected return rate for participation. OCDD also met the targeted return rate for the NCI Workforce Staff Survey.

OCDD made the NCI web-based survey response format available to respondents in the 2022/2023 surveys; hard copy surveys were also sent to the sample survey recipients to ensure equal access to everyone. The OCDD Quality Section is continuing to explore ways to increase the online participation rate for NCI surveys.

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

   The Office of State Printing Mail Operations mailed the Child Family Survey; the cost was $16,833.20 for the invitation letter and the actual mail surveys. The cost of the business reply postage for postage-paid return surveys was $1,495.96. More families than ever completed the survey online this year, which reduced the postage cost. There were no additional costs for the NCI-Workforce survey since providers were emailed a link to complete the survey online.

6. Major Findings and Conclusions:

   The preliminary review of the 2023/2024 Family Survey suggests feedback from family members of service participants still reflects the challenges that families face finding and keeping direct care staff. The 2023/2024 NCI Survey cycle findings will be available in January 2025.

7. Major Recommendations:

OCDD is considering contracting with an outside entity for both the mail return processing of surveys and the in-person survey activities as part of the 2024/25 survey cycle. This would remove any conflicts of interest that occur when OCDD surveys its own services. OCDD should formulate strategies to promote online participation in the Family Surveys for the 2024/25 survey cycle by offering families additional support to use the technology. OCDD can offer that support through phone contact, a dedicated email site, and web-based tutorials. Quality is currently exploring different potential resources for compiling the provider list. The list of invitees is extremely important in order to reach the correct target audience, minimize redundancy, and allow for a strong base in which to calculate the statistically significant return rate of = or <5%. OCDD should also consider offering incentives for providers to complete the State of the Workforce Survey.

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

   Survey information was matched with CMS measures for the HCBS Settings Rule, which addresses community participation and employment goals for persons with developmental disabilities receiving HCBS.

   OCDD reviews NCI data along with other sources, like regional performance indicators from the Human Services Accountability Plan and data from EarlySteps and HCBS waiver performance indicators, as part of its quality improvement process. A workgroup of OCDD Quality staff examines the data to identify trends. When trends or patterns are found, OCDD develops and implements quality improvement projects, with approval from the OCDD Executive Management Team.

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

   https://www.nationalcoreindicators.org/

10. Contact person for more information:
    Name: Pam Sund
    Title: Program Manager 3
    Agency & Program: OCDD Quality Section
    Telephone: 225-342-5646
    E-mail: Pam.Sund@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department: Louisiana Department of Health (LDH)
09-350 The Office of Women's Health & Community Health

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

Assistant Secretary: Tangela Womack

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: Perinatal Mental Health Campaign

A. What was achieved?

The TLC (Talk.Listen.Care) Moms Campaign successfully launched a comprehensive perinatal mental health initiative designed to support mothers across Louisiana. The campaign's key achievement was the creation of a dedicated website (ldh.la.gov/TLCmoms) as the central resource hub, offering accessible information, resources, and support services for mothers experiencing mental health challenges during and after pregnancy. The campaign also included communication efforts through social media and community billboards, ensuring that we reach the mothers and families in need

of necessary support and intervention.

B. Why is this success significant?

This success is significant because it addresses the critical and often overlooked issue of perinatal mental health, which directly impacts maternal and child health outcomes. In Louisiana, maternal mental health services are limited, the TLC Moms Campaign fills a gap by providing a centralized resource for mothers and families, helping to reduce stigma and improve access to care. By responding to Senate Resolution 136, the campaign also demonstrates a commitment to legislative priorities and the enhancement of maternal health services.

C. Who benefits and how?

The primary beneficiaries of the TLC Moms Campaign are mothers and families in Louisiana, particularly those experiencing perinatal mental health issues. By providing easily accessible resources, the campaign empowers mothers to seek help, reducing the risk of untreated mental health conditions. Additionally, healthcare providers benefit from having a reliable resource to guide patients.

D. How was the accomplishment achieved?

The accomplishment was achieved through a collaborative effort involving multiple stakeholders, including the Office of Women's Health and Community Health, the Bureau of Media and Communication and LDH sister agencies. The campaign was developed in response to Senate Resolution 136, which called for enhanced maternal mental health services. By leveraging partnerships, utilizing digital platforms for widespread outreach, and conducting a targeted awareness campaign, the initiative successfully reached mothers and families across the state. Continuous stakeholder engagement and feedback will be integral to expanding the campaign's reach.

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

Yes, this accomplishment directly contributes to the success of our strategic plan. The TLC Moms Campaign aligns with our goals of improving maternal and child health outcomes, increasing access to mental health services, and fostering community partnerships. By addressing a critical health need, the campaign supports our overarching objective of empowering women with the resources and knowledge they need to make informed healthcare decisions, ultimately contributing to healthier families and communities.

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

Yes. The campaign's success demonstrates the effectiveness of cross-sector collaboration, legislative alignment, and the use of digital platforms for public health initiatives. Sharing this approach can inspire similar campaigns in other departments.

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

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

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

  The overall status of our strategic progress remains strong, with notable advancements made in achieving our targeted goals and objectives. Since the establishment of the Office on Women's Health and Community Health (OWHCH) in June 2022, we have successfully executed the first round of regional town halls, which provided critical community input to guide our initiatives. The insights gathered from the town halls have been instrumental in refining our strategic goals and objectives, allowing us to address the health needs of women and communities across Louisiana more effectively. Our progress is marked by increased stakeholder engagement and the development of an impactful public health campaign. As we continue to build our team and refine our strategies, OWHCH remains committed to achieving its mission of empowering women and improving community health outcomes statewide.

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

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

  We are making significant progress in the area of women's health, particularly through our focused community outreach efforts. This success is largely attributed to our collaborative approach. By working closely with sister agencies, community organizations, and Managed Care Organizations (MCOs), we've been able to effectively disseminate information and resources to women in need. These

partnerships have enabled us to leverage existing networks and expertise, ensuring that our efforts reach a broad and diverse audience. The support and engagement from these partners have been critical in amplifying our messages and extending our reach into communities that need it most.

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

   This progress is not a one-time gain. We expect it to continue and even accelerate as we deepen our community engagement and strengthen our partnerships. By maintaining and expanding these collaborations, we are confident that our initiatives will continue to grow in impact, contributing to sustained improvements in women's health outcomes across Louisiana.

- **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 Office on Women's Health and Community Health (OWHCH) plans to make updates to our strategic plan and we are committed to ensuring that the plan reflects the voices and needs of our communities. To achieve this, we are incorporating community-driven responses based on the insights gathered during our town hall meetings.

Additionally, we are strengthening our outreach efforts by partnering with MCOs and community-based organizations to broaden our impact and better serve the population.

- **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?**

  Our strategic plan is coordinated by inclusion of all OWHCH staff in the development of agency goals and objectives. Each staff member provides their unique expertise and knowledge to support the refinement of goals and objectives. Once the strategies are refined, feedback is once again provided by staff and Executive Management Team. OWHCH also works in tandem with the budget office to provide input on potential funding needs. This allow for appropriate resource allocation.

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

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

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

There are no significant management or operational problems or issues.

A. Problem/Issue Description

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

B. Corrective Actions

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

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

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

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

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

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

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

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

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the

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

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

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

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

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

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

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

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

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

1. Title of Report or Program Evaluation:
   Office of Women's Health and Community Health Annual Report

2. Date completed:
   April 2024

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Act 676 of the 2022 Regular Legislative Session requires the submission of an annual report recommending priorities and areas of improvement for women's health in Louisiana.

4. Methodology used for analysis or evaluation:
   We collected quantitative and qualitative data from multiple sources, including town hall meetings, community feedback, health outcomes reports, and program performance metrics.

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

6. Major Findings and Conclusions:
   Throughout the report, we detailed the multifaceted landscape of women's health addressing key challenges, highlighting impactful initiatives, and outlining strategic interventions aimed at fostering positive outcomes. The department continues to analyze the factors influencing maternal health outcomes, including geographic disparities, workforce shortages and social determinants of health with which the OWHCH is evolving our vision for a more inclusive and equitable healthcare system that prioritizes the needs of all women.

7. Major Recommendations:
   N/A

8. Action taken in response to the report or evaluation:
   OWHCH is working to develop a community engagement plan that fosters a socioecological approach by integrating health education, community collaboration, funding strategies and resource distribution, which will result in interventions at multiple levels.

9. Availability (hard copy, electronic file, website):
   Will be published online to the LDH Legislative Reports page.

10. Contact person for more information:
    Name & Title: Tangela Womack, Assistant Secretary
    Agency & Program: Office of Women's Health and Community Health
    Telephone: 225-955-4581
    E-mail: tangela.womack@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department: Louisiana Department of Health (LDH)
09-375 Imperial Calcasieu Human Services Authority

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

Executive Director: Tanya McGee

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

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

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

Accomplishment #1: Mobile Outreach and Services

A. What was achieved?

In partnership with the Region V Office of Public Health, Care-Help of Sulphur, Southwest Louisiana (SWLA) Do No Harm, and Comprehensive Care Center, Imperial Calcasieu Human Services Authority's (ImCal) Mobile Unit, affectionately known as "Pete", has been utilized to conduct vital screening and treatment services for HepC and HIV, along with other sexually transmitted infections (STI).

Due to this coordinated effort:

- 68.8% of the individuals who tested positive for HepC accepted treatment.
- 100% of those individuals who tested positive for HIV accepted treatment.
- 66.6% of the individuals who tested positive for Syphilis accepted treatment.
- 100% of the individuals who tested positive for Gonorrhea-Chlamydia received treatment.

The Office of Public Health provides access to free HepC treatment with Epclusa. Through Pete's monthly visits to the Sulphur Community, participants were provided harm reduction information and supplies and offered screening/testing for Hepatitis C, HIV, Syphilis, and Gonorrhea/Chlamydia. Additionally, participants were offered services for Pre-exposure prophylaxis/Post-exposure prophylaxis **(**PREP/PEP**)** and referred to mental health, addiction, and primary care programs.

B. Why is this success significant?

The Mobile Unit Outreach Program significantly contributed to increasing HepC & other STI testing accessibility in Sulphur and neighboring areas and collaborating effectively with local agencies to reach vulnerable populations. The program aims to expand outreach activities to include more underserved communities, strengthen partnerships with healthcare providers for improved follow-up care, and implement educational campaigns to increase awareness and promote prevention and treatment of HepC and other STIs.

C. Who benefits and how?

The West Calcasieu population being served is largely transient, unhoused, lacking transportation and engaging in high-risk substance use behaviors.

D. How was the accomplishment achieved?

Partnerships with the above listed agencies utilizing ImCal's mobile outreach specialty vehicle.

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

Yes. Increasing access to Behavioral Health (BH) services to our target population while also expanding access to other types of services.

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

Yes.

Accomplishment #2: Opioid Response

A. What was achieved?
LA Bridge has expanded its reach in Southwest Louisiana (SWLA) and is now available at Lake Charles Memorial Hospital, West Calcasieu Cameron Hospital, Oschner American Legion Hospital, and Christus Oschner St. Patrick Hospital with plans for continued expansion. Through the end of fiscal year 23-24, the LA Bridge program served 870 patients in the Emergency Department. The LA Bridge program is successfully linking 80% of participants to treatment and all are provided access to harm reduction services.

B. Why is this success significant?
The program expands access to substance use disorder services by providing substance use navigation services and Medication Assisted Treatment to those presenting in emergency departments with overdose or any substance use emergencies.

C. Who benefits and how?
Persons across the 5-parish area with substance use disorders, as well as their families. Hospital staff also benefit by having a navigator in place to facilitate referrals. The program provides technical assistance to hospital administrators and physicians.

D. How was the accomplishment achieved?
The Louisiana Bridge program, implemented in SWLA in 2021, in partnership with Southwest Louisiana Area Health Education Center (SWLAHEC), Region V Office of Public Health and select local hospitals.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes. Expansion of BH services, particularly relating to opioid use.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. Several other regions have implemented the program and plans to implement statewide are underway.

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

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

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

realized?

Imperial Calcasieu Human Service Authority (ImCal HSA) is on time and on target to meet the goals and objectives set within our 5-year strategic plan. The mission of ImCal HSA is that citizens with mental health, addictions, and developmental challenges residing in the parishes of Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis are empowered, and self-determination is valued such that individuals live a satisfying, hopeful, and contributing life. This mission is accomplished through ImCal's Administrative, Behavioral Health and Developmental Disability Activities. ImCal HSA makes use of best practices in implementing, evaluating, monitoring, modifying existing services so that quality is assured; services meet the needs of those served; and the variety of services available adequately address the range of behavioral health issues identified and are further developed to address service gaps.

ImCal's Agency Goals:

I. Increase public awareness and to provide access to care for individuals and their families who are in need of behavioral health and developmental disabilities services.
II. To ensure that services provided are responsive to client needs, based on evidence-based best practices, and that programs afford the client a continuum of care taking into consideration cultural diversity and abide by all State and Federal guidelines.
III. To promote healthy, safe lives for people by providing leadership in educating the community on the importance of prevention, early detection and intervention, and by facilitating coalition building to address localized community problems.

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

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

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

   Imperial Calcasieu Human Service Authority (ImCal HSA) continues to make steady progress in all three Program Activity areas. Outside of the three accomplishments described in Section I. above, while ImCal has not significantly exceeded any stated objectives and strategies, we have made steady and efficient progress in all objectives and strategies as indicated in our 5-year plan. This becomes more and more difficult to accomplish with the increase in need for services within the community and lack of licensed professionals to fill the need.

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

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

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

   None.

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

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

Imperial Calcasieu Human Service Authority has made steady and efficient progress in all objectives and strategies as indicated in our 5-year plan.

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

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.

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

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

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

Problem/Issue Description #1: Budget Issues

A. Problem/Issue Description

1. **What is the nature of the problem or issue?**
    a. The cost of operations has steadily increased; however, the inflation allowance provided within our continuation budget is not adequate to cover actual inflation costs.
    b. Statutorily dedicated funds for tobacco were cut from our budget with no notice, at the very end of the fiscal year (June 2024), after said funds had already been spent.

2. **Is the problem or issue affecting the progress of your strategic plan?**
   No, not at this time.

3. **What organizational unit in the department is experiencing the problem or issue?**
   All divisions and departments are negatively impacted.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   Patients affected by increased wait times or decrease in services. Contractors who operate social service programs funded by Imperial Calcasieu Human Service Authority (ImCal HSA) are negatively impacted such as Human Immunodeficiency Virus/Intravenous Drug Users (HIV/IVDU) substance abuse outreach program.

   Staff are affected due to scarce resources to perform job tasks.

5. **How long has the problem or issue existed?**
   The problem has existed since FY2023.

6. **What are the causes of the problem or issue? How do you know?**
   Reduction of budget continuation request; Decisions made at the state level to appropriate state general funds through the budget process and reduction of statutorily dedicated funds.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   Consequences may possibly include the loss and/or decreased access to critical services within 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?**
   Reduce social services in the community to alleviate expenses and control discretionary expenditures as much as possible for FY25. Request additional state general funding in FY26 to cover rising costs.

3. **Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?**
   No.

4. **Are corrective actions underway?**
   a. If so:
      - **What is the expected time frame for corrective actions to be implemented and improvements to occur?**

Reduction in social service contracts implemented July 2024.

- 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, not as of this time. Reduction of costs in areas outside of our strategic plan will occur first and funding will be reallocated to the Behavioral Health Division. Community Service outreach programs such as HIV/IVDU and suicide prevention will be reduced.

☒ No. If not, please explain. **See above.**

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

Problem/Issue Description #2: Recruitment and retention of licensed, billable professionals

A. Problem/Issue Description

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

Shortages of licensed professionals in counseling fields has impacted ImCal's ability to find and hire qualified individuals. In addition to struggles with

recruitment, retention of licensed staff can be difficult without the budgetary resources to compete with the private sector. Not only does lack of licensed staff limit services available to the community, but it also prevents us from maximizing self-generated revenue, which can serve as a cushion when budget constraints arise.

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

   Not at this time.

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

   All clinics within the Behavioral Health Division.

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

   Low income individuals in need of critical services, individuals in rural areas where behavioral health services are difficult to obtain.

5. **How long has the problem or issue existed?**

   This is an ongoing issue that has become increasingly dire over the past several years and exasperated Hurricanes Laura and Delta in 2020.

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

   National data show that less individuals are seeking careers in lower-paying, helping fields such as counseling.

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

   Negative impacts on Imperial Calcasieu Human Service Authority (ImCal HSA) ability to fulfill its mission as it relates to ensuring a comprehensive continuum of care within our catchment area.

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?
Imperial Calcasieu Human Service Authority (ImCal HSA) utilized job appointments to hire provisionally licensed providers who are working toward full licensure. These hires have allowed us to serve our communities; however, provisionally licensed providers are not billable. Under a BH Managed Care environment, ImCal HSA is expected to operate similarly to the private sector in order to generate revenue to support the budget.

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

   Various issues related to staffing difficulties have been reported on all of ImCal's annual results. We have struggled not only with recruitment, but other issues restraints caused by Civil Service system, lack of TO, and non-competitive pay scales.

4. **Are corrective actions underway?**
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
      - How much progress has been made and how much additional progress is needed?

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

      Hiring of unlicensed professionals has mitigated staffing shortages but created a new problem of decreased revenues.

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.

   Salary and benefits for the unlicensed professionals cost approximately $375,497.

   b) How much has been expended so far?
   FY24 $357,874.

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?**

Three of the job appointments will be expiring in FY26, so will be requesting in FY26 Budget Submission.

Self-generated revenue is decreased for as long as we employ unlicensed professionals. As these individuals become licensed, retention will be a problem if ImCal cannot offer them competitive salaries. Another risk is the expiration of the job appointment positions they occupy. If ImCal is unable to obtain TO positions, our investment in their professional development will be lost.

Problem/Issue Description #3: Continued displacement of Administrative and Developmental Disabilities offices due to Hurricane Laura in 2020

A. Problem/Issue Description

1. **What is the nature of the problem or issue?**
   Hurricane Laura destroyed the building which housed the Administrative and Developmental Disabilities office. Temporary space was acquired with the expectation that our building would be repaired within 18-24 months. The temporary space is very small and most employees are still working from home, despite the need for some to return to an in person setting. There is no conference or meeting space. Records had to be moved to the Region V Public Health Unit. This requires staff to travel from home, office and the health unit to complete their work which is not efficient and taking its toll on staff burnout. The building is set to be demolished September 7, 2024. Cost per square foot of a new location exceeds previous rental by annual cost of $436,000.

2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)**
   No.

3. **What organizational unit in the department is experiencing the problem or issue?**
   Administration and Developmental Disabilities.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   Individuals served in our DD Division. There is limited space at the DD office to see individuals who are accessing services. Visits must be scheduled around one small screening room. ImCal Board of Directors are unable to meet at Admin office due to lack of space. Moved Board meetings to OPH Regional Office. ImCal leadership has no private meeting areas therefore is using a group therapy room at our Lake Charles BH clinic for most meetings. We have not had the option to bring staff back to in-person work after the pandemic ended due to continued displacement.

5. **How long has the problem or issue existed?**
   Hurricane Laura, 08/26/2020.

6. **What are the causes of the problem or issue? How do you know?**
   Destruction of office building, limited options and increased cost for rental space.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   Staff burnout, inefficient work processes and procedures due to multiple work areas in various buildings across town.

B. Corrective Actions

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

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

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

   ImCal HSA has purchased a plot of land on which to build a new office, large enough to house our DD and Admin offices and went out on bid for construction of new building. Before bid was awarded, an opportunity to purchase a historic building in downtown Lake Charles was made available. With the opportunity to receive, and in-turn sell, historic tax credits, the purchase and renovations to this building is a substantially lower cost than new building construction.

3. **Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?**
   This issue has been on our plan since 2020. ImCal has had to change and adapt

strategies on an ongoing basis as options change.

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?

   ImCal is currently in negotiations with the Lake Charles Housing Authority for the purchase of the historic building downtown.

5. **Do corrective actions carry a cost?**

   ☐ No. If not, please explain.
   ☒ **Yes.** If so, what investment is required to resolve the problem or issue?

   (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:

   a. **What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.**

      The cost to purchase and renovate the Housing Authority Building is estimated at $8,794,287.

   b. **How much has been expended so far?**

      None.

   c. **Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?**

      No, this investment can't be managed.

   d. **Will additional personnel or funds be required to implement the recommended actions? If so:**
      - **Provide specific figures, including proposed means of financing for any additional funds.**

Additional increase of $436,000 from SGF.

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

  Yes, it was requested in FY25 and $192,000 was awarded. Estimated $244,000 is still needed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department:	Louisiana Department of Health (LDH) 09-376 Central Louisiana Human Services District
Department Head:	Michael Harrington, MBA, MA LDH Secretary
Undersecretary:	Drew Maranto
Executive Director:	Rebecca Craig

I. What outstanding accomplishments did your department achieve during the previous fiscal year? For each accomplishment, please discuss and explain each item below.

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

Accomplishment #1: Completion of Phase I of TANF program for Women with Dependent Children:

A. What was achieved?

Phase I of the plan to establish a residential program for Women with dependent children has been completed. The program will support women who are recovering from addiction to substances with surroundings that will provide treatment services, collaborations, and community linkages necessary for women in recovery from substance use/abuse. Support would include all Temporary Assistance for Needy Families (TANF) eligible families to maintain a lifestyle free from the effects of addiction. The supportive

environment is designed for pregnant women and women with dependent children in a community setting to enhance the continued and extended support necessary. This contract will include activities to support program implementation and continuation.

B. Why is this success significant?

The program implementation is intended to establish a structured, supervised, residential service program in Alexandria, Louisiana to provide intermediary support to women 24 hours a day, 7 days a week. Ultimately, the program will utilize evidence-based practice models to support at-risk women who need support to establish mental, emotional, and social rehabilitation to improve successful outcomes of applied treatment interventions. As indicated by the Substance Abuse and Mental Health Services Administration Treatment Quick Guide for Clinicians recommends gender-responsive treatment to "Acknowledge the importance and role of socioeconomic issues and differences among women. Women's substance use and abuse should be framed in their socioeconomic contexts, including, but not limited to, employment, educational status, transportation, housing, literacy levels, and income." A supportive residential program for women in the Central Louisiana Human Services District (CLHSD) will provide a bridge for women transitioning to the community to a permanent housing and employment arrangement while supporting a sober living lifestyle.

C. Who benefits and how?

Women recovering from substance use disorders and their children and families. The communities where they reside.

D. How was the accomplishment achieved?

Phase 1 of the plan to establish a TANF program began with establishing a contract with an organization with the resources and expertise to complete the entire project plan. Following the guidelines of the TANF funding, the contractor located a facility that with remodeling, would meet the needs of the program operations. A needs assessment was conducted, and contractors were established to begin amending the facility's layout and functionality. Necessary program supplies were purchased, and with supervision, remodeling was completed. The contract and CLHSD worked in coordination to overcome barriers that inhibited progress.

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

Yes.

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

Yes.

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

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

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

  Although Central Louisiana Human Services District (CLHSD) is experiencing significant progress towards the goals and objectives established in the strategic plan, some barriers inhibit the optimal operations of the clinics and programs. CLHSD measures and monitors programmatic outcomes and works to ensure compliance with state and federal licensing and grant requirements. In addition, CLHSD manages and responds to financial monitoring and reporting. The District has worked to increase IT Systems Security and oversights. Cybersecurity insurance has been purchased to minimize potential threats to the operations of District programs. CLHSD direct service programs successfully provided services/contacts to more than 22,000 unique individuals in need.

  ◆ **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?

     Primarily, significant progress on the strategic plan has been made in addressing the needs of person who experience chemical dependency. The progress towards establishing a residential 3.1 level of care for Women with Dependent Children not only contributes to an increased success rate of long-term recovery for women but also reduces the likelihood of people who are at risk for needing urgent assistance through the crisis system in our area. These vulnerable populations frequent emergency systems due to their fragile nature when not adequately stabilized and supported. The efforts to establish these important supports have been made possible through TANF funding and were accomplished through contractual agreements with an experienced non-profit provider.

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

     The progress has been initiated and will continue as program services and operations are implemented.

- **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?

       The Central Louisiana Human Services District (CLHSD) Clinic treatment programs have experienced multiple technology challenges related to the current Electronic Health Records (E.H.R.). The current Electronic Health System has not offered clearinghouse features that support ease of billing for services, review of billing submissions, and expedited reimbursement for services rendered. In addition, the current E.H.R. has experienced multiple periods of "downtime" or has been inaccessible for use. The productivity of staff has been affected by these challenges.

    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?

       Management has been actively working to resolve the ongoing issues with the current E.H.R. The improvement efforts have not resulted in sufficient improvement. The District has established an agreement with a different E.H.R. services provider, and staff training has been initiated. Transition to the new E.H.R. is expected to be completed over the next fiscal year.

- **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 overall objectives remain applicable.

- **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?**

    Currently, the plan objective and strategies remain appropriate to the overall success of

the quality and quantity of services. The CLHSD strategic plan is shared with the community, CLHSD personnel, and stakeholders.

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

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

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

Problem/Issue #1: Electronic Health Record (EHR)

A. Problem/Issue Description

1. **What is the nature of the problem or issue?**
   The E.H.R. currently being utilized has not been an efficient program for this organization's requirements and needs.

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?**
   Billing department, compliance department, and clinical program.

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

5. **How long has the problem or issue existed?**
   Since FY 2024.

6. **What are the causes of the problem or issue? How do you know?**
   Undetermined cause of the problems not sufficiently resolved by the contractor.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   Electronic Health Records are primarily designed for general medical facilities/providers and are not always designated for behavioral outpatient services programs. In addition, since the Central Louisiana Human Services District (CLHSD) is a quasi-governmental agency, additional data requirements are needed to satisfy funding source requirements.

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?**
   Another E.H.R. company was identified that provides an alternative to the current system. CLHSD is in the process of transitioning to a new program.

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

4. **Are corrective actions underway?**

   Yes, the transition to a new E.H.R. is expected to occur over 6 months to a year. Orientation and training are initiated for the new E.H.R. program.

   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?

Unsure of exact costs at this time.

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

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

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

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

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

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The LDH has a designated Audit Coordinator for financial audits. The Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal c communication between agency personnel

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

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

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

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

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

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

☒ **Performance-based contracting (including contract monitoring)**
LDH contracts are required to contain a description of the work to be performed

including goals and objectives, deliverables, performance measures and a monitoring plan.

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

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

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

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

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

1. Title of Report(s) or Program Evaluation:
    a. **Office of Risk Management Compliance Review**
    b. **Louisiana Department of State Civil Service**
    c. **Louisiana Performance and Accountability System (LaPAS)**
    d. **Independent Peer Review**
    e. **CARF Accreditation**
    f. **Internal Programmatic Audit**

2. Date completed:
    a. 1/4/2024
    b. June 2023

c. Quarterly reporting (LAPAS)
d. 8/9/2023
e. 7/27/2022
f. Quarterly

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   a. Compliance Review
   b. Compliance Review
   c. Bi-Annual monitoring is conducted to evaluate the Human Services District compliance with the Human Services Accountability Plan
   d. Cooperative review to satisfy Block Grant requirements and cooperative learning.
   e. Accreditation for Quality Performance
   f. Internal Programmatic Compliance Review

4. Methodology used for analysis or evaluation:
   a. ORM external contractor Loss Prevention audits CLHSD records and building inspections to ensure compliance.
   b. La Dept. of Civil Service review of records for compliance to rules, laws, and guidelines.
   c. Review of outcome measures established per DOA-approved indicators.
   d. Peer programmatic and administrative reviews are conducted.
   e. Accreditation program utilized set standards of performance and care. Reviews were conducted through electronic and audio-visual interviews, and compliance is based on the standards of care/performance.
   f. Internal audits are conducted using a review of records, documentation, and on-site review. Reviews are conducted utilizing accreditation, legal, and licensing standards.

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

6. Major Findings and Conclusions:
   Overall program and business compliance. Corrective plans have been developed for all findings.

7. Major Recommendations:
   None.

8. Action taken in response to the report or evaluation:
   Compliance plans were implemented and followed up for continued compliance.

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

10. Contact person for more information:
    Name & Title: Rebecca Craig, Executive Director

Agency & Program: Central Louisiana Human Services District
Telephone: 318-487-5191
E-mail: Rebecca.Craig@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2023-2024

Department: Louisiana Department of Health (LDH)
09-377 Northwest Louisiana Human Services District

Department Head: Michael Harrington, MBA, MA
LDH Secretary

Undersecretary: Drew Maranto

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: Privatization of Pharmacy Services

A. What was achieved?

Replaced limited internal pharmacy with a contracted, full-service pharmacy.

B. Why is this success significant?

With the expansion of Medicaid, the volume of uninsured clients needing pharmacy services dramatically declined. When our pharmacist retired, we looked at how we could continue to serve our uninsured clients while also expanding pharmacy services for those with Medicaid and other billable insurance products. Replacing our internal pharmacy

with a contracted full-service pharmacy would achieve this goal with considerably less cost to our District.

C. Who benefits and how?

All existing uninsured clients were able to continue receiving medications as before. In addition all clients, their family members, our staff, their family members, our contract vendors, and their family members became eligible to get their medications through the new full-service pharmacy. Also, the new full-service pharmacy is working with area physicians to fill and administer their prescriptions for long-term injectable medications for alcohol and opioid use disorders.

D. How was the accomplishment achieved?

Our internal pharmacy space was leased to Genoa Healthcare LLC and the monthly credit received from the lease is used to pay for contracted services which include serving our uninsured clients in a similar fashion to how we did with our internal pharmacy. Genoa renovated the space at their expense to meet their needs and hired staff to run the pharmacy.

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

Yes. Maintaining an internal pharmacy license and adequate pharmacy staff was becoming increasingly difficult. This solution not only stabilized our existing pharmacy service needs but also expanded pharmacy services to a much larger group of individuals.

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

Yes. The privatization of pharmacy services has been a best practice for many of the other local governmental entities and should be considered by any other state agency attempting to maintain an internal pharmacy license and staff.

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

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

Yes.

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

  Since Re-opening our Many Behavioral Health Clinic in 2021, the services provided there have increased to the point of adding an additional day of coverage each month.

Since transitioning to a contracted, full-service pharmacy, our physicians and clinicians are better able to manage the medications of our clients which results in better outcomes. Improved pay grades for clinical staff has allowed us to fill vacancies and better service our clients. Use of 988 is growing and implementation of Crisis services in our service area is near completion. All of this is helping us keep on track in achieving our five-year strategic plan goals and objectives.

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

  None.

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

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

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

  None.

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

- Other? Please specify.

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

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

☐ Yes. If so, what adjustments have been made and how will they address the situation?

☒ No. If not, why not?

No adjustment was needed this year. There were no significant successes or shortfalls to address and the strategic plan remains relevant in its current form.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**

The areas of focus for the strategic plan were based on stakeholder input and the District's End Statement developed by the Northwest Louisiana Human Services District (NLHSD) Board of Directors. The NLHSD Senior Leadership Team then adjusted the goals and objectives of the plan based on input from management staff. The final draft has been disseminated to staff via e-mail and posted on the NLHSD shared folder for all staff to reference when needed. Review of the plan is set to occur twice a year with a summary report to the Board of Directors for their review and input.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such

reports and evaluations at the end of this form.

There are no significant management or operational issues.

A. Problem/Issue Description

1. What is the nature of the problem or issue?
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
3. What organizational unit in the department is experiencing the problem or issue?
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
5. How long has the problem or issue existed?
6. What are the causes of the problem or issue? How do you know?
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

☐ No. If not, skip questions 2-5 below.
☐ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

4. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
      - How much progress has been made and how much additional progress is needed?
   b. If not:
      - Why has no action been taken regarding this recommendation?
      - What are the obstacles preventing or delaying corrective actions?
      - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.

☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:

a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
b. How much has been expended so far?
c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
d. Will additional personnel or funds be required to implement the recommended actions? If so:
    - Provide specific figures, including proposed means of financing for any additional funds.
    - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply.

☒ **Internal audit**
The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste and abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

Internal Audit also provides management with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The LDH has a designated Audit Coordinator for financial audits. The Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved in all written communication related to audits and is kept informed about all relevant verbal communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts

performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

☐ Policy, research, planning, and/or quality assurance functions in-house

☐ Policy, research, planning, and/or quality assurance functions by contract

☐ Program evaluation by in-house staff

☐ Program evaluation by contract

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

☒ **In-house performance accountability system or process**
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

☒ **Benchmarking for Best Management Practices**
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

☒ **Performance-based contracting (including contract monitoring)**
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

☐ Peer review

☒ **Accreditation review**
Northwest Louisiana Human Services District (NLHSD) currently operates under a 3-Year Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation. This accreditation includes an annual conformance review process.

☒ **Customer/stakeholder feedback**
Northwest Louisiana Human Services District (NLHSD) solicits input from LaPAS and C'est Bon surveys, comments on the NLHSD website, verbal and written comments during public forums, and stakeholder surveys distributed during the NLHSD Board's annual strategic planning process

☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☐ Yes. Proceed to Section C below.
☒ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation:
2. Date completed:
3. Subject or purpose and reason for initiation of the analysis or evaluation:
4. Methodology used for analysis or evaluation:
5. Cost (allocation of in-house resources or purchase price):
6. Major Findings and Conclusions:
7. Major Recommendations:
8. Action taken in response to the report or evaluation:
9. Availability (hard copy, electronic file, website):
10. Contact person for more information:
    Name & Title:
    Agency & Program:
    Telephone:
    E-mail: