John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

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

FROM: Ruth Johnson
LDH Undersecretary

RE: Annual Management and Program Analysis Report (AMPAR)

DATE: November 22, 2021

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 2021 fiscal year. These reports summarize the activities of each agency as it relates to management and program analysis, outstanding accomplishments, areas where we are making significant progress and any specific management or operational issues that may exist.

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

Louisiana Department of Health

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

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department:	**Louisiana Department of Health (LDH)** 09-300 Jefferson Parish Human Services Authority
Department Head:	**Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Executive Director:	**Rosanna DiChiro Derbes, Psy.D**

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

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

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

Accomplishment #1: COVID-19 Testing and Vaccination of Jefferson Parish Residents

A. **What was achieved?**

In Fiscal Year 2020-2021, JPHSA partnered with Jefferson Parish elected officials and other local stakeholders, including churches and community centers, to promote and host several COVID-19 testing and vaccination events at its JeffCare East Jefferson and West Jefferson Health Centers. Between January 1, 2021 and June 30, 2021, JPHSA administered 2,198 vaccines to Jefferson Parish residents. Additionally, between August 1, 2020 and October 31, 2020, JPHSA administered 123 COVID-19 tests.

B. **Why is this success significant?**
The COVID-19 pandemic upended life as it was previously known in myriad ways, and posed risk of infection for Jefferson Parish residents. Louisiana had a significant COVID-19 transmission rate throughout Fiscal Year 2020-2021, much of which was concentrated in the New Orleans metropolitan area, in which much of Jefferson Parish is located. In Jefferson Parish, the disease burden of COVID-19 was and continues to be significant. As of July 26, 2021, Jefferson Parish continues to outpace Orleans for total cases with Jefferson reporting 50,084 cases and Orleans reporting 33,139. This translates to Jefferson Parish bearing the burden of 9.8% of the state's total cases to date. In December 2020, the death rate in Jefferson Parish pulled even with that of Orleans and began to repeatedly exceed it. As of July 26, 2021, total deaths in Jefferson stand at 918 and 808 in Orleans.

C. **Who benefits and how?**
All Jefferson Parish residents benefit from increased healthcare resources within our community. In the context of COVID-19, the benefits to the testing and vaccination resources offered by JPHSA are likely far-reaching as they contribute to slowing community spread. JPHSA provided vaccines to current individuals served as well as individuals from the community who were eligible for vaccination. Initially, due to the restrictions for vaccination eligibility, the community sought vaccinations at a higher rate than those served in JPHSA. With all adult individuals eligible by March of 2021, individuals served comprised approximately 85% of vaccines provided by June 30, 2021.

D. **How was the accomplishment achieved?**
As a Federally Qualified Health Center, JeffCare, a program of JPHSA was provided access to federally distributed vaccines through the Louisiana Department of Health. JeffCare was required to submit a CDC COVID-19 Vaccination Program Provider Agreement for each Health Center site and each site was approved as a Vaccination site in December of 2020. Vaccines were ordered through LDH and JeffCare began administration on January 5, 2021.

Additionally, the JeffCare program received Expanded Capacity for Coronavirus Testing (ECT) funding from the Health Services & Resources Administration (HRSA) to support the provision of testing for COVID-19.

JPHSA and JeffCare staff members worked with Jefferson Parish Councilwoman Jennifer Van Vrancken to co-sponsor an event aimed at vaccinating 100 Jefferson Parish residents (the maximum amount given JPHSA's distribution capacity at the time) held on March 20, 2021. Councilwoman Van Vrancken was on hand to show her support, and was interviewed by Telemundo for this event. In preparation, JPHSA sent flyers to 34 East Jefferson churches within Jefferson Parish Council District 5, and utilized Facebook, the JPHSA website, and JPHSA social media accounts to market the event in both English and Spanish. Councilwoman Van Vrancken also advertised the event on her own social media accounts. The event was a success in that 102 COVID-19 shots were administered, including some "angel doses" which were able to be pulled from overfilled vaccine vials. The individuals who received their first vaccine doses at

the March 20, 2021 event were scheduled to receive their second doses on April 17, 2021.

In May 2021, JPHSA and JeffCare staff members worked with State Representative Rodney Lyons to co-sponsor marketing of available vaccinations at JPHSA's JeffCare West Jefferson Health Center. This co-sponsorship specifically targeted the underserved communities of Jefferson Parish. A flyer was created and distributed to many community stakeholders, including the Harvey, Woodmere, and Marrero Community Centers and St. Joseph the Worker church. It was also advertised on both JPHSA and Representative Lyons' social media pages and posted to certain targeted Facebook groups.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes. By hosting these events and administering COVID-19 tests and vaccines with a focus on reaching the underserved, JPHSA was acting in furtherance of its Mission statement to help Jefferson Parish residents lead full, healthy, independent and productive lives. In doing so, JPHSA was also acting in furtherance of the first goal of its strategic plan, which is to ensure the availability of adequate resources to meet Mission and ultimately achieve Vision while adhering to Board Priorities for the provision of services and supports.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes. The collaborative approach JPHSA took in partnering with its local stakeholders to address a community need could definitely be replicated throughout the state in the future. JPHSA was the only LDH budget unit which hosted vaccination events.

Accomplishment #2: Participation in Development of Collaborative to Help the Homeless of Jefferson Parish

A. **What was achieved?**
In Fiscal Year 2020-2021, JPHSA participated in the "Collaboration to Help the Homeless of Jefferson Parish" with community stakeholders and elected officials including Jefferson Parish President Cynthia Lee-Sheng, Senator Patrick Connick, Representative Kyle Green, Representative Rodney Lyons, Jefferson Parish Council members, representatives from the Jefferson Parish Sherriff's office, and representatives from the Jefferson Parish Office of Engagement and Community Programs and Unity. The Collaboration developed a Mission Statement, which is "individuals and families in Jefferson Parish affected by homelessness shall live full, healthy, independent, and productive lives within stable environments to the greatest extent possible with available resources." The Collaborative met for the first time in August 2020 and several additional times thereafter throughout the Fiscal Year. Topics of discussion centered around understanding the definition of homelessness as well as

the state of homelessness in Jefferson Parish and proven strategies to address it. Three work groups were formed to study the needs of Jefferson Parish residents as well as available resources. As of the time of this writing, the work groups are continuing to meet and will report findings back to the full Collaborative at a later date.

B. **Why is this success significant?**
The formation of the Collaborative represents the first time in recent history, if not ever, that so many Jefferson Parish leaders have come together to work cohesively on an issue that affects many Parish residents. By pooling resources and working collaboratively, barriers may be mitigated to achieving meaningful solutions.

C. **Who benefits and how?**
All Jefferson Parish residents benefit from the availability of safe and secure housing for all, including our most vulnerable residents. Those vulnerable residents who have struggled with homelessness will benefit specifically from this initiative as housing needs are better understood by more community leaders and resources are identified.

D. **How was the accomplishment achieved?**
As of the time of this writing, the Collaborative is still in its early stages. JPHSA is serving in a leadership role on the Collaborative and is responsible for recording and maintaining Collaborative minutes. The Collaborative will continue to meet throughout Fiscal Year 2021-2022.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes. Participation on the Collaborative is an example of JPHSA directly acting in furtherance of its Mission statement to help Jefferson Parish residents lead full, healthy, independent and productive lives. In doing so, JPHSA is also acting in furtherance of the first goal of its strategic plan, which is to ensure the availability of adequate resources to meet Mission and ultimately achieve Vision while adhering to Board Priorities for the provision of services and supports.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
While the results of the Collaborative remain to be seen, the engagement of community leaders to discuss and address a wide-reaching problem within the community is certainly something that can and should be replicated state-wide.

<u>Accomplishment #3: Opening of the JPHSA Eunoia Center</u>

G. **What was achieved?**
In Fiscal Year 2020-2021, JPHSA's Behavioral Health Community Services (BHCS) division opened the doors to the Eunoia Center, its Living Room model for individuals experiencing crises in the Jefferson Parish community. The Living Room model

provides crisis respite services, and is a promising practice. The two hallmarks of the model are: it is peer-based, and it is designed to appear non-clinical in nature, hence the name "Living Room." Peer specialists, who have the very specific lived experience ideal for engagement for individuals in crisis, staff the program. The use of peers in this way is an evidence-based practice and provides cost efficiencies for program operations, as peers are generally less expensive to retain than clinicians. Living Room models in other states have shown positive outcomes with regard to reducing hospitalizations. The model is endorsed by the federal Department of Justice as a best practice.

The Eunoia Center first opened in its initial "pilot" stage, wherein it accepted referrals from the Jefferson Parish Mobile Crisis Services team. In this stage it served sixteen Jefferson Parish residents in crisis who may otherwise have presented to an emergency department. Plans for Fiscal Year 2021-2022 include expanding accepted referral sources to include JPHSA's JeffCare Federally Qualified Health Centers as a continuation of the pilot stage, and eventually expanding access to other community providers.

H. **Why is this success significant?**
The Eunoia Center is the first Living Room model-based program in Louisiana. It is significant in that it adds to the crisis continuum in Jefferson Parish, thereby increasing access to services for individuals in need of mental health support. It also serves to keep healthcare costs, particularly for uninsured/underinsured individuals, down by accepting individuals who may otherwise present to emergency departments for crisis resolution. It provides a safe space where individuals experiencing crisis can have their crisis resolved using appropriate supports.

I. **Who benefits and how?**
As discussed above, the Eunoia Center benefits all Jefferson Parish residents by increasing the availability of mental health services, particularly crisis resolution support services, within the community while reducing overall healthcare costs which would otherwise be funded with taxpayer dollars.

J. **How was the accomplishment achieved?**
The Eunoia Center opened its doors on March 22, 2021. Prior to its go-live, the Behavioral Health Community Services (BHCS) Division Director engaged in extensive, ongoing research into program efficacy and sustainability, and ultimately presented a three-year implementation plan for approval from the Executive Director.

Once approval to implement the program was granted, JPHSA contracted with an architect to design the space for Eunoia. It was important to JPHSA that the space have a non-clinical, comfortable feel which is a program hallmark. This included selecting appropriate flooring, lighting, and an open concept space, as well as furniture, paint colors, and wall art. Careful attention was also given to the outdoor space, again with design focused on a comfortable, welcoming space. This included a covered pergola, a bench for seating and greenery to please the eye. The BHCS Division Director was

involved in every decision, always being mindful of the purpose of the space and needs of service recipients coming for services.

JPHSA also spent considerable time in the hiring process to ensure appropriate staff were hired. Specifically, staff hired includes peers with varied experience as well as a Registered Nurse with behavioral health experience.

Once the space and staff were in place, Eunoia was ready to open its doors.

K. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
This accomplishment supports the first goal within JPHSA's strategic plan. The Eunoia Center is an integral program JPHSA offers within the scope of its array of fully integrated services, and thereby serves to help improve personal outcomes for service recipients and their families in support of JPHSA's Mission.

L. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes. As discussed above, the Living Room model is a promising practice. The use of peers to provide crisis respite services is an evidence-based practice. The model has proven to be effective in other states and is endorsed by the DOJ.

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

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

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

  Throughout Fiscal Year 2020-2021 JPHSA remained on target for its stated Strategic Plan Goals and Objectives. Strategies outlined in the Strategic Plan continued to be effective and were strengthened by a strong commitment to continuous Performance and Quality Improvement throughout every division and program within the agency, even while the agency was actively engaged in the COVID-19 pandemic response.

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

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

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

JPHSA achieved significant progress toward reaching this goal in Fiscal Year 2020-2021. As discussed at length above, JPHSA opened a new program, the Eunoia Center, to provide a new service within the Jefferson Parish crisis continuum. This program is set up to bill for services rendered in order to eventually become fully self-sustaining.

In general, JPHSA maintained its resources in a manner that allowed for the preservation of services even in the wake of the ongoing COVID-19 pandemic. This included providing increased telehealth services to ensure individuals continued to receive care safely from their homes, and implementing safety protocols at JPHSA locations for those individuals who needed to be seen in an office setting.

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

JPHSA made progress toward reaching this goal in Fiscal Year 2020-2021. Specifically, JPHSA was able to attract and hire well-qualified candidates despite the disturbances caused by a global pandemic.

Please note in particular:

- Throughout Fiscal Year 2020-2021, JPHSA used brand management as a recruitment tool.

- Throughout Fiscal Year 2020-2021, JPHSA continued to use online job postings for certain hard-to-fill positions beyond the State Civil Service website and its own website by recruiting on external websites including Indeed, LinkedIn, Facebook, and Handshake. Other recruitment efforts included advertising with

professional networks, such as the local Behavioral Health Taskforce, and collaborating with local colleges and universities.

- Throughout Fiscal Year 2020-2021, JPHSA's Executive Management Team monitored staff member retention rates and ensured all staff members received appropriate monitoring, supervision, and development through an ongoing audit assessing supervisor compliance with JPHSA's Staff Development & Supervision Guidelines.

- Throughout Fiscal Year 2020-2021, JPHSA continued to utilize an intensive first thirty-day orientation for new staff members as a tool to ensure up-front investment and engagement with JPHSA practices and policies.

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

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

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

  None.

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

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

  An updated Strategic Plan was developed for implementation on July 1, 2020. Fiscal Year 2020-2021 was the first year in which the updated Plan was operational. The Plan is due for its next update in Fiscal Year 2022-2023.

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

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

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

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

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

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

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

  Regularly scheduled Executive Management Team meetings are used as group supervision, as forums for discussion of progress on meeting/exceeding goals, and for collaborative development of corrective action and/or Performance and Quality

Improvement plans. The Executive Director holds the Executive Management Team accountable on both an individual and group basis for successful implementation of the JPHSA Strategic Plan, Annual Division Business Plans, and the Annual Performance and Quality Improvement Initiatives. The Executive Director focuses a significant portion of the Executive Management Team members' performance reviews on their contributions to the Strategic Plan and Performance and Quality Improvement Initiatives as well as on their degree of success in accomplishing their Annual Business Plan objectives.

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

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

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

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

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

A. Problem/Issue Description

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

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

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

With that said, the ongoing COVID-19 pandemic spurred operational adjustments during Fiscal Year 2020-2021, including remote service delivery, increased monitoring and adjusting of staffing, and implementation of additional safety precautions. Responding to these challenges required innovation and flexibility across all levels of the organization.

B. Corrective Actions

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

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

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

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

5. Do corrective actions carry a cost?

☐ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For

example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:

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

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

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

☒ **Internal audit**

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

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

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
JPHSA is audited on an annual basis through the Office of the Legislative Auditor. The Fiscal Year 2020-2021 audit is underway as of the time of this writing. The Louisiana Department of Health's Office of Behavioral Health (OBH) and Office for Citizens with Developmental Disabilities (OCDD) audit JPHSA as set forth in the Accountability Plan, i.e. ongoing data reporting, annual peer review, and annual on-site audit. The OCDD and OBH Fiscal Year 2020-2021 audits were conducted during the Fiscal Year, with JPHSA receiving no findings or recommendations. The peer review, which focused on clinical practices, was done with Metropolitan Human Services District and produced no findings or recommendations.

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

☐ **Policy, research, planning, and/or quality assurance functions by contract**
In Fiscal Year 2020-2021, JPHSA had **no** contracts for policy, research, planning, and/or quality assurance functions.

☒ **Program evaluation by in-house staff**
Program performance is monitored on an ongoing basis utilizing the JPHSA Strategic Plan, Operational Plan, Division-Specific Annual Business Plans, Annual PQI Initiatives, Staff Development & Supervision Guidelines, and position-specific expectations. All have clearly stated goals/objectives and performance targets and/or outcome measures. Additionally, the annual Maintenance of Accreditation report required by the Council on Accreditation helps ensure adherence to accreditation program and service standards through ongoing monitoring on the division level.

☐ **Program evaluation by contract**
In Fiscal Year 2020-2021, JPHSA had **no** contracts for program evaluation.

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

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

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

☒ **Benchmarking for Best Management Practices**
In Fiscal Year 2020-2021, JPHSA utilized Netsmart's myAvatar platform as its sole electronic health record for behavioral health, developmental disabilities, and primary care services, as well as data collection and analysis. Developmental Disabilities services data is obtained through the Office for Citizens with Developmental Disabilities software. Comparative studies are enabled through other Local Governing Entities reporting into the LaPAS

system as well as through benchmarking against national standards for evidence-based and best practices and through Uniform Data System reporting through the Health Resources Services Administration (HRSA) of the U.S. Department of Health and Human Services. JPHSA's Financial System, Microsoft Dynamics GP, is a highly sophisticated system that allows detailed budget reporting, enabling the measurement of performance against quarterly targets and annual goals as well as identification of trends.

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

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

☒ **Peer review**
The JPHSA Medical Director facilitates ongoing peer reviews among prescribers (physicians and advanced practice registered nurses) as a routine part of practice. Additionally, he leads comprehensive multi-disciplinary peer review in cases of a service recipient suicide or death not associated with a physical disease or chronic condition. JPHSA participates in the Office of Behavioral Health annual peer review with a sister Local Governing Entity. These reviews alternate focus on program and administrative functions. The peer review for Fiscal Year 2020-2021, with Metropolitan Human Services District, focused on clinical functions and practices. The Office of Behavioral Health and Office for Citizens with Developmental Disabilities also conduct annual on-site reviews with peers from other Local Governing Entities as participants.

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

☒ **Customer/stakeholder feedback**

JPHSA fields the U.S. Health Resources and Services Administration Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Telesage Quality of Care Survey within its Health Centers on an ongoing basis. JPHSA invites confidential feedback on its internet site and offers service recipients and their families the means of expressing their view of services received and/or other interactions with JPHSA. This feedback is received and processed by JPHSA's Quality Improvement Specialist, who ensures a response is provided to the individual who gave the feedback within prescribed timelines, and tracks data for use in developing internal Performance and Quality Improvement initiatives. JPHSA requires contractors delivering community-based behavioral health services to field satisfaction surveys with their service recipients and to share results with JPHSA. Staff members have access to confidential comment boxes in all break rooms and may also provide the staff-led committee, Esprit de Corps, with suggestions for improvement. The Esprit de Corps Chairperson has direct access to the Executive Director and Executive Management Team. The members of the Board of Directors, per the Policy Governance Model, actively engage in "community linkages" and report the outcomes of these community stakeholder interactions during each Board meeting. Additional feedback is obtained through active participation in the monthly Jefferson Parish Behavioral Health Task Force meetings and in the quarterly Regional Advisory Committee meetings for Behavioral Health and Developmental Disabilities. JPHSA also participates on the Jefferson Parish Children and Youth Planning Board. The Executive Director and the Chief Administrative Assistant make regular calls on local and state elected officials as well as community partners.

☐ Other (please specify):

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

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

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

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

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

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

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

Name: DanMinh Mui, General Counsel
Title: Division Director, Compliance & Performance Support
Agency & Program: Jefferson Parish Human Services Authority
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Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department:	**Louisiana Department of Health (LDH)** 09-301 Florida Parishes Human Services Authority
Department Head:	**Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Executive Director:	**Richard Kramer**

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

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

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

Accomplishment #1: Opening of new Bogalusa Behavioral Health Clinic

A. **What was achieved?**
A new behavioral health clinic was opened in Bogalusa to replace the inadequate temporary clinic that had been in use.

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

The Bogalusa area has some of the greatest needs in a catchment area, particularly with regard to the opioid epidemic, and the new clinic space allows us to serve the people of the area better with some room for added services planned for the future.

C. **Who benefits and how?**

The people of Washington parish who are in need of behavioral health services and their families.

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

Insurance proceeds from the destroyed old clinic will fund the lease for several years.

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

Yes, goal 1 of the strategic plan speaks to improving the quality of life of those the agency serves who have behavioral health conditions.

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

Possibly, in the sense that we chose to use the insurance proceeds to lease a new space rather than rebuild a clinic in a flood prone area that is likely to be damaged again.

Accomplishment #2: Continued to provide all behavioral health and developmental disabilities services throughout the pandemic

A. **What was achieved?**
The agency continued to provide services throughout the entire pandemic so that those that we serve could still have their needs met to maintain their health and/or recovery.

B. **Why is this success significant?**
The services FPHSA provides are critical healthcare services to vulnerable populations. The pandemic likely exacerbated many of their conditions. Continuation of services was critical regardless of obstacles.

C. **Who benefits and how?**
The people served by FPHSA and their families as well as the taxpayers of the state by preventing unnecessary hospitalizations and other negative outcomes.

D. **How was the accomplishment achieved?**
By employing a mix of virtual services as well as in person services using appropriate health and safety precautions when necessary.

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

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes, but I think it is a best practice that was already shared by many other state agencies also looking after the populations they serve.

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 agency's strategic goals, as outlined in the strategic plan developed in 2019, remain appropriate. Because of the ever changing landscape of provision of healthcare services how to best meet those goals is constantly changing but the goals themselves are the same. Numbers of clients served, outcome measures, quality measures, monitoring reports, accreditation, and developing partnerships in the community all indicate that significant progress continues to be made in this effort.

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

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

Improved allocation of resources through increased self-generated revenue and grant funding, reallocation of existing resources to direct them towards appropriate priorities,

increase community involvement, support of the governing board, and most importantly an engaged and innovative management team are responsible for this progress.

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

This progress is expected to continue to the extent that funding remains stable. The COVID-19 pandemic has negatively affected the agency's finances, and may possibly worsen the longer the pandemic continues. The potential for federal action to discontinue or alter Medicaid expansion could have serious funding implications as most of the people we serve are Medicaid recipients.

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

The ability to use data effectively has compromised by our current electronic health record; it is no longer sufficient for our purposes and we are in the process of replacing it.

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 lack of progress is due to the limitations of the current electronic health record. We have worked with them on improvements for some time, but have exhausted all avenues and will be changing records soon.

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

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

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

The strategic plan, as updated in 2019, is still relevant and appropriate. There are placing that we

are working to improve but all of that activity is consistent with the existing plan and would be normal performance improvement activities rather than departures from the existing strategy.

- **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.

  There are weekly leadership meetings, monthly management meetings, and quarterly forums across the agency to ensure that priorities and expectations are communicated clearly. Outcomes are reviewed at all levels to ensure that the plan is effective and outlier events are analyzed to ensure that causes can't be identified and corrected.

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

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

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

A. Problem/Issue Description

1. What is the nature of the problem or issue? *Recruiting and retaining staff continues to be a challenge and has been exacerbated by the pandemic.*

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) *The recruiting and retention has not, yet, prohibited progress towards the agency's goals but it does impact the degree to which progress can be made beyond the current level.*
3. What organizational unit in the department is experiencing the problem or issue? *Direct care positions in the behavioral health clinics and residential program are currently the most severely impacted.*

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) *Persons served must wait longer between appointments due to a limited number of providers. Longer waits between appointments may result in poorer outcomes and more potential for behavioral health crises is individuals whose symptoms are not managed appropriately.*

5. How long has the problem or issue existed?

6. What are the causes of the problem or issue? How do you know? *Disparities between compensation available by competing agencies is a key factor. Many candidates have been selected for and offered positions but turned them down due to rate of pay. Additionally, former staff have left employment to accept better paying jobs elsewhere.*
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? *Failure to resolve the problem will hinder the agency's ability to ultimate fulfill its mission and complete the strategic plan goals. Management is encouraged, though, by the recent compensation changes approved by the Department of Civil Service and hope to see a positive impact in the coming months. Additionally, the agreement by the legislature to stabilize the budget for the near future should positively impact recruiting and retention*.

B. Corrective Actions
   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?

A. Problem/Issue Description
1. What is the nature of the problem or issue? *Difficulty in accessing and using data from the electronic health record*
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) *Yes to the extent that it may take longer to identify trends or measure outcomes.*
3. What organizational unit in the department is experiencing the problem or issue? *All behavioral health programs*
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) *All internal and external customers are potentially impacted*
5. How long has the problem or issue existed? *The issues have been being addressed for several years with the vendor with some progress but it appears to have reached its limit.*
6. What are the causes of the problem or issue? How do you know? *The limitations of the electronic record itself. We have explored all options within the system and it is no longer sufficient for our purposes. It does not have the required billing or management functionality for the current operations or what we have planned for the future.*
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? *Lack of data makes it harder to understand what is working and what is not. It makes it harder to determine where the resources could be best used and where the priorities might be without having to go through labor intensive manual data collection processes. Additionally, the billing module does not provide reliable information and insurance denials are overstated and difficult to resolve.*

B. Corrective Actions

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

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

2. What corrective actions do you recommend to alleviate or resolve the problem or issue? *We are in the implementation phase of moving to a new EHR which should go live in early 2022.*

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? Yes 1 report
4. Are corrective actions underway? *Yes*
    a. If so:
        - What is the expected time frame for corrective actions to be implemented and improvements to occur? *First quarter of 2022 implementation is expected*
        - How much progress has been made and how much additional progress is needed? *Completion of the build out and implementation are currently underway.*
    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. There is already a cost for the current EHR. The new one is more expensive but not significantly more. The improvements in efficiency and collections should pay for the difference many times over.*
    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? *Yes*
    d. Will additional personnel or funds be required to implement the recommended actions? If so: *Not as of this time*
        - 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 and add comments to explain each methodology utilized. Some examples are included so you can edit as needed.

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

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

Civil Service, Office of Risk Management, LDH, Office of the Legislative Auditor and the Healthy Louisiana plans conduct audits and reviews of FPHSA's processes, procedures and services.

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

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

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

☒ **Benchmarking for Best Management Practices**

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

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

☒ Peer review
Peer reviews are conducted by neighboring LGEs once per year as required by the Substance Abuse Block Grant

☒ Accreditation review
Accreditation review completed by 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, including
    Name:

Title:
Agency & Program:
Telephone:
E-mail:

1. **Title of Report or Program Evaluation:**
   Treatment Independent Peer Review FFY 2021

2. Date completed:
   May 19, 2021

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   The purpose of IPR is to review the quality and appropriateness of treatment services for all providers who receive SAPT Block Grant funding. The goal is to continually encourage quality improvement and enhance treatment outcomes int the LDH/OBH funded substance abuse services delivery system.

4. Methodology used for analysis or evaluation:
   LGE's are paired for reciprocal reviews. The Independent Peer Review Treatment IP Form was used in the 2021 review to assist the provider to identify program strengths and challenges. Performed by multiple disciplines of practicing professionals in the field of alcohol and substance abuse treatment and is based on professional trust and understanding. Is an educational process for both the professionals being reviewed and the professionals conducting the review. As such, the process serves to stimulate professional growth and strengthen the entire profession; and provides a supportive environment where professionals identify program strengths and challenges and provides guidance and advice for improving the quality of care. Is not strictly a monitoring, licensing, or auditing process. It is a method to continuously improve quality, performance, and provide credibility within treatment services to alcohol and drug abusers with the State System.

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

6. Major Findings and Conclusions:
   South Central Louisiana Human Services Authority was FPHSA's peer reviewer. There were no findings or recommendations. One comment documented the presence of treatment plans that were unsigned and marked that they were completed with the person served.

7. Major Recommendations:
   Not Applicable.

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

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

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

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

2. Date completed:
   3.15.21

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

6. Major Findings and Conclusions:
   FPHSA was rated 99.1% compliance.

7. Major Recommendations:
   None.

8. Action taken in response to the report or evaluation:
   There were no recommendations/findings that required corrective action.

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

10. Contact person for more information:
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    Title: Executive Director
    Agency & Program: FPHSA
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    E-mail: Richard.Kramer@fphsa.org

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

2. Date completed:
   12/17/2020 (12/14/20 – 12/17/20)

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 guided by the LGE Monitoring Workbook Tool.

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

6. Major Findings and Conclusions:
   A single finding was made at the ADU unit of the residential facility, at the Bogalusa Behavioral Health Clinic and at the Rosenblum Behavioral Health Clinic. The finding was related to failure to use a custom button in the EHR to document a thorough assessment for women with dependent children that included the facilitation of linkages, as requested, to other community/medical/educational services for women with dependent children.

7. Major Recommendations:
   NA

8. Action taken in response to the report or evaluation:
   Supervisory plan was put in place that required supervisors to monitor clinical staff and their consistent use of the custom button to complete the assessment and refer accordingly.

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

10. Contact person for more information:
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    Title: Executive Director
    Agency & Program: FPHSA
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    E-mail: Richard.Kramer@fphsa.org

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

2. Date completed:
   6/10/2021 (5/18/21-6/10/21 7 sites)

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 guided by the LGE Monitoring Workbook Tool.

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

6. Major Findings and Conclusions:
   MBHC had one case finding related to a missed appointment during which tobacco use, TB, and HIV testing and counseling should have been offered as part of a comprehensive nursing assessment. The person served continued in treatment and assessment was not completed. All other sites reported exceptional ratings.

7. Major Recommendations:
   None noted.

8. Action taken in response to the report or evaluation:
   FPHSA reviewed all reports with leadership and staff and a corrective action plan (for implementation region wide) was implemented immediately. This related to the immediate re-scheduling of all persons who miss nursing assessment appointments. In addition, the person served was scheduled to return to complete the assessment.

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

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

1. **Title of Report or Program Evaluation:**
   Flexible Family Fund Q1 -Q4

2. Date completed:
   Q1 11/2/20; Q2 1/29/21; Q3 4/29/21; Q4 7/27/21

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   An internal performance review of the administration of Flexible Family Funds (FFF) program for compliance with criteria established in the promulgated rule and published in the Louisiana Register (LAC 48:1 Chapter 161) and the FFF manual. The question, "Was all documentation present to make eligibility determination present?" is used for the AP question #3.

4. Methodology used for analysis or evaluation:
   See FFF Manual Appendix B Forms 9.a, 9.b, and 9.c. The internal performance review consists of a quarterly review of the following:
   a) No less than 10% of the total number of currently active FFF records (an annual total of 40%) with representation of every practitioner;
   b) A random sampling of at least one record for each year of the LGE's Service Request List; and
   c) A random sampling of one of the records closed per quarter by that LGE.

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

6. Major Findings and Conclusions:
   In compliance.

7. Major Recommendations:
   Q1 – Q4 NA

8. Action taken in response to the report or evaluation:
   Q1 – Q4 NA

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

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

1. **Title of Report or Program Evaluation:**
   Individual and Family Support Q1 – Q4

2. Date completed:
   Q1- 11/2/20; Q2- 1/29/21; Q3- 4/29/21; Q4- 7/27/21

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

4. Methodology used for analysis or evaluation:
   See IFS Manual Appendix A, Form 6. The internal performance review will consist of a quarterly review of at least 10% of the total number of IFS Plans of Support.

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

6. Major Findings and Conclusions:
   In compliance.

7. Major Recommendations:
   NA Q1 – Q4

8. Action taken in response to the report or evaluation:
   NA Q1 – Q4

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

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

1. Title of Report or Program Evaluation:
   LaPAS Q1 – Q4

2. Date completed:
   Q1- 10/22/20; Q2- 1/20/21; Q3- 4/19/21; Q4- 7/27/21

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 service 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)
   No cost.

6. Major Findings and Conclusions:
   Q1 – The FFF Q4 target is lower than the FY21 performance standard due to fewer individuals aging out of the FFF services, resulting in fewer individuals receiving services.
   Q2 – Due to the COVID-19 pandemic, individuals have received stimulus checks and reprieve from eviction. This resulted in fewer Individual and Family Support requests. Individuals are also reluctant to expose their families to outsiders who may be a COVID-19 carrier. This was evidenced by a decrease in the number of individuals receiving IFS crisis and non-crisis services
   Q3 – Fewer individuals received services than anticipated due to the COVID-19 pandemic, day programs being closed, service providers functioning at a limited capacity, families being reluctant to allow outsiders into their home and Federal assistance programs providing resources. This resulted in fewer new individuals receiving services as evidenced by the decrease in IFS services and IFS crisis services.
   Q4 – The continuation of the COVID-19 pandemic impacted service requests. Federal assistance programs are providing services usually funded by FPHSA. The concern of being exposed to COVID-19 and limited capacity at Day Habilitation programs resulted in a decrease in IFS requests. More individuals received crisis services than anticipated. With children staying home during the COVID-19 panic, unemployment increased and thus resulted in more crisis requests. Due to the severity of the child's disability, some parents found working was incompatible with caring for their child and remained unemployed. OAAS referred more PASRR requests than anticipated.

7. Major Recommendations:
   Q1 Change the FFF Q4 target
   Q2 No changes recommended
   Q3 Change the unduplicated grand total and IFS targets'
   Q4 N/A

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

Q1 Targets were decreased
Q2 N/A
Q3 The Q4 targets were changed to reflect the decrease in IFS requests
Q4 N/A

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

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

1. Title of Report or Program Evaluation:
   Level of Care, Plan of Care Q1 - Q4

2. Date completed:
   Q1- 9/30/21; Q2- 12/30/20; Q3- 3/31/21; Q4- 6/30/21

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   The LOC POC Quarterly Review is a method for obtaining information for CMIS related to the waiver assurance requirements. LOC POC reviews a percentage of waiver plans, initial and annual plans that were approved in the previous quarter. A random sample of names is selected by the OCDD Data System LOC POC Application.

4. Methodology used for analysis or evaluation:
   Data is entered into the OCDD Data System LOC POC Application following the quality review form and Appendix B interpretive guidelines.

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

6. Major Findings and Conclusions:
   Q1 – Performance Indicators were met.

   Q2 - Performance Indicators were met.

   Q3 - Performance Indicator #11, Percentage of waiver participants whose Plan of Care (POC) meets their needs, was met Monitoring includes waiver plans approved by support coordination agencies (SCAs) along with those approved by DDS waiver staff. Four out of five noncompliant POCs were approved by the SCAs.
   Q4 – Performance indicators were met.

7. Major Recommendations:
   Q1 - N/A

   Q2 – N/A

   Q3 – Suggest support coordination agencies have a corrective action plan in place for PI #11. A CAP is not required by FPHSA.

   Q4 – N/A

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

   Q2 - N/A

   Q3 – Suggest SCA have a CAP for PI #11.

   Q4 - N/A

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

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

1. Title of Report or Program Evaluation:
   Waiver Supervisor Monitoring Checklist Quarters 1-4

2. Date completed:
   Q1 – 11/2/20, Q2 – 1/29/21, Q3 – 4/29/21, Q4 – 7/27/21

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   To assure adherence to the memorandum of understanding in the following areas: Allocated waiver personnel, waiver records maintained as required, waiver cases in compliance with regulations, rules and policies, cases comply with appeal/fair hearing requirements. The data is a 25% sample of records monitored for LOC POC.

4. Methodology used for analysis or evaluation:
   See Appendix J OI#:F-7

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

6. Major Findings and Conclusions:
   In compliance.

7. Major Recommendations:
Q1 – Q4 N/A

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

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

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

1. **Title of Report or Program Evaluation:**
Pre-Admission Screening and Resident Review (PASRR) Quarterly Review

2. Date completed:
Q1 11/2/20; Q2 1/29/21; Q3 4/29/21; Q4 7/27/21

3. Subject or purpose and reason for initiation of the analysis or evaluation:
An internal performance review of PASRR adult nursing home admissions to ensure compliance with the Operational Instruction and appropriate placement. The four Case Record Review questions from the monitoring form are used for the Accountability Plan.

4. Methodology used for analysis or evaluation:
See PASRR O.I. #D-10, Appendix C-3. The internal performance review will consist of a quarterly review of 50% of PASRR referrals who were new admissions to the nursing home.

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

6. Major Findings and Conclusions:
In compliance.

7. Major Recommendations:
Q1 – Q4 NA

8. Action taken in response to the report or evaluation:
Q1 – Q4 NA

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

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

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department:	**Louisiana Department of Health (LDH)** 09-302 Capital Area Human Services District
Department Head:	**Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Executive Director:	**Jan Laughinghouse, Ph.D., LCSW-BACS, LAC**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?
For each accomplishment, please discuss and explain each item below.

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:"Let's Talk" Opioid Workshops

A. **What was achieved?**
Capital Area Human Services District (CAHSD) sponsored a "Let's Talk" series that focused on opioids. The four workshops held on April 8th, April 15th, April 18th and April 29th had a combined attended of 147 individuals and a combined Facebook reach of 1,140 individuals.

B. **Why is this success significant?**
Because the agency provided education on opioid misuse prevention and treatment during a time of increasing misuse of opioids and a record number of opioid overdose

deaths.

C. **Who benefits and how?**
Beneficiaries include community stakeholders, those at high-risk for opioid misuse and overdose and family and friends of high-risk individuals.

D. **How was the accomplishment achieved?**
Three of the workshops were held virtually and the adolescent workshop, on April 18th, was held in person. The topics included: Opioid Addiction Recovery and Family Support, How To Protect Your Loved Ones, The Truth About Opioids, and Mind and Body Wellness to Prevent Opioid Misuse. The workshops were livestreamed on social media and recorded and posted on Facebook and YouTube for viewing by those unable to attend.

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: Virtual Faith-Based Forum: Hope & Healing in Response to the Opioid Crisis

A. **What was achieved?**
A virtual forum which included a panel discussion with subject matter experts and community advocates, including EBR Parish Coroner, Dr. Beau Clark; Dr. Louis Cataldie, addictionologist; Tonja Myles, certified peer support specialist; Dr. Leslie Faulkner, community outreach coordinator, DEA, New Orleans; Trudy Bell-Wickham, opioid prevention outreach coordinator, LDH/OPH and Daria Vinning-Asberry, the mother of a woman with an opioid use disorder. Eighty-four people participated.

B. **Why is this success significant?**
The forum was marketed to churches, communities of faith, and their parishioners because people with opioid use disorders often present to churches and faith-based organizations for help. This forum allowed the participants to hear strategies for providing support, assistance, and referral to treatment. Participants we also given a link to access a digital toolkit that can be personalized and used in their respective congregations to provide resources and referral for opioid use disorders.

C. **Who benefits and how?**
Community stakeholders, communities of faith, faith-based organizations, individuals with diagnosed opioid use disorders or those at a high risk and their families and friends.

D. **How was the accomplishment achieved?**
A press release, radio ads, and distribution of the event flier via CAHSD contacts was used to advertise the event. There were a total of 209 radio spots run on Cumulus Gospel station, WXOF-AM, featuring certified peer support specialists, Tonja Myles and Ivan Toldson, during the month of January 2021, reaching a total of 26,800 people. Distribution of the flier was through the CAHSD MailChimp system reaching 450 CAHSD staff and 851 external subscribers with an average open rate of 21%. The flier ad was also included in the CAHSD Connects monthly newsletter.

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: CAHSD Launches Podcast

A. **What was achieved?**
Capital Area Human Services District (CAHSD) launched a podcast to share information on mental health, behavioral health, prevention, and developmental disabilities.

B. **Why is this success significant?**
By using social media, CAHSD is expanding the reach of our services beyond the brick and mortar clinics.

C. **Who benefits and how?**
Community stakeholders, individuals seeking information on topics related to mental health, behavioral health, prevention, and developmental disabilities and their friends and loved ones.

D. **How was the accomplishment achieved?**
Arranging subject matter experts to discuss topics of interest and posting the recorded discussions to social media. Topics discussed to date include: problem gambling, sexual health (HIV/STIs), trauma, and physical health and wellness.

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: Substance Use Campaigns

A. **What was achieved?**
Capital Area Human Services District (CAHSD) launched campaigns on substance misuse that used both social media and traditional media messaging about prevention and treatment resources.

B. **Why is this success significant?**
The topics were responsive to the environment and chosen for relevance based on data regarding the uptick in opioid and stimulant use during the pandemic and the timelessness of messaging (e.g. problem gambling in March, during Problem Gambling Awareness Month and underage drinking during prom and spring break season). Based on analytics, the ads on vaping, stimulants, and opioids had a combined reach of 125,842 on Facebook, 111,763 on Instagram, and 239,230 on Pinterest. The social media ads produced 2, 875 clicks on the CAHSD website. Pandora and Spotify analytics indicated that these ads had a combined reach of 355, 177 and produced 1,000 clicks on the CAHSD website.

C. **Who benefits and how?**
Community stakeholders, individuals with diagnosed substance use disorders or those at a high risk and their families and friends.

D. **How was the accomplishment achieved?**
Content on the various subjects was created and shared either as commercials on Channel 33/Fox 44 (problem gambling and underage drinking) or posted to social media outlets Facebook, Instagram, Pinterest, YouTube, Spotify and Pandora.

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: Vaccination Clinic and Video

A. **What was achieved?**
Capital Area Human Services District (CAHSD) partnered with Genoa Pharmacy to have an on-site COVID-19 vaccination clinic for employees. CAHSD, executive director, Jan Laughinghouse was filmed receiving her first injection of the Moderna vaccine on 1/20/2021 and posted the video to social media.

B. **Why is this success significant?**
One hundred fifty CAHSD employees were vaccinated at the on-site clinic. Many of them signed up for the injections after viewing the video. The vaccination video was viewed over 20,300 times on Facebook, shared on the LDH website, and posted on the *Keeping Calm Through COVID* website.

C. **Who benefits and how?**
Community stakeholders and individuals with vaccine hesitancy.

D. **How was the accomplishment achieved?**
The on-site vaccination clinic was achieved as a collaboration of the CAHSD director of training and emergency preparedness and the Genoa on-site pharmacy. The CAHSD executive director received one of the first injections and filmed it to share the experience with employees and other vaccine hesitant individuals.

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

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

Accomplishment #6: Medication Safety for Seniors: Meals On Wheels campaign with EBR Council On Aging

A. **What was achieved?**
Capital Area Human Services District (CAHSD) and The Office of Public Health partnered together in a Safe Medication Campaign. This campaign consisted of CAHSD working with East Baton Rouge Council on Aging in providing their seniors with information on how to keep their medications safe.

B. **Why is this success significant?**
CAHSD and EBR Council on Aging assembled 4,500 bags that contained the CAHSD *Safe Medication* brochure, a Detera medication disposal bag, and an information magnet with both CAHS and Office of Public Health information.

C. **Who benefits and how?**
Individuals served by EBR Council on Aging and Meals on Wheels benefit from the information provided that will decrease the likelihood of opioid misuse and diversion of opioids to their friends or family members; they also benefit from information on safely managing any opioid they are prescribed.

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

CAHSD and EBR Council on Aging partnered to assemble the bags and disseminate them through their COA's Meals on Wheels Program. The campaign was advertised in Polished magazine and on the Lotus Zone radio show.

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

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

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

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

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

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

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

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

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.

   N/A
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?

The CAHSD two-year strategic plan has been revised to incorporate strategies and recommendations resulting from the 10 work groups that were formed following the 26-session listening tour in April 2021. The work groups address issues under the rubrics of Clinic operations/scheduling, Communications, Employee Relations Committee, Client Engagement and Retention, Intake, Security, Staffing/Re-org, Standard Operating Procedures (Policy/Legal), Technology, and Training. The suggested strategies will align operations, policies, processes, and procedures with the organization's mission and vision.

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

  The Executive Management Team, under the direction of the Executive Director, manages the operational planning process. 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?**
   Impact of COVID-19 on clinic operations and service provision

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

No.

3. **What organizational unit in the department is experiencing the problem or issue?** The entire District is affected.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   The pandemic affects the staff, the individuals served, and community stakeholders.

5. **How long has the problem or issue existed?**
   March 2020

6. **What are the causes of the problem or issue? How do you know?**
   The cause of the problem is a global pandemic. We know about the impact of the pandemic because of the information provided by WHO, the CDC, LDH, GOHSEP, MOHSEP, and other state and local health officials and governmental entities.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   Impacts include poor morale among staff, unsafe working conditions, community spread of a deadly virus, and unmet behavioral health needs in our 7-parish 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.

   Implementation of district-wide COVID-19 Mitigation Strategies began in March 2020 and remain in place.

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

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

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

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

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

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

5. Do corrective actions carry a cost?

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

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

A. Check all that apply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    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, 2020 through June 30, 2021.

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

4. **Methodology used for analysis or evaluation:**
   LaPAS: 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):**
   LaPAS: Cost uncalculated.

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

7. **Major Recommendations:**
   LaPAS: None.

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

9. **Availability (hard copy, electronic file, website):**
   https://www.doa.la.gov/Pages/opb/lapas/login.aspx

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

    Name: Karen Thomas
    Title: Accountant Administrator
    Agency & Program: Capital Area Human Services District
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1. **Title of Report or Program Evaluation:**
   Louisiana Legislative Auditor (LLA) Procedural Engagement

2. **Date completed:**
   June 7, 2021 (covering the period from July 1, 2019 through June 7, 2021)

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

4. **Methodology used for analysis or evaluation:**
   From the LLA procedural engagement exit 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 revenue billings and collections, federal grant revenues and expenditures, payroll and personnel, moving expenditures, and movable property; and reviewed the selection of the new electronic health records system.

   - 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.

   - 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):**
   $51,271.00

6. **Major Findings and Conclusions:**
   Capital Area Human Services District (CAHSD) did not ensure the purchase of its new Electronic Health Record system was in accordance with state bid law and agency policy.

7. **Major Recommendations:**
   None.

8. **Action taken in response to the report or evaluation:**
   Corrective action plan submitted: internal agency policy has been revised and all executive-management level employees and employees with purchasing responsibilities will be trained on the new policy to ensure that this type of failure does not recur.

9. **Availability (hard copy, electronic file, website):**
   https://lla.la.gov/go.nsf/get?OpenAgent&arlkey=80210036APPP-C3ZML4
   https://lla.la.gov/go.nsf/getSummary?OpenAgent&arlkey=80210036APPP-C3ZML4

10. **Contact person for more information:**
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    Name: Karen Thomas
    Title: Accountant Administrator
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    Telephone: (225) 922-0004
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Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department:	**Louisiana Department of Health (LDH)** 09-303 Developmental Disabilities Council
Department Head:	**Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Executive Director:	**Courtney Ryland (8/2020 - 6/30/21)** **Amy Deaville (5/17/21 – present)**

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

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

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

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

A. **What was achieved?**
The Council provided leadership in advocacy, capacity building and systemic change activities that contributed to increased awareness of the need for community-based services for individuals with developmental disabilities and the impact of educational policies and practices on students with disabilities.

Through the Council's technical assistance provided to the grassroots Louisiana Council's Advocacy Network (LaCAN), numerous policies were changed to improve and/or increase community services. Significant policy and practice changes influenced by LaCAN and Council advocacy related to community-based services included: successfully advocating for an additional $500,000 for Families Helping Families Resource Centers and increasing rates in DD waivers with language stating that direct service professionals should receive increased wages, pending rule making and auditing (Act 119); and successfully advocating for Act 450 which requires the state Medicaid program to provide comprehensive dental care for all people 21 years old and older that are enrolled in any Medicaid waiver program for persons with developmental or intellectual disabilities.

B. **Why is this success significant?**
Families Helping Families Resource Centers provide information and referrals, educational programs, training and peer to peer support to families of persons with developmental disabilities. They had not received an increase in rates since 2003.

There is shortage of Direct Support Professionals in Louisiana due to low provider rates and subsequent low wages. The increase of rates will ease the burdens of individuals' inability to find and keep staff and providers' inability to continue to provide quality services.

Comprehensive dental care is significant because dental procedures can be costly and intricate. Medicaid coverage of this will help to lift a significant burden on individuals and families that have had to cover those costs or elect not to have dental needs taken care of due to the cost.

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

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

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

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

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

Accomplishment #2: Capacity Building through Training and Technical Assistance

A. **What was achieved?**

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

Due to the widely received success from the previous year, six more workshops on sexuality and relationships were conducted to provide people with developmental disabilities and their family members with information on recognizing and handling sexual abuse and exploitation.

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

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

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

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

C. **Who benefits and how?**

First and foremost, people with developmental disabilities will benefit from the improved quality of services delivered, reduced staff turnover, better health outcomes,

and improved employment outcomes.

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

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

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

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

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

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

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

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

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

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

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

following for each:

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

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

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

This progress is due to the Council having developed and supported large grassroots advocacy networks and family support agencies over the past thirty years. It is expected that there will continue to be an increase in the influence the Council, self-advocates and family members of individuals with developmental disabilities have on decisions by policy makers. The Council's capacity to educate the general public and policy makers about needed changes to existing policies and/or the impact of pending decisions is well established.

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

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

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

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

The Coronavirus global pandemic prevented a few of the Council's in-person activities/programs from being fully conducted or implemented. Where appropriate and when possible, virtual activities were conducted; however, the cessation of certain activities/programs impeded expected outcomes from being achieved for those initiatives. The Council is closely monitoring the COVID-19 response (particularly due to the increased susceptibility of individuals with developmental disabilities experiencing health complications caused by the virus) and has not allowed in-person activities to be conducted since March 2020. The Council's contractual activities for 2021 were required to provide contingences which allow for opportunities for virtual access until Louisiana is no longer under a governor-declared State of Emergency in response to COVID-19.

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

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

The Council just completed the first year of action planning for its five-year plan (2022 - 2026). Each activity is reviewed for performance outcomes and adjustments are made in response to feedback and outcome data.

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

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

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

members.

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

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

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

There are no 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?

All Council activities are dependent on federal and state appropriations. The Council consistently takes all actions possible to ensure continuation of allocations. One significant issue is the economy in general and Louisiana's capacity to maintain the contributions to supporting necessary programs in the future.

B. Corrective Actions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

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

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

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: Enhanced Telemedicine Service Delivery

A. **What was achieved?**

MHSD continuously seeks to identify and implement approaches that increase access to care for individuals needing mental health or addictive disorders services. During 2019, MHSD elected to implement Telemedicine as a service delivery modality. Telemedicine is the remote diagnosis and treatment of persons by means of telecommunications technology. The decision to build the technology infrastructure needed and to provide Telemedicine in 2019 positioned MHSD to be able to rapidly respond to the COVID-19 pandemic by preventing a disruption in services for person served.

In 2020-2021, MHSD enhanced its Telemedicine service delivery. The MHSD IT Division adopted and implemented a new Telemedicine software. The IT Division was able to identify a user friendly, HIPPA compliant video platform that allowed persons served and providers to easily connect without having to download special applications. Secondly, MHSD began offering new virtual registration/intake options. Lastly, 4 of the 5 MHSD clinics were equipped with video monitors that allowed persons served who do not have access to computers, smartphones or digitally illiterate to have virtual access to providers who are at the clinic, at another clinic or working remotely.

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

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

C. **Who benefits and how?**

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

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

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

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

Yes.

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

Yes.

Accomplishment #2: Expanded use of MHSD Dashboards

A. **What was achieved?**

The continued development of new MHSD data dashboards. Performance dashboards were created for each MHSD division. Additionally, divisional and staff Key Performance Indicators (KPI's) were developed to support productivity reporting.

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

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

C. **Who benefits and how?**

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

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

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

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

Yes.

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

Yes.

Accomplishment #3: Continued Refinement of Recovery Oriented System of Care (ROSC)

A. **What was achieved?**

In FY20-21, during a global pandemic, MHSD managed to continue ROSC efforts in Orleans, Plaquemines and St. Bernard by retaining and gaining interested community

members and providers.

During the third quarter, those relationships transitioned into the development of the ROSC steering committee. This collaborative group consist of behavioral health providers, individuals with lived experience, clinicians, and executive leadership from various agencies.

The purpose of this group is to increase knowledge and understanding of recovery-oriented systems and its benefits. MHSD plans to expand these efforts by educating and training ROSC steering committee members, which will ultimately reach their broader communities and help us better serve persons with mental health and substance use challenges.

A highlight this year was MHSD leadership deciding to train interested members becoming Mental Health First Aid (MHFA) instructors. We anticipate members completing this training in September 2021.

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

This is significant because now we are able to extend of ROSC efforts by leveraging ROSC steering committee members individual networks.

C. **Who benefits and how?**

A ROSC 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

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

Yes.

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

Yes.

<u>Accomplishment #4: MHSD Grant Activity</u>

A. **What was achieved?**

Despite the COVID-19 pandemic, MHSD continued its grant activity with outreach efforts in FY20-21. The status of grant activity in FY20 is provided below:

- MHSD Community R.E.A.C.H Project. Funded by a Baptist Community Ministries (BCM) Transom Grant, this project is focused on educational outreach activities by teams of Peer Support Specialists (PSS). It is designed to educate the larger community about the supports needed for persons in recovery from mental illness and substance use disorders. This project continued to focus on the Beauty/Barbershop and Faith-Based community in efforts to increase awareness of behavioral health issues and resources available within the Tri-Parish area. MHSD was awarded funding for another year of services through 2021.

  Due to the COVID pandemic, outreach team implemented alternative methods in which to continue community outreach (phone calls/emails, mail outs, and virtual events). The team hosted trainings for the community: Mental Health First Aid, Narcan & Opioids, and Clergy trainings. The team continues to be staffed with a Crisis Counselor and Peer Support Specialist. The Crisis Counselor continues to focus on providing brief individual counseling (both in-person or via telephone) within the community in addition to making community referrals and providing education (grief/loss, coping, and stress management). The Peer Support Specialist continues to focus on providing individual peer support to individuals within the community suffering from a behavioral health issue and assisted them in linkages to MHSD for services. The Peer Support Specialist also co-facilitates peer support groups for persons served receiving services at MHSD. Both staff members continue to also provide presentations within the community at local businesses in effort to educate owners on what behavioral health is and services are available at MHSD.

- MHSD Faith Partners Initiative. Funded by a Baptist Community Ministries (BCM) Strategic Grant, this project is designed to provide leadership, training, educational materials, and consultation to clergy and congregational team ministries in the tri-parish area. Through a facilitated process, the faith community can be equipped to recognize mental illness and substance use disorders and link congregation members to professional services for long-term recovery outcomes. This grant was successfully completed and ended September 2019. However, MHSD continues its efforts to provide support/guidance to the faith-based community as it relates to behavioral health issues.

- COAP (Comprehensive Opioid Abuse Site-based Program) Grant. MHSD serves as the sub-recipient of the US Department of Justice (DOJ) and Louisiana Office of Behavioral Health (OBH) grant to identify and engage individuals who use illicit or prescription opioids and have been incarcerated. The grant utilizes peers to go into the correctional setting to conduct peer support groups with these individuals. The ultimate goal of this funded activity is to provide transitional linkage to community-based service upon release, to enhance their recovery efforts and to reduce recidivism. In FY20, Peer Support

Specialists continued to provide support services and MHSD linkage referrals to those individuals recently released from jail as well as those persons served who are on Probation/Parole.

Due to the COVID pandemic, grant staff was not authorized to physically enter the jail or the probation/parole office. The staff instead was able to organize a pre-paid telephone line in which the incarcerated individuals could utilize on a weekly basis to continue individual sessions with the Peer Support Specialists. The grant successfully collaborated with the jail and was able to mail recovery books and educational materials to grant participants in efforts to keep up recovery engagement. Grant staff continued to maintain telephone weekly telephone contact with those individuals recently released from jail , in addition to providing community referrals and linkage to services at MHSD as needed. As of mid-June 2021, the grant staff was approved to return physically entering the jail which allows staff to resume in-person individual sessions and educational groups.

- LaSOR (Louisiana State Opioid Response) Grant 1.0 and 2.0. This grant provides outreach and prevention activity to increase public awareness and education for prevention and treatment for Opioid Use Disorder (OUD). The grant also supplements the costs for MAT Prescribers. This grant continues to provide prevention education and Narcan distribution via in-person community events and/or virtual events due to COVID-19 Pandemic limitations. The grant also continues to provide MAT to eligible persons served via the OBOT (Office Based Opioid Treatment) program. The grant's outreach team continues to successfully partner with community agencies as it relates to referral linkage for individuals. This grant also is staffed with 3 crisis counselors to focus on providing brief individual counseling (both in-person or via telephone) within the community in addition to making community referrals and providing education (grief/loss, coping, and stress management). The grant facilitated a prevention curriculum for high school students via Generation Rx to educate and promote medication safety and prescription drug misuse. MHSD has developed an IOP (Intensive Outpatient Program) which targets those individuals in need of increased substance abuse treatment via individual and/or group therapy, with an emphasis on opioid and stimulant use. The grant also continues to provide medication storage (medication lock bags and prescription bottle timer caps) and safe disposal items (deterra bags) as a form of prevention.

- COVID-19 Crisis Counseling Regular Services Program. The MHSD Behavioral Health Emergency Response Team (BHERT) is our equivalent of the FEMA Crisis Counseling Program and the State of Louisiana's Louisiana Spirit CCP. This model is a non-clinical approach that provides behavioral health support, stress management and resource linkage to those impacted by the COVID-19 pandemic. Those impacted include but is not limited to the General Public, First Responders, Children, the Elderly and staff of MHSD.

The BHERT Model supports short-term interventions that involve the following counseling goals:

1. Assisting impacted individuals in understanding their current reactions
2. Mitigating stress
3. Reviewing disaster recovery options
4. Promoting the use or development of coping strategies
5. Providing emotional support; and
6. Encouraging linkages with other individuals and agencies who may help individuals in their recovery process (recover to their pre-disaster level of functioning). (Fema.gov)

To achieve this mission, BHERT adopts the following key principals of the CCP:

- Strengths Based-Crisis services promote resilience, empowerment, and recovery.
- Anonymous- Crisis counselors do not classify, label, or diagnose people; no records or case files are kept.
- Outreach Oriented- Crisis counselors deliver services in the communities rather than wait for survivors to seek their assistance. This will be implemented with the use of non -traditional outreach methods, such as media, telehealth and marketing strategies.
- Conducted in Nontraditional Settings Crisis counselors make contact in homes and communities, not in clinical or office settings.
- Designed to Strengthen Existing Community Support Systems- The crisis team supplements but does not supplant or replace existing community systems.

The MHSD BHERT team is comprised of a diverse group of individuals with previous emergency preparedness counseling experience. These individuals are under the direct supervision of Metropolitan Human Services District. Counseling services include face-to-face services and/or tele-health virtual services, depending on what is in the best interest of service needs. Positions for BHERT team members include Crisis Counselors, Clinical Coordinator, Operations Coordinator, Resource Linkage Coordinators, and Administrative Assistant. The BHERT utilizes MHSD's Resource Coordination unit for necessary resource referrals. For those individuals that may need services beyond the scope of the CCP, the BHERT relies on the skills of the Clinical Coordinator to make the appropriate recommendation for additional behavioral health services or assessments.

Programmatic Services:

The MHSD Behavioral Health Emergency Response Team adheres to the guidelines set forth by the Center Disease Control and the State of Louisiana to provide services to individuals impacted by the COVID-19 pandemic. With the aid of mass media, the team educates individuals on common reactions to disasters, tips for stress management and grief and loss. The messaging is

consistent with the key principals of the CCP. Due to the social distancing mandate, telecommunications are used in place of face-to-face interaction. BHERT integrates the MHSD crisis line to filter calls of impacted individuals to the BHERT crisis counselors. The BHERT utilizes MHSD's Resource Coordination unit for necessary resource referrals. For those individuals that may need services beyond the scope of the CCP, the BHERT relies on the skills of the Clinical Coordinator to make the appropriate recommendation for additional behavioral health services or assessments.
Services provided under this model:

- Individual and group crisis counseling
- Basic supportive or educational contact
- Community networking and support
- Assessments, referrals, and resources
- Development and distribution of educational materials
- Media and public service announcements.

- MAT PDOA Grant. MHSD served as the sub-recipient of the Substance Abuse & Mental Health Services Agency (SAMHSA) Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) Grant, awarded to the Louisiana Department of Health's Office of Behavioral Health. MHSD implemented and successfully completed the third and final year of this grant that addressed access to treatment, MAT services and coordination of care between providers for persons with Opioid Use Disorders. The grant ended October 2020.

- State Targeted Response (STR) Grant. This grant was SAMSHA funded with the intent of addressing the epidemic use of Opioids, which has resulted in record numbers of deaths in Louisiana. The emphasis of the grant was prevention education for two major targeted groups, school-based sports programs and dental offices, areas at highest risk for first time exposure to opioids. Additionally, the grant supported Naloxone kit distribution and associated trainings. This grant was successfully completed and ended in April 2020. However, MHSD continues its effort to provide Narcan education and distribution to persons served and first responders during the COVID-19 Pandemic.

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 #5: MHSD Professional Development Supervision Retreat

A. **What was achieved?**

The MHSD Executive Director and MHSD Director of Quality and Data Management (QDM) facilitated a 6-session training (i.e., a total of 18 professional development hours) on the topics of basic principles and standards of supervision, utilizing data as an approach to management, and using key performance indicators (KPI) to supervise staff performance. Attendees were MHSD divisional directors and supervisors. Over the course of this training division directors developed KPIs or their division and staff.

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

Effective workforce development and management promote engagement and organizational sustainability and fosters an environment that promotes the provision of services that center on enhancing the lives of persons served.

C. **Who benefits and how?**

MHSD's workforce and the persons they serve. There is increased accountability in supervision and management. Staff benefit by being evaluated more objectively. Supervisors and leadership benefit because data can inform decisions, policies, and procedures. Additionally, persons served benefit because information from KPIs is used to improve the quality of services and strengthening programs.

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

The 6-session training was mandatory for all MHSD division directors and supervisors. Slide presentations were presented at each session along with breakout interactive work groups. Homework was assigned after each session.

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: Satisfaction Survey through CAARS within 24 Hours after Appointments and its use in provider performance management reporting

A. **What was achieved?**
MHSD identified and implemented an automated appointment reminder software that notifies persons served of their upcoming appointments by call, email and text messaging. This same system is used to support the virtual intake/registration process and is used to electronically disseminate the MHSD Satisfaction Surveys following each kept service appointment.

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

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

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

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

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

Accomplishment #7: Title of significant accomplishment: Satisfaction Survey through CAARS within 24 Hours after Appointments and its use in provider performance management reporting

A. **What was achieved?**

MHSD incorporated an automated appointment reminder system (CAARS) which communicates to persons served, their appointment date and time, multiple days prior to their appointment. This same system also automatically sends out MHSD Satisfaction Surveys to persons served 24 hours after receiving services or keeping their appointments.

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

Although the responses received are voluntary, the ratings in the responses are specific to a persons served experience with a particular provider. Thus, in the quarterly provider productivity management reports these ratings are included for supervisor and provider to review.

C. **Who benefits and how?**

The persons served benefits from having the opportunity to express their opinion about their experience regarding the quality of services received nearly immediately. The agency benefits both in the short-term of receiving feedback or concerns that may need to be addressed somewhat immediately, and in the longer-term for continuous quality improvement.

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

This accomplishment was achieved by specifically enabling this feature within the CAARS system and by QDM generating such data in the quarterly provider reports.

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

Yes.

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

Yes.

Accomplishment #8: Title of significant accomplishment: MHSD's Continued Embracement of Diversity, Equity and Inclusion

A. **What was achieved?**

MHSD's continued embracement of the principles of diversity, equity and inclusion within the agency and within the communities we serve.

As part of this embracement MHSD's Human Resource Department conducted a mandatory 2-hour training with employees on understanding one's unconscious bias and how to identify and mitigate biases. The MHSD Newsletter, *MHSD On the Move*, brings together articles, statistics, graphics, and interviews that reflect the current thinking on how to progress Diversity, Equity and Inclusion in the workplace and the community. In FY21, MHSD has highlighted other newsletters devoted to such topics as National Minority Mental Health Awareness, International Women's Day and LGBTQ entertainers. The MHSD Executive Director provided seven lectures and talks at community events regarding Diversity, Equity and Inclusion. Topic examples include, but are not limited to "Addressing Health Equity During the COVID-19 Pandemic presented at the Louisiana Public Health Association in New Orleans, LA," "Mental

Health: Beyond the Stigma presented at the Delta Research and Educational Foundation Research Matters for All of Us in New Orleans, LA," and "It's OK Not to be OK: Youth Mental Health Matters" presented at the City of New Orleans Mayor's Youth Advisory Council Town Hall in New Orleans, LA.

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

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

C. **Who benefits and how?**

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

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

By Executive Leadership prioritizing educating and training around diversity and inclusion.

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

Yes.

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

Yes.

Accomplishment #9: MHSD COVID Vaccination Efforts

A. **What was achieved?**

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

Additionally, MHSD established a COVID vaccination clinic that from February 2021 through June 2021 vaccinated approximately 739 people using the 2 dose Moderna vaccination. Staff members at MHSD Central City Clinic, in conjunction with Genoa pharmacy, coordinated at least thrice weekly vaccination clinics that gradually decreased clinic numbers with decrease in demand/vaccine hesitancy. The opportunity for vaccination was extended to all of our external partners including Odyssey House,

Bridge House/Grace House, Oxford House. Included were persons served in the DD community, as well as their caregivers. Staff members who did not receive a Covid vaccination from an outside agency were vaccinated here, as well as their family members.

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

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

C. **Who benefits and how?**

MHSD staff and the local community benefit. Family members of vaccinated staff and community members.

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

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

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

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

Yes.

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

Yes.

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

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and

whether your strategies are working as expected and proceeding on schedule.

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

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

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

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

MHSD has made significant progress towards its initiative of establishing a quality Tele-behavioral Health Program. Success is attributed to MHSD Executive Leadership's early allocation of resources to this initiative. Originally designed to increase access to care, MHSD purchased telehealth equipment, technology needed for implementation, required staff training, and developed procedures for implementation. Having completed these actions prior to the COVID-19 pandemic, greatly improved the agency's ability to render services while adhering to the COVID-19 guidelines/restrictions.

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

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

responding to administrative and clinical needs.

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

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

  Slow progress was seen in the area of outreach and prevention, although some improvements have been made when compared to FY19-20. Due to COVID-19 social distances guidelines, outreach events and one-on-one prevention activities with at-risk substance use populations were impacted in FY21. Innovative and alternative methods to connect with the community have been and are being implemented.

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

     Lack of progress is due to a set of circumstances related to COVID 19. Outreach programs related to substance use have begun using virtual events to communicate information and messaging in MHSD communities. Following COVID 19 guidelines and precautions, outreach providers will continue to conduct their outreach activities. MHSD will continue to closely monitor progress with this program in FY22.

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

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

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

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

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

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

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

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

A. Problem/Issue Description

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

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

B. Corrective Actions

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

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

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

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

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

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

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

☒ Policy, research, planning, and/or quality assurance functions in-house
MHSD executive leadership created the Quality and Data Management (QDM) division, whose mission is to establish a data driven environment that encompasses data management, performance measurement, monitoring the linkage between performance and budgeting, and supporting continuous quality

improvement across MHSD. The QDM division is responsible for data management, performance management and quality. The QDM division works to educate personnel and other relevant stakeholders about the District's performance, works closely with executive leadership to identify the practical implications of findings, and assists in corrective action planning and evidence-based decision making. The QDM division shares MHSD performance information with district staff, persons served, stakeholders, and the public. The QDM division is responsible for providing support to all district staff to ensure performance data is being collected and to oversee the integrity of the data collection practices.

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

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

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

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

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

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

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

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

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

☐ Other (please specify):

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

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

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department:	**Louisiana Department of Health (LDH)** 09-305 Medical Vendor Administration (MVA) 09-306 Medical Vendor Payments (MVP)
Department Head:	**Dr. Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson** LDH Undersecretary
Executive Director:	**Patrick Gillies** 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: Medicaid Innovation Challenge Participation

A. **What was achieved?**
Medicaid noted substantial losses in enrollment following the 2018 implementation of Medicaid's new eligibility and enrollment system and the subsequent start of quarterly wage data checks. The agency wanted to ensure there was a proper balance between preventing enrollment/ending coverage of ineligible individuals while facilitating enrollment and continuing coverage of eligible individuals.

Louisiana Medicaid enlisted the assistance of Adaptation Health to identify Medicaid-focused and market-ready innovative solutions for member engagement to address these concerns in 2019. The result was the Medicaid Innovation Challenge, a Request for Information (RFI) that culminated in presentations from vendors with best-in-class solutions for improving communication and engagement with Medicaid members. Special interest focused on addressing health disparities within underserved and marginalized/vulnerable populations in the state.

The primary purpose of the Innovation Challenge was always information gathering through Medicaid member focus groups and from the more than 30 vendor responses to the RFI, five (5) of which gave presentations during a virtual showcase in September 2020. In addition to the vendor presentations, the showcase featured a conversation with a panel of experts from a range of healthcare backgrounds. The event provided a forum to educate a broad audience on the innovations and opportunities available to improve member engagement and, in turn, healthcare outcomes Attendees of the showcase included Medicaid agency leadership from Louisiana and several other states, managed care organizations, federal oversight agencies and provider organizations.

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

Medicaid has long relied on traditional methods and tools for the outreach, education, and engagement of the populations the agency serves. This typically includes earned, paid, and social media; digital formats of communication; and direct to the individual contact through things like events and direct mail. The Innovation Challenge provided Louisiana Medicaid a fresh perspective direct from the member by soliciting feedback on communication effectiveness in member focus groups across the state. It became quickly apparent that no one method of delivery that is suitable for all members. A multifaceted approach is key.

It also introduced new engagement tools and creative methods. The Innovation Challenge expanded Medicaid's and the showcase participant's understanding of the opportunities available to improve and address beneficiary communication and more effectively manage enrollment, eligibility and access to care. Understanding the options and engaging with industry leaders is the first step toward implementing original practices with the potential for greater impact.

C. **Who benefits and how?**

The primary purpose and key benefit of the Innovation Challenge was gaining insight into the member experience to improve our communications effectiveness and improve response outcomes as well as the sharing of information. Before making any changes in the methods for outreach, engagement, or communications, Medicaid first gathered information about the wide range of options available.

Additionally, Medicaid has a wealth of out-of-the box concepts to consider for future member engagement with RFI responses from over 30 vendors. That benefit extended to our multi-faceted showcase audience through the presentations of the five selected

vendors. That audience included numerous participants who currently serve Louisiana Medicaid members – from community and provider organizations to managed care organizations. Any one of those groups can also take these lessons learned or seek partnerships with the vendor participants and apply their tools and processes to the supports and services they offer Medicaid members.

D. **How was the accomplishment achieved?**
The Innovation Challenge was a collaborative endeavor between Louisiana Medicaid and the New Orleans-based Adaptation Health. Medicaid management was familiar with Adaptation's work through a similar challenge they had conducted for the state of Arizona in 2018. Adaptation conducted focus groups prior to the Innovation Challenge showcase to help draft the RFI based on real member feedback. LDH released the RFI, gathered proposals, conducted an internal panel review of those submissions, and selected five (5) proposals for the showcase.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, specifically the goals and activities that serve to engage, enroll and retain eligible individuals in the Louisiana Medicaid program.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
There are no best management practices to share for this accomplishment at this time.

<u>Accomplishment #2: Managed Care Organization (MCO) Request for Proposals (RFP)</u>

A. **What was achieved?**
LDH issued its MCO RFP for new Medicaid managed care contracts on June 23, 2021 and the new Medicaid managed care contracts should begin on July 1, 2022.

The RFP and Model Contract focus on the following departmental priorities:

- Behavioral health integration;
- Child and maternal health outcome improvement;
- Disaster planning and recovery;
- Delivery system reform;
- Department of Justice settlement agreement requirements;
- Fraud, waste, and abuse initiatives;
- Health equity;
- Increased MCO accountability and;
- Pharmacy and Non-Emergency Medical Transportation (NEMT) administrative simplification.

B. **Why is this success significant?**
The updated requirements in the Model Contract promote improved health outcomes for more than 1.7 million managed care enrollees and foster better stewardship of federal and state funds.

C. **Who benefits and how?**
Managed care enrollees and the state at large benefit from focused quality initiatives and value based payment arrangements targeted at improving health outcomes and reducing health disparities. Network providers benefit from Model Contract requirements that seek to increase MCO accountability and provide administrative simplification for the program.

D. **How was the accomplishment achieved?**
LDH explored innovations in healthcare delivery, while also looking to increase accountability and address health equity, by seeking input from stakeholders on the departmental priorities listed above. LDH also identified opportunities for improvement by examining lessons learned from the previous procurement and exploring systemic issues identified by business owners during the course of the current contracts.

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

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes, the development of a Model Contract that contains requirements in lieu of using the RFP as the source of requirements is a national best practice.

<u>Accomplishment #3 Reimbursement Rate Increases and Changes to Align Testing with Medicare Rates</u>

A. **What was achieved?**
Medicaid has been committed to ensuring that beneficiaries have access to rapid and reliable testing and providers receive appropriate reimbursements since the onset of the COVID-19 pandemic. We added reimbursement for COVID-19 testing, treatment administration, and vaccine administration at 100% of the Medicare rates. This reimbursement level helped to ensure that providers offer the services that in turn ensures that beneficiaries have access. In addition, this coverage did not have any restrictions or out-of-pocket costs for beneficiaries, as required by federal law.

B. **Why is this success significant?**
Aligning testing, treatment administration, and vaccine administration reimbursement rates simplifies administration for providers, appropriately reimburses them for their services, and ensures that members have access. Additionally, by aligning with national

testing guidelines, Louisianans have access to all appropriate technologies for diagnosis. For treatment and vaccination administration, electing to pay at 100% of Medicare rates shows the department's commitment to Louisiana's recovery from COVID-19.

C. **Who benefits and how?**
Providers benefit with appropriate reimbursements for COVID-19-related services. Beneficiaries benefit by having access to a wide variety of testing technologies and locations, at no cost to them. Additionally, vaccines are generally widely available (see additional information about home-vaccinations below). The state at large also benefits because people who have access to appropriate testing, treatment, and vaccination are less likely to spread COVID-19.

D. **How was the accomplishment achieved?**
Medicaid worked with stakeholders including provider groups to identify this need. Then, Medicaid worked with the Centers for Medicare & Medicaid Services (CMS) to identify the most appropriate path to achieve the goal of appropriate reimbursement and access for beneficiaries. Throughout the Public Health Emergency (PHE), there have been regular check-ins and operations meetings to communicate department decisions. Furthermore, when vaccines initially became available, there were weekly all-hands LDH calls to coordinate activities, anticipate challenges, and provide solutions,

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, this accomplishment aligns with the following agency goals outlined in the strategic plan:

I. To make comprehensive, coordinated care and quality health services available to all who qualify

II. To increase access to community-based services as an alternative to institutional care

III. To reduce the per capita cost of care by balancing health care and prevention spending

More specifically, reimbursement rate increase and testing alignments fall in-line with the Payments to Private Providers program, Activity 1: Medicaid Managed Care, Objective II and Strategy 2.1:

> **Program A: Activity 1: Objective II**: Through the Medicaid Managed Care Activity, increase preventive and primary healthcare use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid Members.
>
> **Strategy 2.1**: Encourage Medicaid recipients to obtain appropriate preventive and primary care in order to improve their overall health and quality of life, and

to ensure that those who care for them provide the coordinated care through managed care programs.

There are no specific goals, objectives, or performance indicators related specifically to LDH's COVID-19 response, as Medicaid completed the strategic plan prior to the PHE.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Communications were efficient and widespread so that stakeholders had access to updates and changes made by LDH for its COVID-19 response around testing and reimbursement alignment.

Accomplishment #4 In-home Vaccine Option

A. **What was achieved?**
Louisiana Medicaid added coverage of in-home COVID-19 vaccinations in alignment with CMS guidelines and effective with dates of service around June 8, 2021.

B. **Why is this success significant?**
By aligning with federal guidelines and rates, program administration is simplified and efforts can focus on implementation. This is a new type of vaccine service reimbursed by Medicaid; it is significant that LDH quickly integrated this additional service into its COVID-19 response, which will increase vaccine uptake.

C. **Who benefits and how?**
Beneficiaries who are homebound, who have significant barriers to physically going to a vaccination site, or who face other challenges will now have greater access to the COVID-19 vaccine. By receiving the COVID-19 vaccine, beneficiaries who are homebound and their families and caregivers will receive protection against severe cases of COVID-19.

D. **How was the accomplishment achieved?**
When CMS approved home administration for COVID-19 vaccines, Medicaid updated its communications to providers and community members via informational bulletin updates. The reimbursement schedule updates align with the new, approved service and reimbursement rate.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, this accomplishment aligns with the following agency goals outlined in the strategic plan:

I. To make comprehensive, coordinated care and quality health services available to all who qualify

II. To increase access to community-based services as an alternative to institutional care

III. To reduce the per capita cost of care by balancing health care and prevention spending

More specifically, the in-home vaccine option falls in-line with the Payments to Private Providers Program, Activity 1: Medicaid Managed Care, Objective II and Strategy 2.2:

> **Program A: Activity 1: Objective II**: Through the Medicaid Managed Care Activity, increase preventive and primary healthcare use, thereby improving quality, health outcomes, and patient experience for Louisiana Medicaid Members.
>
> **Strategy 2.2**: Provide health services in the most integrated setting possible, and emphasize community and home based alternatives where appropriate.

Furthermore, this accomplishment aligns with the strategic plan's goals around providing care for the uninsured as Medicaid is reimbursing enrolled providers for vaccinating uninsured Louisianans. Specifically, in-home vaccine option falls in line with the Uncompensated Care Costs Program. The Program goal is to encourage qualifying providers including Louisiana State University (LSU) facilities, public providers, the Office of Behavioral Health (OBH), and qualifying private hospitals to provide access to medical care for the uninsured and those eligible for Medicaid with Medicaid reimbursements lower than the cost of service.

There are no specific goals, objectives, or performance indicators related specifically to LDH's COVID-19 response, as the strategic plan was complete prior to the PHE.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
CMS provided the guidance and rate for this service and LDH continued to align it with federal guidelines in our response to COVID-19. This methodology has proven to be straightforward and easy to administer in a short amount of time.

Accomplishment #5 COVID-19 Unwind Operational Plan

A. **What was achieved?**
LDH received guidance from CMS via the State Health Officer (SHO) letter dated December 22, 2020, that required states to develop a comprehensive COVID-19 eligibility and enrollment operational plan to support efforts at the end of the PHE. LDH immediately began strategic planning to develop the framework for the document using a team approach inclusive of stakeholders. The first iteration of the plan was developed

in March 2021 and comprehensively covered operations including health plan advisories, informational bulletins, communication strategies, fair hearings, validation of providers, managed care capitation rates, policy changes, system changes, disaster authorities, and approach to processing applications, verifications, changes in circumstances, and renewals. The plan remains a fluid document and the version updates occur monthly based on the current guidance and enrollment figures. Lastly, the plan includes a phased approach to completing any outstanding work within six (6) months after the PHE ends, updated monthly to reflect changes to volumes, guidance, and timeframes.

B. **Why is this success significant?**
The Operational Plan is significant because it serves as a single repository of all actions taken during the PHE and the steps and timeframe necessary to unwind after the PHE. This ensures that LDH has a strategy and roadmap to success at the end of the PHE in regards to ending the eligibility maintenance of effort required by the Families First Coronavirus Response Act (FFCRA).

C. **Who benefits and how?**
The benefit of having the Operational Plan will extend to internal and external stakeholders, staff, and members alike. The plan allows for coordinated messaging to impacted members and providers and stratification of resources and staff workloads both during and after the PHE.

D. **How was the accomplishment achieved?**
The Operational Plan achievements occurred by setting goals immediately and employing the guidance of a Project Manager whose sole responsibility was keeping the team and project plan on target.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes, specifically the goals and activities that serve to engage, enroll and retain eligible individuals in the Louisiana Medicaid program as this is the guiding framework for Medicaid eligibility and enrollment during and after the PHE.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
The Operational Plan uses project management best practices including agile principles for a versioning release schedule, standard models for identifying staff assigned to the project, and monthly project reports.

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

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

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

  Accomplishment #1: Medicaid Innovation Challenge Participation:

  The Medicaid Innovation Challenge works in partnership with Medicaid's eligibility determination and enrollment efforts (Program A: Medical Vendor Administration, Activity 1). The challenge provided new perspectives and helped to identify new ways to apply modern technology to connect and engage with potential and current Medicaid beneficiaries.

  Medicaid is working to ensure, while we implement processes and procedures to prevent enrollment and end coverage of ineligible individuals that we also make sure we are facilitating enrollment and continuing coverage of eligible individuals. A substantial amount of Medicaid loss of coverage results from the beneficiary's failure to respond to requests from Medicaid for additional information. Successful and appropriate outreach and communication has the potential to improve member engagement and reduce the number of eligible individuals lost to administrative actions.

  The goal of the Innovation Challenge was to gather information. Medicaid considers the desired results achieved with more than 30 RFI responses and well-attended showcase. Additionally, the knowledge acquired through the Innovation Challenge has the potential to provide additional support for the long-term goals of Medicaid eligibility and enrollment by improving beneficiary communication and engagement.

  Accomplishment #2: Managed Care Organization (MCO) Request for Proposals (RFP):

  Developing the new RFP is complete and publication accomplished. LDH was able to publish the RFP a week ahead of schedule.

  MCO Provider Incentives

  The COVID-19 Vaccine Administration incentive arrangement remains on target toward achieving Strategic Plan goals and objectives. Strategies outlined in the current Strategic Plan continue to be effective and strengthened by a strong commitment to continuous Performance and Quality Improvement. The performance improvement plan (PIP) metrics are in the table below. There is no indication that the reporting periods listed in the timeline will be unmet. Furthermore, the Managed Care Incentive Payment (MCIP) PIP metrics will be evaluated and incentive payments determined after report submission.

Persons Who Received at Least One (1) Vaccine Dose and Persons Who Received A Complete Vaccine Course

Reporting Period	MCIP PIP Metric	Proposed Target	Value of the Project*
8/16/21	Persons who received at least 1 vaccine dose	Achieve 30% or improve by 10 points	$3,000,000
11/15/21	Persons who received a complete vaccine course	Achieve 40% or improve by 20 points	$3,000,000
1/17/22	Persons who received a complete vaccine course	Achieve 70% or improve by 10 points	$4,000,000
*Funded by state and federal funds (State share would be from risk corridor remittance)			

Reimbursement Rate Increases and Changes to Align Testing with Medicare Rates
The COVID-19 accomplishment contributes to Medicaid reaching the overarching goals of the strategic plan. Louisiana Medicaid has been quick to ensure program administration aligned with federal guidelines, approvals, and rates whenever CMS updated a rate or approved another test to detect COVID-19.

In-home Vaccine Option
As soon as CMS approved the in-home vaccine option, Louisiana Medicaid successfully followed suit to avoid delaying implementation. This has only been an available option for vaccination dissemination for six (6) weeks; utilization data is forthcoming.

COVID-19 Unwind Operational Plan
The Operational Plan supports the goal of having comprehensive, coordinated care and quality health services available to all who qualify by conducting Medicaid eligibility determination and enrollment activities. LDH responded rapidly to new CMS guidance and created a massively complex and comprehensive, strategic approach to compliance. Implementation of the plan is on track. Though eligibility flexibilities may have occurred during the PHE, the progress towards meeting the overall goals and objectives of the strategic plan is positive. LDH still ensures that eligibility determinations meet all timeliness requirements as outlined in the State Plan Amendment and as provided for by CMS. LDH has ensured that all citizens who meet the eligibility criteria receive health coverage that is dire during the PHE.

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

  1. To what do you attribute this success? For example:
     - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
     - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or

needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
- Other? Please specify.

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

Accomplishment #1: Medicaid Innovation Challenge Participation:
The progress is in the gathering of knowledge and the consideration of new and previously untried methods of engagement and outreach. Additional steps are necessary to determine timelines and goals on how this information will be useful internally. Medicaid is still considering those options.

Accomplishment #2: Managed Care Organization (MCO) Request for Proposals (RFP):
The RFP development and Model Contract accomplishments occurred largely through the engagement of key stakeholders and the extensive knowledge of LDH's own business owners. Progress is also attributable to the establishment of a new MCO Manual, established 1/1/2021, which provides a comprehensive resource to the MCOs for operational details and contract clarifications. LDH expects to continue our progress at a steady pace.

MCO Provider Incentives
Month-over-month trends indicate improvement across all five (5) MCOs in the administration of the COVID-19 vaccine. The successes attribute to collaboration between LDH and the MCOs, COVID-19 vaccine interventions, outreach, provider engagement, and incentive payments. Medicaid will continue to monitor progress and improvement.

Reimbursement Rate Increases and Changes to Align Testing with Medicare Rates
Progress will continue as CMS changes reimbursement rates. LDH's decision to align reimbursement rates as they evolve has meant efficient updates with little administrative burden.

In-home Vaccine Option
The progress and successes of the in-home vaccine option is hard to measure since the service integrated into the department's COVID-19 response efforts six (6) weeks ago. However, the quick and efficient incorporation of allowing in-home vaccines as a covered service is of note. Medicaid and Office of Public Health (OPH) have worked closely together for many aspects of the vaccine rollout since the fall of 2020.

COVID-19 Unwind Operational Plan
Medicaid met the goals and objectives for developing the Operational Plan. Plans to complete the final iteration of the Operation Plan by September 14, 2021 and ahead of the anticipated announcement of the end of the PHE are on target. The ability to meet all key project dates and goals has been largely due to having a designated Project Manager

leading this massive project and including contributions and input from the other LDH program offices in partnership. These include the Office for Citizens with Developmental Disabilities, Office of Aging and Adult Services, and the Office of Behavioral Health. Progress will continue at the current pace and rate.

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

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

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

  Accomplishment #1: Medicaid Innovation Challenge Participation:

  (Not Applicable)

  Accomplishment #2: Managed Care Organization (MCO) Request for Proposals (RFP):

  (Not Applicable)

- **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?

  Accomplishment #1: Medicaid Innovation Challenge Participation:

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

No strategic plan revisions are necessary for this accomplishment.

Accomplishment #2: Managed Care Organization (MCO) Request for Proposals (RFP):

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

Reimbursement Rate Increases and Changes to Align Testing with Medicare Rates:

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

No strategic plan revisions are necessary for this accomplishment.

In-home Vaccine Option:

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

No strategic plan revisions are necessary for this accomplishment.

COVID-19 Unwind Operational Plan:

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

No strategic plan revisions are necessary for this accomplishment.

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

  The Division of Planning and Budget coordinates the Performance-Based-Budgeting activities including the Strategic Plan, Operational Plan, and the Louisiana Performance Accountability System (LaPAS). This section develops and reviews objectives, performance indicators, and strategies for programs within the Office of the Secretary (OS), other LDH agencies, and for some Local Governing Entities (LGEs). Each agency and LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans then circulate to OS 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 2022. In Medicaid, each project target division generates weekly reports and goals with progress update. These updates are prepared for leadership to assess progress on strategic priorities.

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

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

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

A. Problem/Issue Description

1. **What is the nature of the problem or issue?**
   With the end of the COVID-19 PHE potentially looming, Medicaid is under-resourced to handle the impending workload for the eligibility maintenance of effort unwind. Eligibility verifications have backlogged without Medicaid being able to take action for over a year and a half. Staff members facing personal PHE struggles and fear of return to work due to safety concerns amplifies this issue.
2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)**
   Yes.
3. **What organizational unit in the department is experiencing the problem or issue?**
   Eligibility Field Operations (EFO) is experiencing this issue.
4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   This problem affects external customers, specifically Medicaid enrollees. Additionally, if enrollee information is not correct, this affects provider payments

if retroactive corrections occur.

5. **How long has the problem or issue existed?**
   This has been a problem since the passage of the Families First Coronavirus Response Act.
6. **What are the causes of the problem or issue? How do you know?**
   Medicaid measures workload volume based on monthly renewals and pending tasks as well as historical trends. We know of ongoing employee concerns from communications with our staff about return to work.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   The consequences of failure to comply with the timeline set by CMS could potentially be disallowed funds, audit, as well as, loss of public resources that should have been cost avoided. In addition, we anticipate staff fatigue and attrition resulting from the workload volume and fear of return to work.

B. Corrective Actions

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

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

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

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

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

5. Do corrective actions carry a cost?

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

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

A. Check all that apply.

☒ **Internal audit**
OS ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within OS 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.

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 OS, 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 OS, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

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

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

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

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

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

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

Report #1

1. **Title of Report or Program Evaluation**: Continuity of Care for Newborns
2. **Date completed**: January 2021
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Louisiana Department of Health (LDH) submits the following report in response to ongoing reporting provision of Act 311 of the 2013 Regular Louisiana Legislative Session. This repost provides the incidence and causes of the re-hospitalization of infants born premature at less than 37 weeks' gestational age and within the first six months of life.

4. **Methodology used for analysis or evaluation: Cost (allocation of in-house resources or purchase price)**: Act 311 requires an assessment of the incidence and causes of all re-hospitalizations of infants born premature at less than 37 weeks' gestational age and within the first six months of life. The report utilizes Vital Records data obtained from the Office of Public Health for establishing gestational age and Medicaid claims data/MCO encounter data stored in the Medicaid Data Warehouse for identifying the primary discharge diagnoses that triggered the re-hospitalizations.
5. **Cost (allocation of in-house resources or purchase price)**: Compiled by University of Louisiana at Monroe (ULM) staff; falls within scope of work of contract.
6. **Major Findings and Conclusions**: The re-hospitalization rate for infants born during calendar year 2019 who were born premature at less than 37 weeks' gestational age and are in their first six months of life is 4.24 percent. The calendar year 2019 re-hospitalization rate was 4.87 percent. This indicates that the re-hospitalization rate in this group of newborns has improved slightly over the past two reporting years.
7. **Major Recommendations**: (Not Applicable)
8. **Action taken in response to the report or evaluation**: (Not Applicable)
9. **Availability (hard copy, electronic file, website)**: https://ldh.la.gov/index.cfm/newsroom/detail/2928

10. **Contact person for more information:**
    Name: Patrick Gillies
    Title: Executive Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-9240
    Email: Patrick.Gillies@LA.GOV

Report #2

1. **Title of Report or Program Evaluation**: Louisiana Medicaid Diabetes and Obesity Report
2. **Date completed**: February 2021
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Per Louisiana Revised Statute (RS) 46:2616 and RS 46:2617, an annual diabetes and obesity action plan submission is necessary to the Senate and House Committees on Health and Welfare after consulting with, and receiving comments from, the medical directors of each of its contracted Medicaid partners.
4. **Methodology used for analysis or evaluation**: Each Medicaid managed care plan is required to complete a template that requests data designed to meet requirements of RS 46:2617. The template consists of 12 reports that gather diabetes and obesity prevalence and utilization within each plan to address diabetes and obesity items in RS 46:2617. The resulting 60 reports aggregated across the five plans to yield 12 reports for Healthy Louisiana. The Healthy

Louisiana reports are in the "Diabetes and Obesity Action Report for the Healthy Louisiana Program".

5. **Cost (allocation of in-house resources or purchase price)**: Compiled by University of Louisiana at Monroe (ULM) staff; falls within scope of work of contract.
6. **Major Findings and Conclusions**: Managing obesity and diabetes is a complicated endeavor, and the strategies described in this report serve as a foundation for healthier Louisiana residents. Changes must occur in multiple parts of the health care system, community settings and in personal behaviors in order to affect the obesity and diabetes epidemic.
7. **Major Recommendations**:
   a. Promote Well-Ahead Louisiana's Community Resource Guide as a tool to identify local (by parish) health-related resources. This resource is available at http://wellaheadla.com/Well-aheadcommunity/community-resource-guide
   b. Encourage the use of community and faith-based organizations to promote the importance of healthy eating and physical fitness.
   c. Encourage the use of outpatient nutritional services provided by registered dietitians for all patients and all diagnoses, not just those patients with diabetes and obesity.
   d. Promote the use of diabetes self-management education (DSME) programs or incorporate elements of these programs into case management activities for patients with diabetes. DSME programs have been associated with improved health outcomes for patients with diabetes.
8. **Action taken in response to the report or evaluation**: (Not Applicable)
9. **Availability (hard copy, electronic file, website)**: https://ldh.la.gov/index.cfm/page/2115

10. **Contact person for more information:**
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Report #3

1. **Title of Report or Program Evaluation**: Medicaid Managed Care Quarterly Transparency Reports SFY 2021
2. **Date completed**: Quarterly 2021
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: In response to ACT 482 of the 2018 Regular Legislative Session, the Louisiana Department of Health (LDH) is required to submit the Medicaid Managed Care Quarterly Transparency report. This report includes only those expansion population counts and expenditures for individuals enrolled in an MCO for either full or partial benefits.
4. **Methodology used for analysis or evaluation**: The methodology updates for

pulling data regarding earned income started in State Fiscal Year 2021 (July 1, 2020 to June 30, 2021) to assure that the income corresponds to the current reporting period. The five MCOs received payments to manage the care of individuals in the expansion population for medical, specialized behavioral health, pharmacy, and transportation services.

5. **Cost (allocation of in-house resources or purchase price)**: Compiled by internal staff.
6. **Major Findings and Conclusions**: (Not Applicable)
7. **Major Recommendations**: (Not Applicable)
8. **Action taken in response to the report or evaluation**: (Not Applicable)
9. **Availability (hard copy, electronic file, website)**: https://ldh.la.gov/assets/docs/LegisReports/ACT482_SFY2021_Q1_Revised.pdf

10. **Contact person for more information:**
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Report #4

1. **Title of Report or Program Evaluation**: Healthy Louisiana Claims Report
2. **Date completed**: Quarterly 2021
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:**
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Report #5

1. **Title of Report or Program Evaluation**: LaCHIP Annual Report (Mid-Year)
2. **Date completed**: March 2021
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**: 155,789 children and pregnant women have acquired access to critical healthcare coverage in SFY 2021. 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:**
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Report #6

1. **Title of Report or Program Evaluation**: Medicaid Forecast Report SFY 20/21
2. **Date completed**: Monthly
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Provide the budget changes because of House Bill (HB) 516 from the 2021 regular session.
4. **Methodology used for analysis or evaluation**: Program staff develops budget projections based on utilization trends, enrollment trends, and other known factors affecting the management of the Medicaid program. Actual year-to-date expenditures come from the Medicaid Data Warehouse and ISIS.
5. **Cost (allocation of in-house resources or purchase price)**: Compiled by in-house staff
6. **Major Findings and Conclusions**: (Not Applicable)
7. **Major Recommendations**: (Not Applicable)
8. **Action taken in response to the report or evaluation**: (Not Applicable)
9. **Availability (hard copy, electronic file, website)**: Medicaid Forecast Reports SFY 2020/2021 | Department of Health | State of Louisiana (la.gov)

10. **Contact person for more information:**
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Report #7

1. **Title of Report or Program Evaluation**: Response to HCR 52 of the 2020 Regular Legislative Session: CMS Interoperability and Patient Access Rule
2. **Date completed**: October 2020
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Provides available resources to assist with compliance, as well as a financial and

resource impact statement.

4. **Methodology used for analysis or evaluation**: Evaluation of current vendor solutions and initiation of a competitive bid process for infrastructure needs.
5. **Cost (allocation of in-house resources or purchase price)**: Compiled by CMS and third party applications.
6. **Major Findings and Conclusions**: The rule presents significant implementation challenges; however, the mission is to achieve the vision of an interoperable health ecosystem in which patients are empowered to manage their health more effectively and payers can deliver increased value.
7. **Major Recommendations**: Not Applicable.
8. **Action taken in response to the report or evaluation**: LDH will continue to monitor other state implementations and upcoming CMS guidance to inform planning and implementation processes.
9. **Availability (hard copy, electronic file, website)**: https://ldh.la.gov/assets/docs/LegisReports/HCR52RS20209302020.pdf

10. **Contact person for more information:**
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Report #8

1. **Title of Report or Program Evaluation**: Response to HR 38 of the 2020 Regular Legislative Session: Remote Patient Monitoring
2. **Date completed**: January 2021
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Provide uses of digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit, synchronously or asynchronously, that information securely to health care providers in a different location for assessment and recommendations.
4. **Methodology used for analysis or evaluation**: (Not Applicable)
5. **Cost (allocation of in-house resources or purchase price)**: Report completed by in-house staff
6. **Major Findings and Conclusions**: Remote patient monitoring services may be a beneficial option to many Louisianans living with chronic illness and other medical issues and already in use by Medicaid beneficiaries.
7. **Major Recommendations**: (Not Applicable)
8. **Action taken in response to the report or evaluation**: LDH will continue to engage stakeholders to ensure that Medicaid beneficiaries have access to important services to meet their medical and behavioral health needs.
9. **Availability (hard copy, electronic file, website)**: https://ldh.la.gov/assets/docs/LegisReports/HCR52RS20209302020.pdf

10. **Contact person for more information:**
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Report #9

1. **Title of Report or Program Evaluation**: Quarterly Crowd-Out Report (HCR 57)
2. **Date completed**: May 2021
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Provides data from potential Medicaid enrollees about their private health insurance status and participation in, or offers of, employer-sponsored insurance at both the time of their application and the time of their eligibility redetermination.
4. **Methodology used for analysis or evaluation**: During the application and renewal process, potential and active Medicaid enrollee are asked about their private health insurance status and participation in, or offers of, employer sponsored insurance. Additionally, at renewal, applicant checks occur against Third Party Liability (TPL) data files that determine if the enrollees have private insurance. Due to the PHE, standard renewal packets were paused from March 2020 through January 2021.
5. **Cost (allocation of in-house resources or purchase price)**: Report complete by in-house staff.
6. **Major Findings and Conclusions**: As of 6/23/21, LDH has sent 116,884 standard renewal packets and 438,646 members were eligible for renewal during the third quarter reporting period.
7. **Major Recommendations**: (Not Applicable)
8. **Action taken in response to the report or evaluation**: (Not Applicable)
9. **Availability (hard copy, electronic file, website)**: Response to HCR 57 of the 2020 Regular Session | Department of Health | State of Louisiana

10. **Contact person for more information:**
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Report #10

1. **Title of Report or Program Evaluation**: Response to State Resolution (SR 49) of the 2020 Second Extraordinary Session

2. **Date completed**: April 2021
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: This response is necessary to examine federal and state policy changes and other factors that have contributed to the child uninsured rate.
4. **Methodology used for analysis or evaluation**: In collaboration with The Department of Insurance, The Louisiana Budget project, Louisiana Partnership for Children and Families and Georgetown Center for Children and Families, LDH researched available health insurance programs for children, the drivers of the increased uninsured rates and provided recommendations based on those findings.
5. **Cost (allocation of in-house resources or purchase price)**: Report completed by in-house staff.
6. **Major Findings and Conclusions**: There are multiple drivers and trends contributing to the growing child uninsured rate. This report seeks to draw attention to these areas while proposing strategies and best practices for addressing them.
7. **Major Recommendations**:
   a. Provide state support for navigators and CACs.
   b. Build and leverage community partnerships.
   c. Increase state outreach and communications footprint.
   d. Consider implementing a new CHIP Buy-In program.
8. **Action taken in response to the report or evaluation**: (Not Applicable)
9. **Availability (hard copy, electronic file, website)**: file:///Z:/Legislative%20Reporting/2020%20SES%20Reports/SR%2049/SR%2049%20Report%20FINAL.pdf

10. **Contact person for more information:**
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Report #11

1. **Title of Report or Program Evaluation**: Transportation Network Companies for NEMT Services (HR 14)
2. **Date completed**: April 2021
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: This report is necessary to improve the availability and reliability of NEMT.
4. **Methodology used for analysis or evaluation**: Data analysis of NEMT brokers of eight reports, using the period of January 2019 through October 2020.
5. **Cost (allocation of in-house resources or purchase price)**: Report complete by in-house staff
6. **Major Findings and Conclusions**:
   a. Improve communication between provider/broker and member and increase

provider availability.
   b. Develop state criteria to allow for the utilization of TNCs for NEMT.
   c. Consider contracting with a single statewide NEMT broker.
7. **Major Recommendations**:
   a. Improve communication between/broker and member and increase provider availability.
   b. Develop state criteria to allow for the utilization of TNCs for NEMT.
   c. Consider contracting with a single statewide NEMT broker.
8. **Action taken in response to the report or evaluation**: (Not Applicable)
9. **Availability (hard copy, electronic file, website)**:
   HR_14_2020_SES_FINAL_4.28.21.pdf (la.gov)

10. **Contact person for more information:**
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Report #12

1. **Title of Report or Program Evaluation**: Medicaid Reimbursement Rates for Primary Care Services (HR 1)
2. **Date completed**: April 2021
3. **Subject or purpose and reason for initiation of the analysis or evaluation**: Study the costs and benefits of setting Medicaid reimbursement rates for primary care services at levels that are at least equal to Medicaid rates for those services.
4. **Methodology used for analysis or evaluation**: LDH conducted a fiscal and programmatic impact analysis of the rate increase to complete the requirements of this legislation.
5. **Cost (allocation of in-house resources or purchase price)**: Compiled by in-house staff
6. **Major Findings and Conclusions**: Raising reimbursement rates for primary care in Medicaid to match rates provided through Medicare would result in a significant fiscal impact to LDH.
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/HR_1_2020_SES_FINAL_4.28.21.pdf

10. **Contact person for more information:**
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Annual Management and Program Analysis Report
Fiscal Year 2020-2021

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

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

Undersecretary: **Ruth Johnson**

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

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

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

Accomplishment #1: LDH & Governor Edwards Celebrate Five-Year Anniversary of Medicaid Expansion

A. ***What was achieved?***

On July 01, 2021, Louisiana marked five years since expanding Medicaid coverage through the Affordable Care Act for the hard-working poor across our state. To date, more than 638,000 citizens are benefitting from access to quality healthcare that many otherwise have never been able to afford.

The expansion allowed residents to use their insurance to visit a primary care doctor for an annual check-up, get prescriptions, and maintain wellness visits and health screenings.

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

The fifth anniversary of Medicaid expansion marks a significant milestone in improving the health and well-being of Louisiana residents.

Prior to expansion, Medicaid eligibility for adults in Louisiana had not changed since 2013, leaving most childless adults ineligible for coverage, regardless of how low their incomes were.

Within the first year, more than 433,000 Louisiana residents who lacked coverage for essential healthcare services and prescription drugs gained coverage because of Medicaid expansion. Since Medicaid expansion in 2016, the uninsured rate among adults reduced from 22.7% in 2015 to 11.4% in 2017.

C. ***Who benefits and how?***

Louisiana residents and those underinsured have benefitted from this accomplishment. The expansion of healthcare coverage has dramatically changed the landscape for vulnerable communities and the healthcare sector for the better, and it has provided a critical safety net during the ongoing global COVID-19 pandemic.

The positive health benefits Louisiana residents have had over the past five years include:

- An average of 72% of adults enrolled have visited a doctor's office during each year of Medicaid expansion.
- More than 105,000 women have been screened for breast cancer
- Over 63,000 adults have received colon cancer screenings
- About 100,000 adults have been diagnosed and provided opportunity for treatment for either diabetes or hypertension

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

Gov. John Bel Edwards first adopted Medicaid expansion in 2016 as his first official act as governor, making Louisiana the first state in the Deep South to participate. Since then it has provided preventive care as well as life-saving diagnosis and treatment for a multitude of serious diseases.

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

Yes, this accomplishment contributes to the success of our strategic plan. LDH is committed to protecting vulnerable communities and providing a safety net for those who may lose health coverage because of economic conditions or other events, and Medicaid has been instrumental in protecting Louisiana communities during the COVID-19 crisis."

Overall, Medicaid expansion has made has made it possible for many more Louisianans to have access to quality healthcare.

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

No, this accomplishment was an Act signed into law by the governor, and does not represent a Best Management Practice.

Accomplishment #2: Louisiana Department of Health Reports Sustained Improvements in Reducing Maternal Morbidity

A. ***What was achieved?***

The Louisiana Department of Health (LDH) reported additional progress in reducing severe maternal morbidity among birthing persons who experience hemorrhage and severe hypertension in facilities that are part of the Louisiana Perinatal Quality Collaborative (LaPQC).

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

The LaPQC's report, "Reducing Maternal Morbidity Initiative – Final Report," was issued in May of 2021 revealed that severe maternal morbidity among hemorrhage was reduced by nearly 35%, and severe maternal morbidity among hypertension was reduced by almost 12%.

Programs like the LaPQC are successful in supporting improved changes, and brings a new focus on reducing Louisiana's low-risk first-time Cesarean delivery rate.

C. ***Who benefits and how?***

Those persons living in Louisiana who are preparing to give birth will benefit from this accomplishment. Quality improvement work in birthing facilities is an important and necessary component to assure that Louisiana birthing persons experience safe, equitable and dignified birth.

The Reducing Maternal Morbidity Initiative was designed to reduce the occurrence of two recognized contributors to maternal morbidity and mortality: preventable hypertension and/or hemorrhage, while also reducing disparities in outcomes.

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

The LaPQC has been working with 42 birthing facilities, including hospitals, using quality improvement science to create sustainable change that improves maternal outcomes. The final report covers work that began in 2018 with the launch of the Louisiana Department of Health's LaPQC, authorized under the Louisiana Commission on Perinatal Care and Prevention of Infant Mortality.

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. Louisiana has become a model in the country for working to improve maternal outcomes, linking public health data to drive very specific transformational change. Since August 2018, the LaPQC has grown to 42 birthing facilities, meaning that nine out of every 10 births in Louisiana occurred in a LaPQC participating facility by the end of the Reducing Maternal Morbidity Initiatives.

For more information about the LaPQC, visit https://partnersforfamilyhealth.org/lapqc.

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

No, this accomplishment does not represent a Best Management Practice.

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

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

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

LDH/Office of the Secretary Strategic Plan: Yes, the strategic plan for the Department is on time for accomplishment. Our 5-Year Strategic Plan, which was revised in May of 2019, covers fiscal years 2020-2025. The next update will occur in three years. This plan provides: (1) a general picture of intended performance across the agency, (2) a general discussion of strategies and resources the agency will use to achieve its goals, and (3) general confidence and reliability that agency performance information will be credible.

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

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

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

discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

Health Services Standards (HSS) is making significant progress in rule revision, as they have dedicated full time resources to this endeavor and have closely collaborated with stakeholders to continue our progress. HSS also achieved 100% successful completion of State Performance Standards and the Centers for Medicare and Medicaid Services (CMS) Performance Standards.

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

  None

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

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

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

  In FY19, LDH revised its 5-year strategic plan. This revised plan is good through FY 2025 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 (Health Standards); address needed rule revisions for consistency with processes and new statutes (Legal & Internal Audit); and address resources needed for improved efficiencies.

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

  On a Department-wide level, Performance-Based-Budgeting activities (including, but not limited to, strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. If modifications are needed, recommendations are made directly to the Assistant Secretaries or the Executive Directors. In addition, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from their review should be used to improve strategic and operational planning, or program management operations.

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

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

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

No department management or operational problems exist.

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

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

B. Corrective Actions

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

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

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

Undersecretary: **Ruth Johnson**

Executive Director: **Lisa Schilling**

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

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

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

Accomplishment #1: CARF Three-Year Re-Accreditation

A. **What was achieved?**

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

The CARF is an independent, nonprofit accrediting body whose mission is to promote the quality, value, and optimal outcomes of services through a consultative accreditation process that centers on enhancing the lives of the persons served. Founded in 1966 as the Commission on Accreditation of Rehabilitation Facilities, and now known as CARF International, the accrediting body establishes consumer-focused standards to help organizations measure and improve the quality of their programs and services.

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

This accreditation decision represents the highest level of accreditation awarded to an organization and shows the organization's substantial conformance to the CARF standards. An organization receiving a Three-Year Accreditation has put itself through a rigorous peer review process. It has demonstrated to a team of surveyors during an on-site visit its commitment to offering programs and services that are measurable, accountable, and of the highest quality. Achieving national accreditation is cited as a goal in the SCLHSA's Strategic and Operational Plans. However, achieving a perfect score of 100 was something that was a surprise to our organization and achieved in only three (3) percent of CARF Surveys conducted in either Canada, Europe or the United States. Approximately 1,877 standards of care were reviewed for this outstanding accomplishment. This accolade came during the mist of a pandemic and with the added pressure of maintaining one level of care throughout the pandemic regardless of CDC sanctions and changes in service structure to accommodate the patients and staff.

C. **Who benefits and how?**

The entire SCLHSA organization benefits from the accreditation process. The staff receive validation for the agency's exceptional work product and the quality service delivery provided to our clients on a daily basis. The SCLHSA clients benefit by receiving outpatient services from an organization that has achieved accreditation and focuses on evidence-based and best practices for treatment/services delivery, client satisfaction, and improving performance. Mechanisms are built into the accreditation process to provide continuous opportunities for systems improvement. This includes:

1. Assurance to persons seeking services that a provider has demonstrated conformance to internationally accepted standards;
2. Improved communication with persons served; person-focused standards that emphasize an integrated and individualized approach to services and outcomes; accountability to funding sources, referral agencies, and the community; management techniques that are efficient, cost-effective, and based on outcomes and consumer satisfaction;
3. Evidence to federal, state, provincial, and local governments of commitment to quality of programs and services that receive government funding;
4. And guidance for responsible management and professional growth of personnel.

In addition, payor sources such as Medicaid, Medicare and other private Health Plans require accreditation; therefore, SCLHSA will continue to be able to maximize funding

opportunities as a result of this success.

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

Achieving accreditation requires a service provider to commit to quality improvement, focus on the unique needs of each person the provider serves, and monitor the results of services provided. SCLHSA began its accreditation process with an internal examination of its program and business practices. The examination consisted of the SCLHSA staff conducting an in-depth self-evaluation review of agency policies, procedures and documents. The administrative team conducted numerous site visits and mock surveys at all seven behavioral health clinics, the developmental disabilities office and the pharmacy of which all complied with CARF standards. Due to the COVID-19 Pandemic, SCLHSA accreditation survey was conducted by ZOOM and comprised of three expert practitioners selected by CARF. During the three-day survey, SCLHSA had to demonstrate that it conformed to a series of rigorous and internationally recognized CARF standards. The survey team visited all aspects of the agency by ZOOM to include administration (leadership, fiscal, human resources, information technology, compliance/risk, quality, environmental services, etc.), developmental disabilities, integrated care (health home), pharmacy and all five behavioral clinics. Interviews were conducted with staff, clients, contractors, stakeholders, board members and representatives from LDH. Based on the results of the survey, CARF prepared a written report of the SCLHSA's strengths and areas for improvement. Since SCLHSA demonstrated exemplary conformance to the standards, the agency earned a three year CARF accreditation which is the highest level of accreditation that can be achieved. Once again, the SCLHSA was pleased to receive a perfect score on this triennial accreditation with references to its areas of strength in relation to services, staff and overall compliance with standards. Additionally, each year during the term of accreditation, the SCLHSA must submit a report to CARF documenting additional improvements it has made to its service array.

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

CARF is committed to providing the greatest value for a provider's accreditation investment. Customers look for CARF accreditation as their assurance that an agency's programs or facilities are of the highest quality. Payers recognize CARF accreditation as a demonstration of superior performance for their clients. As a service provider, SCLHSA now has the advantage of utilizing clearly defined and internationally accepted standards to ensure that our services maintain excellence. Among the many benefits provided by CARF accreditation are: business improvement, service excellence, competitive differentiation, risk management, funding access, positive visibility, accountability and peer networking. All of these factors contribute to our strategic plan by assisting us in the development of policies, procedures and the in initiation of services that are aligned nationally with best practices in the fields of behavioral health and developmental disabilities.

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

"Accreditation" is a comprehensive evaluation process in which a health care organization's systems, processes and performance are examined by an impartial external organization ("accrediting body") to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards. Accreditation bodies or entities evaluate and rate a wide variety of health care organizations, including care management companies, health insurance plans, pharmacy benefit managers, utilization review organizations, wellness organizations, and other health vendors, both in the commercial sphere and through government programs such as Medicare and Medicaid. Accreditation includes a process that identifies best practices and promotes continuous quality improvement supported by ongoing performance measurement. Advisory groups help to draft and periodically review accreditation standards. The independent evaluation itself typically occurs in two stages, starting with an examination of documentation during an off-site "desktop review" followed by an "onsite survey" of operations. Health care organizations that earn accreditation from a nationally recognized accrediting entity validate their level of achieving quality and accountability. Through the accreditation process, accrediting entities can encourage health care organizations to keep pace with emerging evidence-based clinical and quality improvement standards more readily than if undertaken by legislation or regulation alone. In the commercial insurance market, many states use accreditation to comply with state licensure or contract requirements. Some states also require accreditation before an organization can perform a certain function, such as utilization management or external medical necessity reviews. Accreditation often supplements state regulations and reduces the burdens of state oversight by enabling regulators to focus limited agency resources on problematic areas identified in audits. Payers - whether a third-party funder, referral agency, insurance company, or governmental regulator looks for CARF-accredited service providers to lessen risk and provide greater accountability. Behavioral health payers prefer CARF International as an independent accrediting body of health and human service providers. Accredited providers have proven they have applied a comprehensive set of standards for quality to their business and service delivery practices. Because CARF accreditation signals a provider's demonstrated conformance to internationally accepted standards, it can significantly reduce governmental monitoring and help to streamline regulation processes. The value of CARF Accreditation is more than a certificate hanging on the wall. CARF Accreditation is evidence that an organization strives to improve efficiency, fiscal health, and service delivery -- creating a foundation for consumer satisfaction. With the addition of the Health Home (Integrated Care/Primary Care Program) and Services Coordination (DD) this year, SCLHSA is now considered a one stop shop for patients with its holistic approach to care. This designation is not only desired by patients, but by health insurance agents as well.

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

To answer this question, you must determine whether

your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

  Overall, South Central Louisiana Human Services Authority has remained on target with progress toward achieving its Strategic Plan Goals and Objectives. The Authority consistently utilized all strategies outlined in its Strategic Plan to effectively demonstrate performance and quality improvement on a continuous basis. In addition to Strategic Plan Goals and Objectives, implementation of efficiency strategies also produced positive results in the areas of client engagement, documentation of clinical treatment, lowered no-show rate, client satisfaction (internal satisfaction quarterly and annual survey results improved over previous year and showed high marks for all providers, clinicians, support staff, and perceived positive outcomes), and staff retention.

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

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

The entire SCLHSA staff contributed to the success of the CARF Accreditation process. This past year has been one of the most difficult to navigate with the COVID pandemic. The pandemic pushed everyone to their limits both mentally and physically, but our staff stood up in an amazing way to ensure that our patients had what they needed to continue treatment and not miss a step. SCLHSA put the technological resources in place to make sure that all staff had the tools they needed to work from home and to work on site. We never shut down. We kept all our sites open and rotated teams in for services because it was important to maintain as much normalcy as we could for our behavioral health and developmental disability clients. We offered group meetings by ZOOM so that patients could hear the voices of the clinicians

and other patients who have been a part of their recovery and ultimate resiliency to keep them mentally and physically healthy. We increased our telehealth services and added telephonic as well. Our CALL Line staff response was doubled after hours with licensed clinicians, peer support specialists and providers for medication management. We continued our injection services – just made them more efficient as a drive thru at each site. We saw crisis, aftercares and walk in clients in person daily – they were a priority. The list goes on and on, but the bottom line is that we asked our staff to step up and they did. Our patients felt it, the surveyors heard and saw it. SCLHSA staff made it happen.

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

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

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

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

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

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

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

South Central Louisiana Human Services Authority is not experiencing any significant 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?**

N/A as South Central Louisiana Human Services Authority is not experiencing any significant lack of progress.

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

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

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

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

The South Central Louisiana Human Services Authority, a Local Governing Entity, adheres to the Carver Policy Governance Model. The Board of Directors establishes the Authority's Mission, Vision, and Priorities, and selects an Executive Director to provide ongoing administration and operational management of the Authority. The Executive Director presents the Board of Directors with monthly updates and an annual Ends Policy Monitoring Report detailing progress toward the organization's Strategic Plan Goals and Objectives. As an organization that has adopted and actively practices both Accountable Care and Performance and Performance Improvement models/philosophies, South Central Louisiana Human Services Authority continuously communicates, monitors, reports, and implements corrective action/process improvement activities with regard to Strategic Plan Goals, Objectives, and Performance Indicators via a broad range of venues (from

individual supervision to performance reporting available to staff).

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

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

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

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

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

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

There are no significant issues to report.

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

B. Corrective Actions

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

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

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

☒ **Internal audit**
South Central Louisiana Human Services Authority's (SCLHSA) 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 the agency's performance using benchmarks set forth in the Council on Accreditation of Rehabilitation

Facilities (CARF) standards. SCLHSA will implement process improvement and/or corrective action as needed. In addition, 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 a biennial basis through the Office of the Legislative Auditor. The Louisiana Department of Health (LDH) - Office of Behavioral Health (OBH) audits SCLHSA biannually for grant funding and peer review purposes. LDH- Office of Citizens with Developmental Disabilities (OCDD) also audits SCLHSA biannually. Licensing Standards and the Louisiana Department of State Civil Service audits the agency annually as well as Office of Risk Management for Safety and Risk Exposure.

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

☒ **Policy, research, planning, and/or quality assurance functions by contract**
The South Central Louisiana Human Services Authority Adult, Child and Prevention Services Contract Monitors meet monthly with all contracted services for review of contract objectives and to gather service data information. The contract agency or individual has the opportunity to share any issues with service provision or funding at that time.

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

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

are reviewed and changes may be implemented to the contract process for performance improvement purposes.

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. The South Central Louisiana Human Services Authority coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis as well with the Board of Directors, Executive Management Team and all staff. Explanatory notes are provided for positive and negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made directly to the LDH - Division of Planning and Budget if modifications or additions are needed.

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

☒ **Benchmarking for Best Management Practices**
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to national benchmarks from leading states involved in performance-based budgeting activities. Benchmarking is a way of discovering what is the best performance being achieved – whether in a particular company, by a competitor or by an entirely different industry. This information can then be used to identify gaps in SCLHSA's organizational processes in order to achieve a competitive advantage. Using the benchmarking process, SCLHSA can determine the best standard of performance based on other companies' success. Recommendations are made directly to LDH Assistant Secretaries or Secretary, if modifications or additions are needed to any agency planning document.

☒ **Performance-based contracting (including contract monitoring)**
Contracts are required to contain a statement of work (SOW) to be performed and also includes individual and program goals and objectives, deliverables, performance measures and a monitoring plan. Feedback is given at quarterly intervals on the above monitoring features.

☒ **Peer review**
South Central Louisiana Human Services Authority's Performance Improvement Program uses peer review as part of a Provider's ongoing performance and quality improvement initiative. The Authority's Medical Director leads a comprehensive multi-disciplinary peer review in case documentation and review of systems. The Authority initiated this ongoing peer review process that is conducted annually as part of the agency employee evaluation process and for compliance with standards implemented for the CARF accreditation process and other regulatory agencies.

☒ **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 is filed prior to the end of the triennial timeframe. As stated previously, South Central Louisiana Human Services Authority has active process improvement functions that focus on meeting and/or exceeding requirements set forth in the Commission on Accreditation of Rehabilitation Facilities (CARF) Standards, and the Louisiana Department of Health., etc.

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

☐ Other (please specify):

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

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

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

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

The South Central Louisiana Human Services Authority monitors and evaluates its operations and programs on an ongoing basis as described throughout this report and has a well-developed decision-support function in place. Data is analyzed (including trending and projecting future performance) and discussions are held during Board of Director, Executive Management Team Meetings and other SCLHSA Committee Meetings. Findings are shared during individual and group supervision and at All-Staff meetings, as appropriate. Corrective action and/or process improvement plans are developed and executed as needed, and are monitored by the Executive Management Team on a routine basis and by the Executive Director as necessary.

Information concerning South Central Louisiana Human Services Authority's internal reports may be obtained by contacting:

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

or

Kristin Bonner
Deputy Director
South Central Louisiana Human Services Authority (SCLHSA)

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Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department: **Louisiana Department of Health (LDH)**
09-310 Northeast Delta Human Services Authority

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

Undersecretary: **Ruth Johnson**

Executive Director: **Dr. Monteic Sizer**

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

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

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

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

Accomplishment #1: Integrated Care Network and Services

A. **What was achieved?**
NEDHSA successfully implemented numerous special initiatives that stem from our integrative behavioral health approach. The key component of NEDHSA's innovative

approach to our client-centered integrated care program involves the formal establishment of partnerships with community-based agencies and programs. The development and maintenance of a successfully integrated service network are vital to the operation and administration of the integrated approach. Ongoing relationship-building efforts and communication through regular meetings, community involvement, and education, and outreach continue to be the driving forces underlying the agency's success and improved outcomes of the individual served. Some of these initiatives included:

Louisiana Opioid Crisis

To continue NEDHSA's efforts to provide ongoing education about Louisiana's opioid crisis, NEDHSA's Prevention and Wellness services for FY21 focused on educating community leaders, school-aged children, and the general community. NEDHSA's Opioid Use Disorder Prevention Manager spoke at a faith-based conference to address the issue and share how faith-based leaders and organizations can help bring hope and healing. Also, NEDHSA hosted its own events for National Prescription Drug Take-Back in Ouachita and Morehouse parishes. The agency collected 65 pounds of unused and expired prescription pills.

Faith-Based Outreach

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

NEDHSA partnered with New Living Word Ministries (NLW) to provide outreach services to residents of Lincoln Parish. In addition to food distribution, the NLW outreach workers also provided Hepatitis B and C, HIV/AIDS, substance abuse, and mental health treatment education and linkage to testing and treatment services. These services are part of the NEDHSA SAPT Block Grant Requirement for high-risk populations. NEDHSA also partnered with St. Joseph Missionary Baptist Church of West Monroe to host a virtual webinar to discuss "Transforming Grief Talk: The Role of Grief and Loss in Addiction Recovery."

SOWS Program

The NEDHSA Second Opportunity Workforce Solutions (SOWS) program provides supportive employment services to citizens who are clients of NEDHSA and its integrated care network, including citizens who are non-violent criminal offenders being released from incarceration. This program addresses access to employment, which is a social determinant that significantly affects a person's health and ability to thrive in society. The SOWS Program utilizes evidence-based practices to develop Individual Outcome Plans, which reinforce a client's treatment progress. Job readiness skills are provided to assist participants in achieving and maintaining employment in their community of choice. Since it began as a pilot program during the 4th quarter of FY17, approximately 328 clients have been referred to SOWS, with 178 clients being

admitted to the workforce program. In FY2021, 99 clients were referred to SOWS. Of these, 68 got admitted. The number of clients who remained employed for at least 30 days, 60 days, and 90 days in FY2021 are 34, 29, and 22, respectively.

Partners in Employment Program

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

In FY 21, NEDHSA and its partner Goodwill hosted a webinar on the PIE program to build an inclusive workforce and show what diversity in the workplace looks like.

Operation Golden Years

In FY21, NEDHSA continued its partnership with the University of Louisiana at Monroe's College of Business and Social Sciences for its Operation Golden Years initiative. The Operation Golden Years initiative focuses on helping seniors with addiction, drug, and mental challenges and was created to provide increased awareness and support to individuals in our region who are aged 60 and above. The program provides home and community-based services to seniors in need and education and information to seniors about prescription medications and NEDHSA's existing behavioral health and substance abuse and addiction services. The MOU with ULM will allow for increased services, access, and opportunity for our region's older populations. Twice a year, NEDHSA partners with other organizations to provide prescription take-back boxes as part of National Prescription Take Back Day, allowing seniors to dispose of unused prescription medications safely.

Underage Drinking

In FY 21, NEDHSA brought awareness to underage drinking, drug use, mental health, and more among the teenage population in northeast Louisiana in a two-hour Virtual Youth Summit event. The theme for the Youth Summit was "The Power of Youth," which focused on the impact youth can make in the community and helped them understand the power within themselves. The goal of this event was to raise awareness of underage drinking and help youth recognize the power they have for positive change. The event featured three panelists and a keynote speaker.

Tobacco Prevention

In FY 21, the Tobacco Treatment Team at NEDHSA partnered with Madison Parish's Prek-12 and Beyond Next Era Youth Group for the National TAKE

DOWN TOBACCO campaign. The campaign brought youth activists, educators, parents, health advocates, and concerned citizens together to raise awareness against tobacco use in their community, encourage youth to reject the tobacco industry's deceptive marketing, stay tobacco-free, and urge elected officials to take action to protect kids from tobacco.

Emotional Wellness

In FY 21, NEDHSA launched a series of webinars to help citizens in the region improve their emotional wellness. The series shared information on the following topics: nurturing your emotional and physical health, the impacts of being bullied, and emotional wellness management techniques. The series of three videos were viewed more than 240 times.

COVID-19 Social Health Impact

In FY 21, NEDHSA released the results of an online survey to assess the impact of the COVID-19 pandemic on citizens' behavioral, physical, and social health in the service region and beyond. The survey revealed 30 percent of respondents were concerned with having a loved one or household member get COVID-19. More than 18 percent were worried about unknowingly giving someone the disease while they showed no symptoms themselves. The results revealed more than 21 percent of respondents reported increased loneliness, sadness, depression, frustration, irritability, or anger. Each age group of clients reported feeling an overall decline in mental health, with 31 percent of the 18 to 25 age group reporting a decline in mental health.

NEDHSA's Prevention and Wellness Department partnered with the National Guard-Region 8 COVID-19 Vaccination Task Force to provide information on behavioral health and prevention and wellness services in Franklin, Ouachita, and Richland parishes COVID-19 vaccination sites.

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

Clinical Services Initiatives that are implemented ensure that our citizens have access to the care they need, no matter where they enter the health care system, to address the various social determinants faced.

C. **Who benefits and how?**

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

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

NEDHSA consistently works to understand the unique behavioral health needs of the citizens of northeast Louisiana and actively puts programs and services that meet citizens' needs and fill healthcare gaps.

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

YES

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

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

Accomplishment #2: Integrated Behavioral and Primary Healthcare:

A. **What was achieved?**

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

The PIPBHC program is located at Bastrop BHC and Monroe BHC, with expansion to all other NEDHSA clinic locations going forward. In FY2021, 72 clients were enrolled in the PIPBHC Grant program. Six-month reassessments were completed on 35 clients, 104 clients completed 12-month reassessment, 112 clients completed 18-month reassessment, and 44 clients completed 24-month reassessment. Additional agency staff, a data analytics professional, was hired to assist in data compilation of the effect of the social determinants in the Northeast Delta on medical and mental health

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

Behavioral Health and Primary Care Integration are one of the three interdependent frameworks representing NEDHSA's logical framework of program and service delivery. Agency programs and services are built on the foundation of healthcare integration and specifically developed to address the ongoing needs of the clients served. Since its establishment in 2013, NEDHSA has worked to provide integrated health services by not only offering clients access to outpatient and inpatient services for behavioral health and substance abuse and addiction disorders, but also providing clients with access to prevention and wellness programs and other services aimed at treating the whole person. Integrated care further addresses the clients' social and socioeconomic needs, including housing, transportation, and employment, as well as primary healthcare needs. Serving as a grant awardee for this important federal initiative, NEDHSA was allowed to expand existing primary health services by providing funding for additional services and programs related to primary healthcare,

significantly expanding our primary healthcare team, and reaching more clients in need of primary healthcare. Expanding PIPBHC-specific programmatic services to an additional NEDHSA clinic is another step in the agency's goal of fully integrated healthcare services at all outpatient clinics in the future.
By increasing access to healthcare, NEDHSA is able to provide much-needed primary healthcare services to our behavioral health clients. Many of our mental health and substance abuse clients have never visited a dentist or a primary care physician. The lack of primary health access may not only encumber needed behavioral health treatment, but may also lead to the development of preventable illnesses easily detected with basic health screenings. Further, lack of access to regular, ongoing primary care can have a negative impact on patient medication and treatment plan compliance, satisfaction and contentment with health services providers, quality of life, and other variables essential to the maintenance of health and wellness. Thus, having the ability to expand our integrated behavioral and primary health integration program through the acquisition of grant funds continues to have a significant impact on the clients we serve.

C. **Who benefits and how?**

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

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

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

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

Yes, one of the primary strategic initiatives outlined in NEDHSA's Strategic Plan for

FY 2020-2025 is Integrated Behavioral and Primary Healthcare, specifically acknowledging SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) Program and its goals of improving the physical health status of people with mental illness and addictions.

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

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

Accomplishment #3: Developmental Disabilities Services:

A. **What was achieved?**

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

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

technical assistance and training to approximately 60 private provider agencies and three Support Coordination agencies within the region that is contracted to provide supports and services to Waiver participants within the region.

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

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

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

C. **Who benefits and how?**

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

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

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

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

YES (See Section II below.)

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

Yes, this level of support, both financially and philosophically should be shared with other executive branch departments and agencies.

Accomplishment #4: Prevention and Wellness Services:

A. **What was achieved?**

NEDHSA successfully implemented several Prevention and Wellness programs and initiatives, which serve as an integral part of our integrative behavioral health and primary care approach. The NEDHSA Prevention program uses research-based curriculums, environmental strategies, coalition-building, and other proactive and data-driven strategies to prevent and reduce risk-taking behaviors. NEDHSA Prevention and Wellness services include Information dissemination, formation and implementation of community coalitions, community education, alternative activities for youth, school-based interventions, and tobacco retailer (SYNAR) compliance checks. Below is a brief summary of prevention activities for FY21:

LaSOR NARCAN Training and Kit Distribution

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

SYNAR Checks

The SYNAR Program, overseen by the Substance Abuse and Mental Health Services

Administration (SAMHSA), requires states to establish and enforce laws to prohibit the distribution and sale of tobacco products to minors. Regular SYNAR checks are performed to ensure compliance with these laws.

School-Based Opioid Education
During FY20, NEDHSA provided opioid education to students who are in 3rd to 11th grade.

Prevention and Wellness Community Events
In FY21, NEDHSA's Prevention and Wellness Department hosted a series of events aimed at building stronger communities one person at a time. As the COVID-19 pandemic increased the level of anxiety and trauma in our region, especially for those already dealing with mental illness and other challenges, NEDHSA hosted these events to help the people of northeast Louisiana remain hopeful and informed. The events were well-attended and included the following:

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

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

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

- I Am Enough for God:
  Addressing the Opioid Crisis

- Thanksgiving Turkey Giveaway:
  The Prevention and Wellness Department teamed with Northeast New Start Outreach providing meals for families during the holidays in West Monroe High School, the West Monroe Community Center, and in Winnsboro, LA. Information on accessing the agency's resources, Deterra, and other giveaways were provided during the event.

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

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

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

C. **Who benefits and how?**

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

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

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

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

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

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

Accomplishment #5: Regional COVID-19 Response:

A. **What was achieved?**

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

COVID-19 Information Portal

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

We Will Rise: Creating Hope - Daily Inspirational Calls

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

COVID-19 Client and Community Access

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

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

All of the additional initiatives and actions put into place in response to the COVID-19 pandemic were important to the promotion and maintenance of our clients' mental and behavioral health and personal well-being. Recognizing the potential effects and devastation of COVID-19, NEDHSA proactively sought to identify our clients' concerns and the specific issues faced that may contribute to their increased behavioral, physical, and social health needs through implementing the COVID-19 Social Health Impact Assessment. NEDHSA also recognized the

necessity of being calm amidst the storm for our clients who already struggle with many aspects of daily living and were now faced with an uncertain future due to the pandemic and subsequent loss of employment, food insecurities, and other challenges. Therefore, offering daily messages of hope and providing a public platform through the COVID-19 Information Portal on our agency website was important in maintaining a positive connection with our clients and contributing to the promotion of their mental health.

C. **Who benefits and how?**

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

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

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

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

Yes.

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

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

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

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

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

Northeast Delta Human Services Authority's (NEDHSA) strategic plan goals were implemented as outlined in the FY2020-2025 Strategic Plan. Continued progress is being tracked, documented, and reported. Performance improvement processes were implemented in FY19 and continued in FY20 and FY2021 to monitor the number of referrals to NEDHSA partner agencies. The number of persons receiving individual and family support services, Flexible Family Fund services, and developmental disabilities services is noted in the FY2021. Achievement in meeting performance standards is further evidenced by the agency's expansion of services and quality of care.

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

  Northeast Delta Human Services Authority (NEDHSA) is tracking above average on many indicators, but not significantly higher than anticipated. We consider this a measure of stability in our ability to project with increased accuracy and managing the expectations of meeting our goals.

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

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

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

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

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

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

None, as NEDHSA is not experiencing any significant 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?

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?

After completing the 5-year strategic plan for FY2015-2020, NEDHSA revisited its strategic plan to make sure it properly reflects the goals and objectives of the agency and captures areas for improvement for the upcoming years. NEDHSA's FY2021-2025 Strategic Plan was developed with an outcomes-based approach where evaluation, planning, and development of services and programs will be data-driven. New strategies are added to existing ones in order to achieve agency goals. This will allow us to build upon our current successes and further grow in areas where we are continually evolving.

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

Our strategic plan is centrally located on the agency's intranet for all employees to view. A large percentage of the performance indicators are also reported in LaPAS and

through AIP reviews. Our agency has quarterly performance improvement committee meetings to discuss the performance indicators and strategies to enhance our delivery of services. As leadership makes data-driven decisions about management and funding, we consider the performance indicators to help us determine how to streamline our funds and processes for improved outcomes.

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

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

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

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) that 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 challenge in the oversight process for NEDHSA to ensure accountability and successful outcomes. Corrective action for deficits and issues stemming from the SCA's and the private agencies contracted with them are sometimes delayed. It is also noted that various contributing factors may lead to compliance issues with OCDD policies and procedures, including high turnover rates of the support coordination agencies. OCDD is aware of these issues, and is working on an appropriate resolution that will ultimately improve our outcomes. Additionally, there is a need for additional staff to reach more people, address barriers, provide technical assistance, and advocate.

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

3. **What organizational unit in the Department is experiencing the problem or**

issue?
The developmental disability department is experiencing these issues.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   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 issue has been ongoing for 4-5 years.

6. **What are the causes of the problem or issue? How do you know?**
   Noted possible cause of these issues may be the structure of the system. 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?**
   The impact gets reflected in quality of care and services/supports. Some consumers may not receive or have access to services. The overall health and wellness of consumers may become at risk. Failure to meet contract requirements means lost revenue, increased turnover, and increased absence from work.

B. Corrective Actions

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

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

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

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

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

- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

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

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

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

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

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

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

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

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

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

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

NEDHSA has a Corporate Compliance Department which collaborates with the various NEDHSA departments to update and develop policies. In addition, corporate compliance oversees the functions of quality assurance functions, such as peer reviews and quality assurance meetings.

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

NEDHSA's Corporate Compliance Department conducts evaluations of clinical services through record reviews, reviews of consumer complaints, critical incident analysis, and review and analysis of measures in the TeleSage Outcomes Measurement System (TOMS).

☐ Program evaluation by contract

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

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

made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

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

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

☒ Peer review

NEDHSA participates in OBH's annual peer-review process for block grant funding.

☒ Accreditation review

NEDHSA is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

☒ Customer/stakeholder feedback

NEDHSA collects consumer satisfaction surveys on a quarterly basis along with TOMS quality of care surveys on a semiannual basis.

☐ Other (please specify):

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department:	**Louisiana Department of Health (LDH)** 09-320 Office of Aging and Adult Services
Department Head:	**Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Assistant Secretary:	**Elizabeth Adkins** Interim Assistant Secretary

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: National Adult Protective Services Association (NAPSA) Certification

A. **What was achieved?**
The Office of Aging and Adult Services, Adult Protective Services (APS) program completed the National Adult Protective Services (NAPSA) Certification Program of all eligible program personnel.

B. **Why is this success significant?**
Achievement of the NAPSA Certification Program by APS staff is significant because it provided advanced, in-depth training designed to maximize the APS professionals'

existing knowledge and skills. The Louisiana APS program is one of only nine states nationwide to achieve comprehensive program certification.

C. **Who benefits and how?**
NAPSA Certification provides advanced training and establishes and certifies a higher level of expertise in the field of protective services, thereby promoting confidence in the competency and integrity of the APS program throughout our communities and with APS professionals across the nation.

D. **How was the accomplishment achieved?**
APS management provided monitoring of course completion progress, coordination of support, and guidance for all enrolled staff members to ensure the completion of all advanced level training modules by all eligible APS staff members enrolled in the certification program.

Upon the completion of the required advanced level training courses by all enrolled, eligible APS staff members, APS management coordinated with the NAPSA Certification Program designee and the San Diego State University E-Learning Coordinator and submitted verification of the completion for the training courses by APS staff resulting in the successful certification of all enrolled, eligible APS staff members.

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

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
The successful certification of all eligible APS staff members promotes an advanced knowledge base and skills throughout the agency. In addition, it promotes public confidence in the competency and commitment of APS to our service population and stakeholders. Finally, it is an accomplishment to share with other agencies which seek to enhance staff knowledge and training for improved health and safety outcomes for populations served.

Accomplishment #2: Permanent Supportive Housing (PSH) Pandemic Performance

A. **What was achieved?**
The Permanent Supportive Housing office successfully housed 675 disabled households during the height of the pandemic.

B. **Why is this success significant?**
This is important to assuring the state's compliance with the Americans with Disabilities Act and the U.S. Supreme Court *Olmstead* decision. It is also essential to the state's agreement with the U.S. Department of Justice (DOJ) in moving disabled individuals from institutions into the community by providing safe and affordable housing and home based

community services to support successful tenancies. Additionally, this achievement includes over 250 disabled homeless households and several disabled households displaced by Hurricane Laura.

C. **Who benefits and how?**
Low-income individuals with disabilities and their household members benefit from having access to high quality, community-integrated, affordable housing with tenancy supports to help them be successful tenants and maintain housing stability. PSH has a 94% program retention rate and 59% of households see an increase in income after they are housed by the program. PSH reduces inpatient hospital, emergency department, and institutional care which benefits the health outcomes of the population it serves, as well as taxpayers.

D. **How was the accomplishment achieved?**
This accomplishment was achieved through strong partnerships with both state and local level agencies. Several homeless continuums partnered with the state to move homeless individuals into hotels to reduce the risk and spread of Covid19 within this incredibly vulnerable population. The PSH office reached out to these agencies and offered to coordinate and conduct screenings to determine PSH eligibility. Those who were eligible were housed quickly through our tenant based subsidies to speed up the housing process. Through our partnership with LHC, HUD also granted waivers to remove some barriers. Staff was also creative in finding safe ways to complete tasks that are required under Federal guidelines in terms of viewing units, completing paperwork and conducting inspections. They also reached out to landlords who typically rent on a short-term basis who were losing money during the pandemic and pitched the benefits of working with a long-term subsidized program. The program continued to work with the Transition Coordinators with OAAS and OBH to transition individuals from nursing homes and worked with OCDD to house a number of individuals from a group home that was shutting down. Additionally, through joint applications with the Louisiana Housing Corporation, the program was awarded an additional 139 tenant based subsidies and 134 new subsides under the 811 program. These awards significantly increased the program's ability to house disabled households during the pandemic.

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

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

<u>Accomplishment #3: COVID-19 Flexibilities for Home and Community-Based Services (HCBS)</u>

A. What was achieved?

Due to the COVID-19 Public Health Emergency (PHE), Louisiana Department of Health/Office of Aging and Adult Services implemented COVID-19 flexibilities for our Home and Community-Based Services (HCBS) to assist participants and providers. The flexibilities are described below:

Adult Day Health Care (ADHC) Providers:

- Provided retainer payments and time-limited rate increases to ADHC providers to help with the ADHC center closures.
- Created a per diem structure, Health Status Monitoring, to allow per diem payments for ADHC providers that completed wellness checks on ADHC Waiver Participants Added ADHC providers as a provider type for Home Delivered Meals under the ADHC Waiver.

Adult Day Health Care (ADHC) Waiver:

- Added Home Delivered Meals and Activity Sensor Monitoring services under the ADHC Waiver.
- Allowed ADHC Waiver participant to remain in the ADHC Waiver program even if he/she fails to attend the ADHC center for a minimum of 36 days per calendar quarter.

Long Term-Personal Care Services (LT-PCS)

- Increased Long Term-Personal Care Services (LT-PCS) to the maximum of 32 hours per week for ADHC Waiver participants since the ADHC centers were closed.
- Allowed participants to verbally designate/authorize or make changes to their responsible representatives.
- Allowed participants the freedom to choose another LT-PCS provider, if the designated provider was not able to provide services.
- Allowed the Level of Care Eligibility Tool (LOCET) to be used to determine if an individual meets eligibility qualifications for LT-PCS and to determine resource allocation while identifying Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) until the individual is able to have a Minimum Data Set-Home Care (MDS-HC) assessment completed. (The LOCET is a telephone screening tool used by OAAS to preliminarily determine nursing facility level of care for OAAS program eligibility.)
- Allowed the LTC Access contractor to conduct face-to-face requirements (assessments/Plan of Care (POC) meetings, etc.) telephonically or virtually.

Community Choices Waiver (CCW)

- Allowed CCW participants to receive more weekly service hours than assigned for his/her support category, if needed.
- Allowed Monitored In-Home Care (MIHC) providers to conduct their face-to-face requirements via telephonic monitoring.
- Modified the MIHC's principal caregiver requirements to allow the principal caregiver to be the participant's curator; tutor; legal guardian; responsible representative; or the person to whom the participant has given representative and mandate authority (also known as power of attorney).

- Allowed participant to remain in CCW Self-Direction Services even if he/she fails to receive services for 90 days or more.

Personal Assistance Services (PAS), including Self-Directed PAS for CCW, PAS and LT-PCS

- Implemented Hazard Pay for Direct Service Workers (DSWs) working with HCBS participants that test/tested positive for COVID-19 or when a participant has to quarantine due to participant's household member testing positive for COVID-19.
- Allowed PAS or LT-PCS to be provided in the home of the DSW without prior approval from OAAS.
- Allowed the participant to live in the home with the DSW.
- Allowed participants to receive PAS or LT-PCS in another state without prior approval from OAAS.
- Modified DSW requirements to allow the DSW to be the participant's spouse; curator; tutor; legal guardian; responsible representative; or the person to whom the participant has given representative and mandate authority (also known as power of attorney).
- Modified the minimum age required for DSWs.
- Waived background checks on DSWs that live with the participant.

ADHC Waiver, LT-PCS, and CCW

- Allowed individuals to concurrently serve as a responsible representative for more than 2 participants without an exception from OAAS.
- Allowed exceptions to the requirements that services must be provided in accordance with the approved POC and/or supporting documentation.

Support Coordination Agencies (SCAs)

- Allowed SCAs to conduct face-to-face requirements (assessments/POC meetings, etc.) to be conducted telephonically or virtually.
- Allowed SCAs to obtain verbal agreements and/or electronic signatures (from providers/participants, etc.) for required participant documents.
- Allowed the current assessment/re-assessment for ADHC Waiver and CCW to remain in effect past the annual (12 month) requirement. (Allow an extension for re-assessments for up to 1 year past the due date.)
- Allow participant to remain in the CCW or ADHC Waiver program even if services are interrupted for a period of 30 consecutive days as a result of the participant not receiving and/or refusing services.

B. Why is this success significant?

By allowing these flexibilities, the State recognized the needs of the participants and the providers that serve this vulnerable population. Participants were able to stay in their home and receive their needed services during this PHE and providers were able to keep their businesses open and meet the needs of their participants.

C. Who benefits and how?

By implementing these COVID-19 flexibilities, OAAS HCBS participants were able to receive their needed supports and remain in their homes during this pandemic. Providers were able to make modifications to their procedures based on these flexibilities and continued to provide the necessary services to their participants.

D. How was the accomplishment achieved?

In March 2020, when the Federal Government declared the PHE, LDH/OAAS reviewed the current Waiver documents, State Plan Amendments (SPAs) and rules to determine what flexibilities were needed and documented these needed flexibilities. Once the State obtained approvals from CMS through the Appendix K, 1135 and State Plan Amendments and the Emergency Rule was published, LDH/OAAS issued further guidance through memorandums, meetings, and the OAAS COVID-19 Frequently Asked Questions (FAQs).

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, these HCBS flexibilities have been shared with other agencies within LDH as well as other states. OAAS has met with stakeholders and will continue to meet with stakeholders to discuss the possibility of continuing some of these flexibilities beyond the PHE.

Accomplishment # 4: My Place La (Money Follows the Person) Transitions Successes in Light of COVID-PHE

A. What was achieved?

The Deficit Reduction Act of 2005 (Section 6071) enacted the Money Follows the Person (MFP) demonstration, designed to help states move Medicaid-enrolled individuals from institutions back into the community in an effort to systemically rebalance the state's long-term care options. In SFY2010-2011, the Centers for Medicare and Medicaid Services, approved a supplement to the already approved state budget, providing OAAS the opportunity to operate the My Place La program with 100% federally reimbursed funding. The demonstration was slated to terminate in CY 2020, with transition activity ending at the end of CY18. To date, the demonstration's funding and activities have been extended through several short-term Congressional extender acts supported by national and state advocacy groups. Recently, funding for Money Follows the Person was extended yet again for three additional years by the Consolidated Appropriations Act of 2021. High performing MFP states, which is measured in annual transition benchmarks, are given priority in asking annually for additional funds for the continuation of their programs. Louisiana remains a high performing MFP state.

Despite COVID-19 lockdowns and social distancing orders as it relates to Nursing

Facility residents, OAAS's My Place staff were able to transition 243 people from March 13, 2020 through June 30, 2021 continuing the program success of achieving annual transitional benchmarks. This also allowed nursing facility residents the opportunity to transition back home to a more contained environment as COVID 19 was rapidly spreading in long term care facilities.

B. Why is this success significant?

Whereas other MFP states were struggling to meet transition benchmarks due to long-term institutional lock downs and social distancing orders, OAAS's My Place La program was able to come up with creative solutions that allowed the continuation of transitions to occur safely. Per CMS's request, the OAAS My Place director was asked to attend conference calls with other MFP states to provide guidance and discuss the creative solutions Louisiana utilized that allowed the continuation of transitions to occur during this public health emergency. This guidance assisted other MFP states in creating useful workarounds to combat their programs inability to transition participants due to social distancing and lockdown mandates. Achievement of transitional benchmarks allows for continued funding of My Place and keeps Louisiana recognized by CMS as a high performing MFP state.

C. Who benefits and how?

The Office of Aging and Adult Services, Medicaid, and nursing facilities recipients desiring to transition back into the community benefit from My Place Louisiana initiatives. Continued success of transitional benchmarks yields continual funding of the program which allows OAAS the ability to create infrastructure to support successful transitions presently and in the future. The department benefits in that for every transition that occurs, the department receives enhanced FMAP for Medicaid services that are provided for the first 365 days after someone has transitioned and signed up to participate in the demonstration. The cost savings is put into a rebalancing fund in which the Office of Aging and the department can utilize to expand or improve Medicaid long term care services. CMS benefits from the completion of surveys conducted on participants which measure their satisfaction with Medicaid services received in an institutional setting versus Medicaid long term care services received in the community. Most importantly, the My Place Louisiana participants benefit by having access to needed supports that remove barriers that prevent their ability to transition back into the community.

D. How was this accomplishment achieved?

This accomplishment was achieved by the OAAS My Place staff working in conjunction with OAAS regional office staff, contract Home and Community Based Services support coordination agencies, Nursing Facility discharge staff, the Louisiana Permanent Supportive housing program, and local housing resources. All those involved worked to coordinate and facilitate the timely and successful transition of participants from institutional care to home and community based care in the community. The aforementioned entities worked together in collaboration to ensure that the workarounds of continued nursing facility priority waiver offer deliveries, housing applications, and virtual assessments and discharge planning continued during the public health pandemic. All collaborative work allowed LDH/OAAS and My Place to be successful in their

transitional benchmarks for the calendar year.

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

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, lessons learned on this accomplishment should be shared so that other departments or agencies can benefit from learning about barriers and/or success of the demonstration and to develop or promote "best practices" with institutional to community living transitions. Louisiana's My Place program, recognized by CMS as a high performance MFP state, and has been asked several times (by CMS) to provide guidance and support to other MFP states that are struggling to achieve transition benchmarks.

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.

OAAS continues to make progress in many areas related to its strategic goals and objectives.

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

The accomplishments above contribute significantly to the OAAS strategic progress. They correspond to OAAS strategies, as outlined in the OAAS Strategic Plan, and have helped the agency make progress on Program Goals including:

1. Achieve and maintain a legally compliant and appropriately balanced LTSS system, which assures choice within a sustainable, cost-effective continuum of community-based services and facility-based services.

2. Improve access, quality and outcomes for populations receiving and at risk of needing long-term supports and services.

3. Ensure vulnerable adults are protected from abuse and neglect while living in community settings.

4. Administer and operate OAAS programs in a cost-effective manner while achieving high quality outcomes.

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

  Adult Protective Services' (APS) completion of the NAPSA Certification Program, by promoting the OAAS Strategic Plan Goals: #2- "Improve access, quality, and outcomes for populations receiving and at risk of needing long-term supports and services" and #4- "Ensure vulnerable adults are protected from abuse and neglect while living in community settings. Permanent Supportive Housing (PSH) Pandemic Performance and the Home and Community Based Services (HCBS) flexibilities among the Public Health Emergency are accomplishments that contributes to the OAAS guiding principles to "increase awareness of need of aging and disabled adult population, specifically related to meeting long term care needs while supporting choice and self-determination" and "to adopt rules, policies and procedures that, while consistent with legal requirements, are also easily understandable, practical, and flexible." The My Place Louisiana, Money Follows the Person (MFP) Transitions program and continued funding, are helping OAAS make progress on maintaining an appropriately balanced LTSS system and will help the office improve on LAPAS measures related to the percentage of LTSS recipients who are served in the community. The continued success of the My Place program allows OAAS to continue their work on the rebalancing of long term care funding from institutional based care to home and community based options for the citizens of Louisiana. The rebalancing is realized in the savings to Medicaid which averages $30,567 for each person transitioning from Medicaid institutional based care to home and community based care (HCBS). The savings, coupled with the enhanced FMAP that is given for the first 365 days of a person's HCBS, is rebalanced to assist the department in funding additional nursing facility priority waiver offer slots. This allows for the continuation of nursing facility priority waiver offers to residents desiring to return back to the community to receive their long term care services.

1. **To what do you attribute this success?** For example:
   - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?

   Progress would not have occurred without specific department action.

   - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

   Accomplishments were achieved through both allocations of new resources and strategic use of existing resources.

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

Most efforts were joint with other agencies, with the exception of the Adult Protective NAPSA certifications was led by OAAS.

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

These accomplishments will produce ongoing gain.

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

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

Due to structural issues in statute and regulation, Medicaid spending for nursing facility care continues to rise faster than increases in access to and payment for community-based care. Furthermore, delivery of Long Term Services and Supports (LTSS) alone is not sufficient to address the significant chronic care needs of the population served by OAAS; a problem which contributes to the state's low ranking on various national health and LTSS scorecards.

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

The lack of progress in rebalancing more towards community-based care and away from use of nursing homes is due primarily to statutory requirements and constraints that impact Medicaid long term supports and services funding and is likely to continue, especially as the population ages.

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

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

  OAAS made revisions to its strategic plan in FY19, and the plan is good through 2025. It was not necessary to make substantial revisions this fiscal year.

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

  The vision that OAAS maintains of increasing access to home and community-based services as a sustainable, cost-effective alternative to nursing home care, in addition to improving access, efficiency, and quality in all OAAS programs, is key to integration of the OAAS strategic plan in other departmental processes such as budget and business plan development. Whether it takes the form of AMPAR reporting, LAPAS performance indicators, "transformative" business objectives, or budget explanations/justifications, OAAS strategic goals and objectives are clear, consistent over time and administrative changes, and understood by all OAAS staff. OAAS has been fortunate in having access to data that allows management and staff to monitor program outcomes, often against national goals and benchmarks. This allows OAAS to adjust strategies as needed to attain office objectives. Because OAAS administers Medicaid funded programs, OAAS works very closely with that agency and other LDH offices to assure strategies and goals are aligned.

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

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

There are no significant management or operational problems to report.

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
      There are no significant department, management or operational problems to be noted.
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.) N/A.
   3. What organizational unit in the department is experiencing the problem or issue?

N/A.

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

B. Corrective Actions

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

☒ No. If not, skip questions 1-4 below.
☐ Yes. If so, complete questions 1-4 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, 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, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

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

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

☐ Peer review
☐ Accreditation review
☒ **Customer/stakeholder feedback**
OAAS conducts consumer experience surveys with recipients of Medicaid home and community-based services and uses survey findings to improve those programs and services. OAAS also meets regularly with external stakeholders including quarterly provider trainings/meetings at the regional level; quarterly meetings with Support Coordination agencies; and Advisory Group meetings for the Department of Justice Agreement.

☐ Other (please specify):

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department: **Louisiana Department of Health (LDH)**
09-324 Louisiana Emergency Response Network

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

Undersecretary: **Ruth Johnson**

Executive Director: **Paige Hargrove**

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

Accomplishment #1: Media campaign to educate public on signs and symptoms of stroke and heart attack and the importance of seeking care at a hospital during COVID

A. **What was achieved?**

Media campaign to alert citizens to signs and symptoms of Stroke and Heart Attack, the importance of calling 911 and transport to a hospital – despite fears of COVID.

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

Stroke and STEMI are time sensitive illnesses with high morbidity and mortality rates.

C. **Who benefits and how?**

Citizens of Louisiana experiencing stroke or STEMI and their families.

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

LERN surveyed neurologists and cardiologists in all 9 LDH regions to validate concerns brought forth by stakeholders throughout the state regarding in the decline in the number of patients presenting to the hospital emergency rooms with diagnoses of stroke and STEMI (heart attack). Once validated, LERN partnered with the American College of Cardiology to develop an educational infographic which was shared

statewide via LERN's Facebook, the LERN Newsletter and with all hospital and EMS partners. We asked hospitals and EMS to use their media platforms to sound the alarm and provide education in their communities. The LERN Stroke Medical Director was interviewed by several media outlets and LERN encouraged the regional stroke champions to engage the media as well.

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

Yes – Goal 3: Ensure all citizens gain access to the statewide networks for trauma and time sensitive related illnesses.

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

It shows the importance of utilizing collaborative partnerships and the agency structure (regional commissions) to evaluate a problem and implement a plan.

Accomplishment #2: Management of the EMS Tactical Operation Center (TOC) August - November:

A. **What was achieved?**

During 2020 hurricane season, Louisiana had five named storms make landfall, three of which were hurricanes. The EMS Tactical Operations Center (EMS TOC) was activated from August – November 6, 2020. The EMS Tactical Operations Center manages the incoming resources and coordinates response to deploy assets where they are needed. Louisiana Emergency Response Network (LERN) coordinated ambulance and para-transit assets to ensure patients were transported out of harm's way. A total of 359 ambulances and 131 paratransit vehicles were utilized across the state.

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

EMS systems and regional hospitals were greatly impacted by the 2020 hurricane season – specifically south west Louisiana. There were not enough EMS assets in the area or state to respond to the critical needs of the impacted area. LERN, through the state health officer, activated the state EMS surge contract and the federal contract. This provided the assets needed to safely and quickly evacuate Lake Charles Memorial Hospital and respond to other community needs. This is significant because the coordination and activation of these assets saved lives by transporting hospital patients to non-impacted hospitals out of the area and transporting citizens to shelters.

C. **Who benefits and how?**

Patients, EMS providers, hospitals, and community members all benefitted from this accomplishment.

- Patients

LERN facilitated the evacuation of 127 patients out of Lake Charles Memorial Hospital (both placement, transport, and tracking). They benefit by having their health care provided by a hospital that is operational and able to meet their needs.

- EMS providers:
  EMS did not have enough units to meet the demands of the community. These additional units/staff benefited EMS by helping them meet the needs of their community and provide needed rest for their staff. In addition, some agencies were impacted by COVID and needed additional staff to simply maintain their normal response times and service to their catchment areas. LERN assigned units to these agencies until quarantine was complete.

- Community:
  Lake Charles and surrounding areas were severely impacted by Hurricane Laura and Delta. The community benefited from the para-transit vehicles which were utilized to transport individuals and families to hotels outside of the affected area.

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

The ESF-8 network prepares yearly to respond to disasters. This was accomplished by maintaining the Hospital Preparedness Program network, conducting annual drills and maintaining relationships with response partners. The State EMS Surge Contract was also key to the response effort.

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: Implemented STEMI Data Collection for STEMI Receiving Centers

A. **What was achieved?**
Louisiana Emergency Response Network (LERN) developed data collection requirements and implemented process for STEMI (ST-elevated myocardial infarction) Receiving Centers.

B. **Why is this success significant?**
A key component of any system of care is quality metrics/performance measurement. As a state it is important to know if the STEMI System of Care we developed in 2014 meets national benchmarks. This success is significant because we now know our strengths and where we need to improve in order to provide timely access to quality STEMI care statewide.

The most deadly type of heart attack is STEMI, which is a total or nearly total blockage of a coronary artery that supplies oxygen-rich blood to part of the heart muscle. Lack of blood and oxygen causes that part of the heart to fail.

C. **Who benefits and how?**
All STEMI patients. STEMI Receiving centers benefit because we are giving them the tools for Performance Improvement and data that compares their metrics to other receiving centers in Louisiana as well as to national benchmarks. Our data indicates that as a state our STEMI Receiving Centers do very well assessing patients that present directly to the Receiving Center by EMS or private vehicle (Door to Balloon time median = 89 minutes. National benchmark is 90 minutes). We do not do as well on patients transferring into the Receiving Center from outlying community hospitals (Median = 135 minutes). LERN is working with Referral Centers and EMS to improve this time. Faster Door to Balloon time = better outcomes for heart patients.

D. **How was the accomplishment achieved?**
Our STEMI System and data collection are based on the American Heart Association guidelines. Utilizing nationally recognized criteria helped to foster "buy in" by our hospital partners. After a successful pilot, the LERN Board set a goal of 100% submission by Q1, 2021. We achieved 95% submission. This was also achieved through the leadership of our STEMI Medical Director and the work of LERN three RN Regional Coordinators. They worked directly with hospitals to implement this project.

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

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

<u>Accomplishment #4: Pediatric Trauma Program at Children's Hospital New Orleans</u>

A. **What was achieved?**
Children's Hospital New Orleans committed to the development of a Level II Pediatric Center. They achieved the first step by attesting to meeting the LERN defined requirements and the LERN Executive Committee approved their Program. They should receive a consultative visit from the American College of Surgeons in early 2022.

B. **Why is this success significant?**
There are zero pediatric trauma centers in Louisiana. There are only two other Trauma Programs in Louisiana. One is located in North Louisiana at Ochsner LSU Health

Shreveport and the other in Baton Rouge at Our Lady of the Lake Children's Hospital.

C. **Who benefits and how?**
Children injured in Louisiana South of Alexandria. More children die of injury each year than from all other causes combined. Only 57 percent of the nation's 74 million children live within 30 miles of a pediatric trauma center that can treat pediatric injuries, regardless of severity. Although most traumatic injuries are treated in hospital emergency departments, hospitals may not have the resources needed to treat injured children. For example, they may lack specially sized medical equipment, or surgeons willing/capable of operating on pediatric patients. Pediatric trauma centers, however, are required to have these resources.

D. **How was the accomplishment achieved?**
The LERN Board directed the LERN Executive Director and the Trauma Medical Director to engage hospitals with pediatric capability and ask them to consider pursuing pediatric trauma center verification. We focused on existing adult trauma centers and other hospitals specializing in pediatric medicine. We made the case for the need and community benefit.

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

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
The trauma program and medical director consultation is probably unique to LERN. Developing mechanisms to provide consultation and a road map to achieve a desired goal should be a best practice for all.

Accomplishment #5: LERN Communication Center Expanded duties in support of Region 5 during Hurricane Laura/Delta

A. **What was achieved?**
The LERN Communication Center activated an emergency contingency plan to route patients that fell outside of normal operations.

B. **Why is this success significant?**
This was necessary due to the limited number of facilities able to care for patients post hurricanes Laura and Delta. Many facilities were left without power, water, staff, and/or HVAC. Facilities that managed to stay open were very limited in their capabilities. During this time, the LCC directed movement of 87 patients to resourced hospitals in other regions. This is significant because it allowed the impacted hospitals to decompress and focus on getting services back on line. It also allowed patients to receive care in fully functioning hospitals in a timely manner.

C. **Who benefits and how?**
Impacted hospitals and patients in Region 5.

D. **How was the accomplishment achieved?**
The strong Designated Regional Coordinator (DRC) network, established through the ESF-8 network and the Hospital Preparedness grant, has fostered strong working relationships between LERN, the hospital and EMS DRCs at the regional level. We kept in constant communication as we supported them with additional ambulance assets, para-transit assets and hospital evacuations. The DRCs asked if we could help direct "non-LERN" patients that would probably need admission, out of the region. We were happy to assist.

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

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

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

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

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

  Yes, Louisiana Emergency Response Network (LERN) is progressing towards meeting the goals and objectives set forth by our strategic priorities. Progress was slowed a bit due to COVID-19. Returns on investment are being met, but without comprehensive trauma, stroke and STEMI registries it is difficult to demonstrate outcomes.

  Goal I: Decrease risk adjusted trauma-related deaths and incidents of morbidity and mortality due to trauma in Louisiana.

  - Six Louisiana Trauma Centers are participating in the Trauma Quality Improvement Program (TQIP). The collaborative allows for us to look at benchmark risk-adjusted outcomes as a state system against all nationally participating TQIP centers, discover areas for system-level trauma center quality improvement and identify and share best practices among collaborative participants.

- We do not have a comprehensive trauma registry. We have 11 hospitals submitting data to the state trauma registry. This is up from seven in CY 16. We made tremendous progress fixing the major issues encountered in 2019 with our trauma registry. LERN's software vendor is a stand-alone product that does not directly participate in the Trauma Vendor Alliance. We have been working with them for several months to map additional fields from the submitting hospitals to the state trauma registry. Unfortunately, none of the trauma facilities in Louisiana uses the same software as the state. All data has to be mapped into the state registry from 3 other software vendors. ESO has acquired all of three of these vendors and is working towards making a single streamline software solution. If the state could move to this product, we would eliminate mapping issues and other software inconsistencies with importing outside data from multiple sources. The state would have the added benefit of working with one vendor for all data related issues. The transition to ESO comes with a significant cost that is outside of the current budget capabilities of LERN. Fortunately, we finally completed the mapping in June 2021.

- We now have nine designated trauma centers in the state.
    - University Health Shreveport – Level I Trauma Center
    - University Medical Center New Orleans – Level I Trauma Center
    - Rapides Regional Medical Center – Level 2 Trauma Center
    - Our Lady of the Lake Regional Medical Center – Level 2 Trauma Center
    - North Oaks Medical Center – Level 2 Trauma Center
    - Lafayette General Medical Center – Level 2 Trauma Center
    - Lakeview Regional Medical Center – Level 3 Trauma Center
    - St. Tammany Parish Hospital – Level 3 Trauma Center
    - Lake Charles Memorial Hospital – Level 3 Trauma Center

All of these efforts are improving morbidity and mortality, but we need a comprehensive registry and an upgraded state trauma registry in order to provide valid data.

Goal 2: Maximize the return on investment (ROI) of state dollars and supplement of general fund dollars with alternative funding sources.

- The LERN Call Center tracks secondary transfers as part of its performance metrics. The LERN benchmark is less than 5%. Secondary transfers, especially for time-sensitive illnesses such as trauma, stroke and STEMI, are detrimental to patient outcomes. A considerable number of these transferred patients undergo potentially preventable, repeated CT scans adding radiation dose to patients and costs to the healthcare system. Patients directed by the LERN Call Center, for the past 3 years, have a 3% secondary transfer rate. In CY 2020 the secondary transfer rate for the LCC was 4%. We believe this increase was due to the bed capacity issues statewide due to COVID and multiple hurricanes. In CY 2018, patients not directed by the LCC had a 24% secondary transfer rate and in CY 2019 this increased to 31% and in CY

2020 a further increase to 37%. Cutting down on secondary transfer's saves money. We are not able to attribute a dollar amount to this efficiency. We continue to depend on the state general fund for LERN Operations.

- We received a grant from the Living Well Foundation for $21,330 to teach Emergency Nurse Core Curriculum to nurses in the Foundation catchment area.
- We received $40,000 in grant funding to support the EMS Registry.
- We received $60,000 in equipment from the Hospital Preparedness Grant to upgrade equipment in the LERN Call Center that was at their end of life.
- Anticipated returns on investment are being realized in terms of efficient use of resources.
- We continue to look for grant funds.
- Funding bill for LERN presented in 2019 Regular Session. The bill did not pass.

Goal 3: Ensure that all citizens gain access to the statewide networks for trauma and time sensitive related illnesses.

- LERN has participation agreements with 98.3% of the Tier 3 hospitals in the state.
- The expansion of the number of trauma centers from two in 2011 to 9 in 2020 provides 82.2% of the population with access to a trauma center within a 60-minute drive time. This is up from 40% in 2011.
- LERN developed a Trauma Program status for those hospitals working towards trauma center designation. This expands access to high level trauma care. Three hospitals have taken advantage of this process and subsequently passed verification by the American College of Surgeons (ACS):
    - Lake Charles Memorial Hospital
    - St. Tammany Parish Hospital
    - Lafayette General Medical Center

  The following three hospitals have been approved as a trauma program:
    - Ochsner LSU Health Shreveport attested to meeting Level II Pediatric Program requirements. ACS-COT survey in July 2021. Site survey by ACS was extended 1 year due to COVID-19.
    - Our Lady of the Lake Regional Medical Center – Consultation visit by the ACS extended 1 year due to COVID-19. ACS consultative survey is scheduled for October 2021.
    - Children's Hospital New Orleans – Consultation visit requested for October 2021, but not yet scheduled due to the American College of Surgeons being backlogged from COVID delays.
- When considering the nine Verified Trauma Centers and the three trauma programs, 82.2% 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 has made significant progress in generating trauma center interest in Northeast Louisiana.

We anticipate at least two hospitals submitting an attestation to LERN as a Level III Trauma Program. The LERN Trauma Medical Director provides consultative services monthly.

- 100% of the population has access to the LERN Call Center for assistance with direction to the most appropriate resourced hospital for trauma, stroke or STEMI.
- LERN established criteria for four levels of stroke hospitals. These levels are used by the public and EMS to access the appropriate hospital for stroke care. Due to new levels of stroke care nationally, the LERN Board changed the nomenclature from Level 1-4 to accommodate Thrombectomy Capable Stroke Centers. The new LERN Levels are: Comprehensive Stroke Center (CSC= formerly Level I), Thrombectomy Capable Stroke Center (TSC= new), Primary Stroke Center (PSC = formerly Level II), Primary Stroke Center with Endovascular (PSC-E = new), Acute Stroke Ready Hospital (ASRH = formerly Level III), and Stroke Bypass Hospital (formerly Level IV). A stroke bypass hospital does NOT have the capability of taking care of stroke patients. LERN has built a network of stroke centers that provides the public access to either a CSC, TSC, PSC/PSC-e, or an ASRH to 99.3% of the population.
- Performance metrics for stroke meet or exceed national benchmarks:
    - Door to Needle for Acute Stroke Ready Hospitals = 52.5 minutes with 73% of treated patients receiving alteplase within 60 minutes and 30% within 45 minutes. 6% were treated within 30 minutes of arrival. National benchmark is 60 minutes.
    - Door to Needle for CSC, TSC and PSC = 40 minutes
- LERN established criteria for STEMI Receiving centers which require 24/7/365 access to a cardiac catheterization lab. In CY 2020, the LERN Board re-evaluated the STEMI Receiving Center Requirements and vetted the agreed upon changes with the 9 Regional Commissions and the State STEMI Workgroup. These changes were adopted by the LERN Board in January 2021. There are 37 STEMI Receiving Centers in the state. These 37 hospitals provide 96.6% of the population with access to a STEMI Receiving Center within a 60-minute drive time.
    - Door to Needle time for Louisiana STEMI Receiving Centers = 62 minutes
- LERN also formalized the burn system in Louisiana, helping to provide timely burn care statewide. LERN continues to meet with the LERN Burn workgroup to implement and evaluate the state burn system. The 4 burn medical directors developed a course for LERN's learning management system = "Burn Basics for EMS". LERN secured 3 continuing education hours for paramedics who successfully complete the course. 140 EMS practitioners have completed the course.
- Despite COVID, LERN continued education efforts across the state as appropriate and safe. For CY 2020, those courses included:
    - Trauma Nurse Core Curriculum (TNCC) = 25 classes, 251 students
    - Emergency Nurse Pediatric Course (ENPC) = 25 classes, 203 students
    - 12 Lead EKG Course = 8 classes, 263 students

  - Rural Trauma Team Development Course = 1 class, 34 students
  - Stop the Bleed Course = 13 classes, 252 students
  - AIS Course – 1 class, 32 students
- EMS Registry continues to be developed. We now have 41 EMS agencies participating in the registry. In December 2012, we only had 13 providers submitting data to the state registry. We are sharing data from the EMS Registry with LDH for an opioid surveillance project. We submitted data to NEMESIS again this year per our goal and are completely compliant with NEMSIS 3.4 requirements. Developed standard EMS reports for specific metrics which are distributed to EMS agencies quarterly.
-

Goal 4: **Establish** and codify protocols that specify the role of LERN in ESF-8 activities.

- Continue LERN's role in the ESF-8 to include manager of the EMS Tactical Operations Center during a disaster.
- LERN involvement in disaster drills throughout the state
- Conducted tabletop exercise with the EMS Surge Ambulance contractor to test our processes and procedures.
- LERN is leading efforts to build out the BURN Annex in the state disaster response plan. This will fill requirements of the Hospital Preparedness grant. Focus is on education, training/drills and regional burn resources.
- Activated TOC for Hurricanes Laura and Delta.
- Coordinated transport and placement of 127 patients evacuated from Lake Charles Memorial Hospital.

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

1. To what do you attribute this success? For example:
   - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?

This pass year Louisiana Emergency Response Network (LERN) finalized the STEMI Data Collection process. This progress is a direct result of the LERN Board's directive, leadership of the STEMI Medical Director, and the LERN Staff. These results would not have been generated without the specific department action. We have 95% of STEMI Receiving Centers submitting data to LERN. The engagement and participation of our nine LERN Regional Commissions also contribute to our success.

We also made significant progress with our burn system. We now have:

- Burn Destination Protocol
- ED Burn Guidelines
- EMS Burn Guidelines

- Burn Basics for EMS on line education course

This success is directly related to LERN's efforts to develop the State Burn System. This would not be possible without the organization and coordination efforts of LERN.

- Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

Yes – progress is directly related to specific department actions. LERN is the lead agency for the development and implementation of the states trauma and time-sensitive illness systems of care (stroke and STEMI). New policies were developed by the LERN Board to require all STEMI Receiving Centers to submit data to LERN. The goal was 100% by Q1, 2021. We achieved 95%.

The addition of the LERN Data Manager has been key to our ability to aggregate the STEMI Data and produce reports for the individual hospitals. LDH approving this FTE has been a game changer for LERN. Continued improvements in Quality/Performance Improvement processes are directly related to allocating a FTE for a Data Manager. Since this position was added, we have:

- Redesigned the Case Review ACCESS Data Base. This improvement allows us to track/trend PI issues. This is important in pinpointing specific system issues (Ex: Hospital, EMS, or LERN).
- Developed an error report which allows for efficient scrubbing of data and more accurate reports for our regional partners. This also saves a significant amount of time for the LERN Call Center Supervisor. The process is 100% more efficient.
- Standardized regional commission reports.
- Developed STEMI Data repository to include individual hospital reports comparing individual performance to the state and national benchmark.
- Developed Stroke reports for individual hospitals which compares individual performance to the state and national benchmarks.
- Utilizing the EMS Registry to evaluate trauma patient transports.

- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success? No, this is not related to the efforts of multiple departments.
- 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?

No, we will continue to make progress with the STEMI System of Care. The data reports will help us target interventions to improve the system. The efficiencies brought forth by the data manager will continue.

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

1. To what do you attribute this lack of progress? For example:
    - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?

The major area we are experiencing a significant lack of progress on is, lessening the dependence on the state general fund for LERN funding. However, this is not a management issue.

Concerns center on the EMS paramedic shortage. The LERN Communication Center is currently staffed, but it has become increasingly difficult to find staff. This is the result of two factors:

- EMS shortage
- Due to this shortage, EMS providers are paying higher salaries than the current staffing contract allows or the LERN budget can cover.

- Is the lack of progress due to budget or other constraint?
  The ability to pass a tax or fee is due to the political climate in Louisiana. Most trauma systems are funded by a tax or fee. LERN has been unsuccessful on two attempts to pass legislation to fund LERN outside of the general fund. One was a fee to land lines and the other was a fee added on the driver's licenses.

  The EMS shortage is due to the factors affecting the industry: COVID and EMS now being able to work in non-conventional roles (community para-medicine, IV infusion). This expansion is good for the profession, but the supply of paramedics needs to keep pace.

- Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
  See above.

- Other? Please specify.

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

   Lack of funding will continue to be a limiting factor in LERN being able to fully build out systems of care for Trauma, Stroke and STEMI. The reliance on the state general fund will continue until we can pass legislation to create a dedicated funding source outside of the State General Fund to fund the system. The registry will continue to be an issue until as a state we legislate mandated participation and purchase a registry capable of integrating EMS registry data with trauma registry data. State trauma systems funded via fees or fines use this revenue to fund the state trauma registry.

- **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 2018, we developed new strategic priorities for 2019-2021. At the August 2021 meeting, we will establish a new 3-year strategic plan for 2022-2024.

  ☐ No. If not, why not?

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

  The Executive Director provides a report to the LERN Board of Directors (BOD) at least quarterly. This report includes progress to goals for each strategic priority. The strategic plan is completely re-evaluated annually by the LERN BOD. The LERN Regional Commissions are informed through the Tri-Regional Coordinators, the LERN Administration and Medical Directors. The Tri-Regional Coordinators also submit quarterly Commission Activity Reports (CAR) that provide information on what is being done at the regional level to achieve strategic priorities.

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

("Problems or issues" may include internal concerns, such as organizational structure,

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

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

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   An issue is the EMS shortage in the state. While it is not currently a problem, it is a concern. LERN Communication Center has two part-time positions that has not been able to be filled. The last person that was offered a position turned down the offer due to pay. Often times the part-time employees work full time at an EMS agency. Currently, EMS is paying premium over time. Budget constraints do not allow LERN to match or exceed these pay scales.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.
   Not currently.
3. What organizational unit in the department is experiencing the problem or issue?
   LERN Communication Center. We are having to pay over-time to accommodate staff vacations at a higher rate than normal.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   EMS industry as a whole are facing staffing shortages.
5. How long has the problem or issue existed?
   Problem has become concerning for LERN in the past 4 months.
6. What are the causes of the problem or issue? How do you know?
   National EMS shortage.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   The LERN Communication operates 24/7/365. By statute R.S 40: 2845. A.(1) The Board shall Establish and maintain a statewide trauma system that shall include a centralized communication center for resource coordination of medical capabilities for participating trauma centers as defined by R. S. 40:2171 and emergency medical services. If we cannot adequately staff the communication center, we will not meet this legislative mandate.

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?
   Increase in hourly rates for LERN Call Center Communicators.
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   No, this is a new problem and it will be addressed in the next budget cycle.
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?
        This is a new concern and it will be addressed in the next budget cycle.

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.
      Existing staffing contract needs to be increase by 4% (36,360) to not only improve our ability to hire staff, but to retain our existing staff.
   b. How much has been expended so far?
      Annual contract is $909,000
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
      No, this cannot be absorbed in the LERN Budget.
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of

financing for any additional funds.

- $36,360 annually. The LCC Staffing Contract is actually funded out of LDH's budget via a LINCCA agreement with Louisiana Clinical Services.

- Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests? No

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

A. Check all that apply.

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

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

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

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

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

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

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

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

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

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

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

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

B. Did your office complete any management reports or program evaluations during the

fiscal year covered by this report?

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

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

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

1. **Title of Report or Program Evaluation:**
   LERN Annual Report FY 19-20

2. **Date completed:**
   March 2020

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
   Required by LERN Legislation La R.S.40:2845

4. **Methodology used for analysis or evaluation:**
   Data included in the report is obtained from call center data, from the EMS registry, stroke registry, and education-tracking log.

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

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

7. **Major Recommendations:**
   None.

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

9. **Availability (hard copy, electronic file, website):**
   Available on the LERN Website www.LERN.La.Gov – specifically via the following link:
   https://lern.la.gov/wp-content/uploads/LERN-Annual-Report-2020_FINAL_20210325_Web.pdf
   Hard copy available upon request.

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

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department: **Louisiana Department of Health (LDH)**
09-325 Acadiana Area Human Services District

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

Undersecretary: **Ruth Johnson**

Executive Director: **Brad Farmer**

I. What outstanding accomplishments did your department achieve during the previous fiscal year? For each accomplishment, please discuss and explain each item below.

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

Accomplishment #1: Partnership Heart of Hospice and Families Helping Families to provide a Easter baskets for children with developmental disabilities and/or dealing with mental health issues in the community

A. **What was achieved?**
Partnered with Heart of Hospice and Families Helping Families to give Easter Baskets to kids with DD and/or Mental Health issues

B. **Why is this success significant?**
It allowed the community and children with developmental disabilities and/or mental health issues to interact and receive an Easter basket . Also provided children with DD and/or dealing with Mental Health issues the same opportunities available to all.

C. **Who benefits and how?**
Children with developmental disabilities and/or dealing with Mental Health issues 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 Heart of Hospice and Families Helping Families. Easter baskets were collected through their networks and all assisted with delivery of the baskets to the children.

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

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

Accomplishment #2: Continued Partnership with OCDD regarding the tiered waiver system

A. What was achieved?
Partnered with OCDD for the continued administering of the tiered waiver system.

B. Why is this success significant?
It changed the way the request for waiver services registry (waiting list) is implemented. It has gone from a first come first serve registry to as needs based screening process.

C. Who benefits and how?
Individuals with developmental disabilities and their families. It will allow quicker access to home and community based services.

D. How was the accomplishment achieved?
OCDD partnered with the district and authorities throughout the state to screen all of the individuals on the registry. Once done, the needs of those individuals were established. Priority was given to those with the highest, most urgent need. Once approval from CMS was given, waiver opportunities began under this new criteria in the final quarter of fiscal year, 2017-2018.

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

Yes

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

Yes

Accomplishment #3: Initiation of Telehealth Services

A. What was achieved?

Telehealth prescriber services were initiated in January 2020, followed by full provision of clinical services by all staff beginning March 2020 (due to COVID-19 restrictions).

B. Why is this success significant?

The initial prescriber services were implemented to fill service time vacated by contract prescriber moving out of the area. Going to full-delivery of telehealth services was the only way for clients to receive non-emergency services once offices were closed due to COVID-19.

C. Who benefits and how?

All clients benefit from the continuation of routine, non-emergent, services.

D. How was the accomplishment achieved?

The initial prescriber telehealth was provided through contract with Genoa. The remainder of the telehealth deployment involved monitoring changes in telehealth restrictions among the clinical disciplines and providing staff with direction, training, and support in use of televideo platforms for provision of services.

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

Yes

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

Yes

Accomplishment #4: Behavioral Health Coverage for COVID-19 shelter at Chicot State Park

A. **What was achieved?**

AAHSD was able to fulfill participation in the ESF-8 portion of coverage for the shelter. Both on-site and on-call coverage was provided in order to assess impacts of sheltering/COVID-19 on residents housed.

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

This success insure that the behavioral health needs of residents were addressed appropriately, which allowed for the sheltering operation to remain safe for all involved.

C. **Who benefits and how?**

Shelter residents, as well as shelter staff personnel and residents of Louisiana, in general, who potentially have need for shelter placement.

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

Through coordination with Region IV OPH, LDH, and DCFS; via shift staffings, phone contact with shelter residents, and coordination with outside agencies, when necessary, to facilitate behavioral health assessments of incoming shelter residents, as well as referral for assessment for hospitalization.

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

Yes.

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

Yes.

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

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

AAHSD submitted our initial five-year Strategic Plan in June 2019. Thus far, our goals and objectives are being met and the plan is on target for successful completion.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the

effectiveness of your strategies? Are anticipated returns on investment are being realized?

AAHSD is progressing towards accomplishing goals and objectives, such as: developing clear policy objectives; providing behavioral health treatment services as part of the State's continuum of care; improving accessibility; increasing stakeholders' involvement; and, providing quality services and supports. These strategies are effective in ensuring persons served receive the highest quality care.

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

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

     Other? Please specify.

  AAHSD is on target for making the progress that was projected in the five-year Strategic Plan. Progress is due largely to reorganizing our internal structure, developing new policies and procedures, utilizing the expertise of the Governing Board, conducting staff training, and implementing a team structure and approach to management. We are continually working to improve policies/systems and making necessary changes to become more effective and efficient.

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

  Progress is expected to continue on an 'on-target pace' as we conduct regular ongoing meetings of teams (Accreditation, Health/Safety, Quality Improvement, and Senior Management), participate in ongoing external reviews, and conduct ongoing internal reviews. Our efforts so far have not been 'one-time events' but the building of infrastructure and operating systems to ensure ongoing success.

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

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

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

None.

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

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

☒ No. If not, why not?
The AAHSD five-year Strategic Plan gave a clear overview of goals and objectives to accomplish. The plan fully encompasses administrative and programmatic issues for ongoing review/improvement.

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

All senior managers gave input into the development of the strategic plan and received a copy of the final version. Senior managers shared this with their departments and staff. This strategic plan, along with the annual management report, is made available to all staff and is included as public information on our website so the community at large and other interested stakeholders can be fully informed as to these plans. The Strategic Plan was also shared with our Governing Board.

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

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

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

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

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?

There are no significant operational or management issues to report.

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

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

☐ Internal audit

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

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

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

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

☐ In-house performance accountability system or process

☐ Benchmarking for Best Management Practices

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

☒ Peer review
Medical Doctors and OCDD peer review process

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

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

☒ Other (please specify):
Human Services Accountability Plan (AP) monitoring visits by OBH and OCDD

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

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

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

1. **Title of Report or Program Evaluation:**
   AAHSD Management Report
2. **Date completed:**
   June 2021

3. **Subject or purpose and reason for initiation of the analysis or evaluation**
   The AAHSD Management Report is offered as partial fulfillment of the standards set forth by CARF and is designed to summarize the results of the program plans; quality assessment; goals and objectives; the data collected in the areas of effectiveness, efficiency, service access, and consumer satisfaction; and from other operating systems and to provide a synopsis of 'significant events'.

4. **Methodology used for analysis or evaluation**
   Review of AAHSD systems including: Corporate Compliance, Health and Safety (including Accessibility), Human Resources, Information Management, Outcomes Management System, Quality Improvement, and Risk Management.

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

6. **Major Findings and Conclusions:**

   - AAHSD developed and signed a contract with LDH for services in Acadiana.
   - AAHSD clinical and administrative policies and procedures were reviewed by Civil Service, Office of Risk Management, and LDH.
   - AAHSD received successful reviews from the MCOs, State licensure, and State contract performance indicators.
   - 2020/2021 budget submitted and approved. AAHSD maintained operations within budgetary guidelines.
   - AAHSD realized an increase in collections for self-generated revenue. AAHSD has doubled its self-generated collections in the past three years.
   - Professional and service contracts maintained and monitored by AAHSD. Monitoring was increased to at least quarterly for all contracts (some monitored monthly). The monitoring process has received positive comments from two separate regulatory reviews.
   - Employees completed Civil Service PES as required.
   - AAHSD continued its employee training program/schedule and utilized two online training programs – LEO and Relias Learning. Targets and timeframes were met.
   - All Senior Managers have maintained a succession plan for their respective areas.
   - AAHSD did implement a new pay/performance structure as outlined by State Civil Service.
   - AAHSD maintained credentialing by all four MCOs within the State plan.
   - AAHSD conducted and/or participated in numerous public events, health fairs, community forums, and other professional forums. This is reflected by the increase in number of stakeholder surveys.
   - AAHSD was monitored by: ORM, LDH/OBH and OCDD, LDH/Bureau of Health Standards, State Civil Service, and the Fire Marshal. All reviews were successful.
   - AAHSD assumed operation of services, including the provision of crisis services within our designated area.
   - Selected staff has completed training in Applied Suicide Intervention Skills Training (ASIST) and have provided training to sixty-three (46) community practitioners.

- AAHSD was trained and participated in OPH/Emergency Preparedness exercises/activities.

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 2020-2021

Department:	**Louisiana Department of Health (LDH)** 09-326 Office of Public Health
Department Head:	**Courtney N. Phillips, PhD** LDH Secretary
Undersecretary:	**Ruth Johnson**
Assistant Secretary:	**Kimberly Hood, JD, MPH**

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

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

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

Bureau of Sanitarian Services - Accomplishment #1: Virtual Reality Training

A. **What was achieved?**

The Office of Public Health, Bureau of Sanitarian Services partnered with a Louisiana based company to develop and implement a new method to augment our current methods in training sanitarians on retail food regulatory standards. The Virtual Reality (VR) training module allows sanitarians to become submerged into a retail kitchen using either VR goggles and handsets or a desktop with a mouse. The training aims to improve the identification of critical and non-critical violations thereby enhancing retail food safety inspections for accuracy, thoroughness and consistency between inspectors. The training

experiences were developed in collaboration with experienced sanitarians, while also gaining the input/feedback from all levels of experience by launching a demonstration during a sanitarian annual training seminar. The training environment was designed to focus on violations that are challenging for sanitarians, as well as those that are often overlooked, as identified by our Quality Assurance inspections. The interactive method of training allows training to occur at the desktop, allowing in person training to focus on other topics that are best trained in person. The modules can be adapted to meet the changing needs of instruction.

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

The result is an immersive training experience that creates a baseline of consistent instruction with reduced training time. The key priorities during the development of the training were to embrace sanitarians' active lifestyles to develop a training that mimicked the experience of performing inspections in the field, while ensuring regulations and inspection processes were deployed throughout the state with a focus on uniformity.

C. **Who benefits and how?**

Sanitarians were introduced to the training experience during sanitarian orientation and retail food boot camp, with plans to make it accessible to all our professionals, thereby enhancing our efficiencies and immediate access to training experiences. Data reveals traditional training experiences can achieve up to 50% information retention where immersive and interactive training environments can achieve up to 90% information retention. The new training platform was able to reduce training experiences from 4-hour sessions down to a one-hour training running through both a virtual reality and PC-based module covering over 10 critical violation identification scenarios.

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

Sanitarian Services partnered with local development studio, Digital Twin Studios, once the technology was introduced to the Department. The initial roll-out of our immersive learning experience yielded comprehensively positive feedback relative to its value and opportunities to enhance professional efficiencies. The platform will be utilized in every regional public health sanitarian office to accelerate access to training and is designed to be easily modified for use in other states. The link below details a case study developed in partnership with MBA students from the University of Louisiana at Lafayette; it provides an immersed perspective of the user when inspecting a commercial kitchen.
https://documentcloud.adobe.com/link/track?uri=urn:aaid:scds:US:d620fd73-2e21-4cd3-8bf6-7d5819a511f7

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

Yes, this accomplishment helps to address the objectives for Improved Workforce Development in the strategic plan.

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

agencies?

Yes, using innovative training such as virtual reality technology is a consistent, efficient and effective way to conduct training in certain regulatory type training environments. This represents a way in which OPH is utilizing the state's resources in a cost-effective manner.

Bureau of Nutrition Services (BONS) – Accomplishment #2: Requirements of USDA/LDH Settlement Agreement Fulfilled

A. **What was achieved?**

Louisiana's Office of Public Health (OPH) Special Supplemental Nutrition Program for Women, Infants, and Children (LA WIC) successfully satisfied the terms of a legal settlement agreement between the Louisiana Department of Health (LDH) and the United States Department of Agriculture (USDA). This settlement was due to inadequacies in how LDH was invoicing for WIC infant formula rebates and the misclassification of WIC-authorized vendors.

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

This resulted in Louisiana investing over $2.5 million of state general funds in Vendor Integrity and modernization. It also allowed LDH to retain $4.1M in state general funds that could have possibly been imposed as penalties from USDA. These funds were freed to sustain and improve public health service delivery to Louisiana residents. Additionally, LA WIC successfully implemented improvements to its vendor integrity activities, allowing the Program to satisfy performance measures agreed upon with the USDA, and decreasing the monitoring requirements that were in place during the settlement's effective timeframe.

C. **Who benefits and how?**

Louisiana's WIC families, WIC-authorized vendors, and taxpayers benefit from this agreement's satisfaction – not only are we now able to keep Louisiana's funding in Louisiana rather than sending to USDA, but we were also able to revamp how LDH/OPH bills formula companies for rebates while implementing quality improvement initiatives to ensure effective and efficient administration of the LA WIC Program. Updates to the billing process have allowed for an increase in the accuracy of billing processes and in some cases have resulted in Louisiana collecting higher rebate payments than we have been able to in the past. Quality improvement measures focused on updating written policies and procedures and improvements in information technology systems, allowing LA WIC to build a lasting infrastructure for WIC Vendor Management functions, to improve cost containment efforts, and to improve overall program integrity.

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

The settlement's successful satisfaction was accomplished through careful collaboration between USDA, the LDH Division of Fiscal Management, the Office of Public Health (OPH) Bureau of Finance, and the OPH Bureau of Nutrition Services (BONS) Business

and Vendor Operation sections. Through centralizing billing responsibilities and increasing documentation requirements, BONS was able to improve communication protocols and demonstrate accuracy and competency to USDA/regulatory staff. LA WIC collaborated with the USDA, a Vendor Management Consultant, and the LDH Bureau of Legal Services to develop and implement USDA-approved policies and procedures for Vendor Management and Operations. LA WIC cross-referenced its policies against the Code of Federal Regulations and the Louisiana Administrative Code to ensure the consistent and correct application of Program rules and regulations. In addition to establishing and maintaining USDA-approved policies and procedures, LA WIC developed and implemented tools, template forms, and template notification letters for use by Program staff to reduce errors, increase standardization and ensure compliance with established procedures.

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

Yes – this success speaks to improvements in Program services and to increased accountability and transparency within the Program, to WIC families and authorized vendors, and to those agencies charged with regulating the WIC Program.

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

No.

Bureau of Infectious Diseases (BID) /STD /HIV – Accomplishment #3: Decreased Human Immunodeficiency Virus (HIV) Diagnoses

A. **What was achieved?**

The Bureau of Infectious Diseases (BID), STD/HIV/Hepatitis Program (SHHP) identified fewer people diagnosed with an human immunodeficiency virus (HIV) infection in the past year than in any of the previous 10 years. There were 728 people newly diagnosed with HIV in 2020. The number of people newly diagnosed with HIV in Louisiana has declined by 40% since 2014 from 1,205 new cases in 2014 to 728 in 2020. In 2018, Louisiana dropped below 1,000 newly diagnosed persons with HIV for the first time since 1988, (with the exception of 2005 and 2006, due to severe interruptions to HIV surveillance, testing and medical services because of Hurricane Katrina).

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

The U.S. Department of Health and Human Services (HHS) has developed a plan to "End the HIV Epidemic" in the US (2019) by reducing new HIV infections by 75% in five years and 90% in ten years. Louisiana has also developed a local plan to end the HIV epidemic in the state, with a focus on significantly decreasing new HIV infections. SHHP has developed and funded interventions to improve outcomes across the HIV care continuum including: 1) increasing the percentage of undiagnosed persons becoming aware they are living with HIV; 2) linking newly diagnosed persons to HIV-related

medical care; 3) ensuring persons living with HIV (PLWH) are retained in medical care and have access to effective antiretroviral therapy; and 4) increasing the proportion of people who are virally suppressed which leads to a decrease in HIV transmission in the community and improves the long-term health of PLWH.

C. **Who benefits and how?**

Persons at risk of acquiring HIV and those living with HIV have benefited from SHHP funded/supported interventions. These interventions include, but are not limited to, the provision of direct supportive services to PLWH and those at highest risk of HIV infection; reengagement activities that reconnect PLWH who have fallen out of care back into care; routine and focused screening in healthcare and non-healthcare setting for persons at risk for HIV; rapid linkage to care and antiretroviral treatment for newly diagnosed PLWH; syringe services programs (SSP) that ensure persons who inject drugs (PWID) have access to clean and sterile needles and are linked to substance use disorder treatment and other harm reduction services; condom distribution; and ensuring access to HIV pre-exposure prophylaxis (PrEP) in communities most at risk of HIV. All of these interventions are evidence-based and shown to decrease levels of virus in the community and reduce the potential for HIV transmission.

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

The reduction in new HIV diagnoses was achieved through an integrated approach that focused on high impact prevention interventions such as increasing PrEP access, condom distribution, and disease intervention/partner services, along with sustained high levels of HIV screening to detect new HIV infections earlier. Additionally it also included linking PLWH to care within seven days, re-engaging PLWH who have fallen out of HIV-related medical care, and increasing the proportion of PLWH who achieve viral suppression with the intended result of reducing health disparities among vulnerable and marginalized populations. In addition, the provision of Ryan White services for PLWH (i.e., case management, assistance with medications for uninsured individuals, and assistance with premiums and cost share for insured individuals) has helped improve retention in care and viral suppression. In Louisiana, viral suppression among persons in care has increased from 70% in 2013 to 87% in 2020.

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

Yes. This accomplishment is directly related to one of SHHP's major priorities: to decrease new HIV infections. This is also a goal of the CDC National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention Strategic Plan for 2020 (Goal I: Decrease Incidence of Infection) and the HHS "Ending the HIV Epidemic: A Plan for America."

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

Yes. The implementation of SHHP's HIV prevention and care/services interventions was carried out by a large cross-unit team, and SHHP has collaborated with many other LDH, OPH, and community partners to realize the reduction in new HIV diagnoses in the state. These interventions and their collaborative implementation could be replicated to address other health issues in the state. Several of the interventions started out as pilot projects in a single region and have been expanded statewide. SHHP interventions have also been used by CDC as models for other state health departments and the SHHP team has been called on to provide technical assistance to several other state health departments as a result.

Public Health Laboratory – Accomplishment #4: Strategic Placement of Lab Services to Meet Customer Needs

A. **What was achieved?**

Following an active storm season in 2019, Office of Public Health (OPH) management determined there was need to further streamline and improve turnaround times for testing of drinking water. Safe Drinking Water (SDW) and private well water samples need to be tested quickly during recovery from highly-sensitive events (i.e. boil advisories) and natural disasters (i.e. hurricanes, tropical storms, and flooding). As per the Environmental Protection Agency's (EPA) requirements, SDW water samples must be tested within 30 hours of collection. This time requirement can be difficult to achieve because of delays from road closures and extended courier transport times encountered during extreme storm events. Due to increased demands by several public health regions for more rapid response SDW testing capability, it was determined that OPH Laboratory's presence should be expanded to strategically place testing closer to the source of the collected samples. The expansion of OPH within these regions was achieved through the following actions:

1. Reactivation of a mobile laboratory unit to serve communities along the coastal regions during natural disasters and flooding event
   Hurricane Laura devastated the Lake Charles area on August 27, 2020, causing prolonged power outages and compromising the integrity of the region's water supply. A mobile SDW laboratory, which had been inactive for over 15 years, was reactivated and outfitted with the necessary supplies and certified for SDW and private well water analysis. The OPH mobile laboratory became operational on September 8, 2020 and was deployed to Jennings, LA to analyze water samples for Lake Charles and affected areas. Scientists were deployed and rotated work assignments on a weekly basis in order to ensure uninterrupted services at the main central public laboratory. Between September and October 2020, the mobile laboratory analyzed approximately 831 SDW, disaster assistance, and private water supply water samples for the South Louisiana region.

2. Establishment of a new SDW laboratory in the Central Louisiana region
   In collaboration with public health regional staff and local government, OPH was able to set up the Rapides Regional Water Laboratory (RRWL) within the

Rapides Parish Health Unit in Alexandria, LA. The RRWL provides a sheltered SDW laboratory to serve Louisiana's coastal and central regions on a daily basis and during disaster events. The newly equipped 480 square foot SDW laboratory was certified and became operational on October 15, 2020. Since becoming operational, the RRWL has tested 7,484 routine and 1,039 disaster assistance SDW samples. In addition to the SDW samples, approximately 164 private well water samples have been analyzed. Currently, 80-90% of collection sites within public health regions 4 (Lafayette), 5 (Lake Charles) and 6 (Alexandria) are receiving a 28-hour turn-around time (TAT) from collection to report. Prior to the RRWL becoming operational, approximately 50-60% of sites within Regions 5 (Lake Charles) and 6 (Alexandria) were averaging 40-45 hours TAT.

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

Besides the benefit to the coastal regions during a disaster response, the presence of the Rapides Regional Water Laboratory (RRWL) and mobile laboratory has allowed samples from the Central Louisiana region to be processed quicker than when previously they required transport to the Shreveport, Baton Rouge, or Amite laboratories. The mobile laboratory, along with an EPA mobile laboratory, were the first water labs to service the Lake Charles community following Hurricane Laura. The RRWL served as a support laboratory and processed overflow samples from the OPH and EPA mobile laboratories. The OPH mobile lab and the RRWL were instrumental in bringing the affected water systems back into compliance. The RRWL currently analyzes Safe Drinking Water (SDW), disaster assistance, and private water supply water samples for public health regions 4 (Lafayette), 5 (Lake Charles), and 6 (Alexandria). When needed, the RRWL may also receive water samples from the Shreveport Regional Water Laboratory and other regions within Louisiana to ensure continuity of operations and minimize turnaround times.

C. **Who benefits and how?**

The residents of Louisiana benefit from the establishment of the RRWL and the reactivation of the OPH mobile laboratory. The RRWL currently analyzes safe drinking water samples and private water supply samples from public health regions 4 (Lafayette), 5 (Lake Charles), and 6 (Alexandria). If required, boil advisory and emergency samples from the Shreveport Regional Water Laboratory and other state regions can be analyzed at the RRWL. In addition, should labs in Baton Rouge or Amite become overburdened by high sample loads, this lab can help share in the analyses. The reactivation of the OPH mobile laboratory proved to be a great success. Approximately 95-105 water systems were assisted during the Hurricane Laura disaster. As a follow up to the success of the disaster response, OPH Laboratory has implemented a plan to recertify the mobile laboratory yearly and have it ready for deployment during the active months of Louisiana's hurricane season.

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

The accomplishment was achieved through a collaborative effort with multiple entities within the Office of Public Health to include the Bureau of Regional Clinical Operations,

Engineering, Sanitarian Services and the OPH Laboratory. The OPH Laboratory quickly worked to establish, train, and certify the RRWL and mobile laboratory to respond to environmental needs following emergency boil advisories and natural disasters. Scientists were required to adapt to adverse and changing work conditions in the field while continuing to provide an essential service to the citizens of Louisiana. The OPH RRWL and mobile laboratory provided environmental services on a seven days a week, 24-hours a day basis for a 2-month period following Hurricane Laura's landfall. With over 19 microbial team members trained and prepared to staff the RRWL and mobile laboratory, LDH and OPH are adequately prepared to safeguard the integrity of Louisiana's water systems.

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

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

Yes, the reactivation of the OPH mobile laboratory and the establishment of the Rapides Regional Water Laboratory represents a best management practice (BMP), because these accomplishments represent management's ability to hear the "voice of the customer," assess the data metrics behind the needs, and redesign services to provide the customer critical services in a cost effective and accurate manner. It demonstrates that some government services are best executed in a centralized fashion and others need to be strategically placed closer to the source of the request. The level of collaboration that made this endeavor successful represents the best of governmental staff working together across industries to provide excellent customer service to those served.

Bureau of Family Health (BFH) – Accomplishment #5: Data from the OPH-Bureau of Family Health Louisiana Perinatal Quality Collaborative "Reducing Maternal Morbidity Initiative" shows that Louisiana has made significant progress toward ensuring safe, equitable, and dignified births for all birthing persons in Louisiana

A. **What was achieved?**
On Mother's Day 2021, the OPH-Bureau of Family Health Louisiana Perinatal Quality Collaborative (LaPQC) released the results of the first initiative to reduce the occurrence of two recognized contributors to maternal morbidity and mortality: preventable complications related to hypertension and/or hemorrhage, while also reducing disparities in outcomes. **The results of the *LaPQC Reducing Maternal Morbidity Initiative (RMMI)* show that maternal morbidity among birthing persons who experience hemorrhage and severe hypertension decreased in LaPQC participating facilities between 2016 and June 2020**. In particular, the LaPQC surpassed the goal of a 20% reduction in severe maternal morbidity (SMM) among individuals who experienced hemorrhage (34.8%), but did not meet the goal of a 20% reduction in SMM among individuals who experienced severe hypertension (11.6%). While the SMM disparity gap

still exists, there were decreases in disparity for SMM among hemorrhage, with non-Hispanic Black birthing persons experiencing a 49.3% decrease from baseline.

LaPQC grew from working with 31 birthing facilities to working with 42 birthing facilities, including hospitals, across Louisiana, using quality improvement science to create sustainable change that improves maternal outcomes. This means that **9 out of every 10 births in Louisiana occurred in a LaPQC participating facility** by the end of the RMMI.

Through the guidance of the LaPQC, facilities worked to implement evidence-based best practices related to the management of hemorrhage and hypertension, as well as health equity. During the RMMI, the LaPQC Planning Team held 18 Coaching Calls, organized three in-person Learning Sessions, conducted in-person visits through their Listening Tour, and worked with hospitals to engage sound improvement science principles to bring about sustainable change. At each stage of this work, the LaPQC sought to elevate the patient experience by elevating patient stories and incorporating health equity work throughout all elements of improvement.

As a part of their work with the LaPQC, participating birthing facilities worked to implement evidence-based best practices that worked to reduce maternal morbidity by increasing readiness and response to hemorrhage and hypertension. Among the three key process measures that track implementation of these processes, the percent of **patients receiving timely treatment of hypertension increased by 210.8%**, the percent of patients receiving a **hemorrhage risk assessment at admission increased by 78.3%**, and the percent of patients having **blood loss measured through quantitative methods increased by 171.8%**.

B. **Why is this success significant?**
The work of the LaPQC and results of the RMMI are significant not only because these data show a decrease in the unexpected negative outcomes of labor and delivery that can lead to both short- and long-term consequences for birthing persons, but also because they highlight the effectiveness of focused, high-quality improvement work directed towards health outcomes. These outcomes are so significant, they have been recognized on national calls, and the LaPQC team has been engaged by similar teams in other states to provide guidance and support.

C. **Who benefits and how?**
The quality improvement work championed and led by the LaPQC benefits birthing persons, families, and neonates through the promotion of safe, equitable, and dignified birth for all Louisianans. Fewer unexpected events coupled with greater application of best practices that promote readiness and response work to improve health outcomes as well as the birth experience. Hospitals, health care systems, and providers also benefit because they feel more prepared to respond as a team to obstetric emergencies.

D. **How was the accomplishment achieved?**
The LaPQC works with birthing facilities to implement evidence-based best practices

that improve maternal and neonatal health outcomes connected to the delivery experience. Using the Model for Improvement and IHI's Breakthrough Series as a foundation, the LaPQC leads birthing facilities through a structured approach to improvement. This approach involves the implementation of best practices using Plan-Do-Study-Act cycles, data collection and analysis, and collaborative learning. In addition to providing the structure and tools for implementation, the LaPQC facilitates informational calls, in-person meetings and site visits, and other collaborative learning events so hospital-based improvement teams can learn from each other.

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

Yes. The success of the LaPQC represents a model for how maternal-child health work can be done both in terms of outcome, but also in terms of programmatic structure. The LaPQC is part of a larger coordinated effort that is bringing **public health data to action for policy and systems change**. LaPQC arose from needs identified through findings from the review of maternal deaths conducted through the Louisiana Pregnancy Associated Mortality Review (PAMR) processes. Other related initiatives that have arisen through PAMR and LaPQC efforts include a comprehensive review and revision of the licensing requirements for birthing centers and hospitals, the upcoming establishment of a voluntary registry of the state's doula workforce, initiatives to address recognition and appropriate response to maternal depression, and other efforts through the Louisiana Commission on Perinatal Care and the Prevention of Infant Mortality.

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

The LaPQC engages the Model for Improvement, as well as other proven improvement science methodologies. This approach has applications outside of public health and health care, and could be used to improve both programmatic outcomes as well as the programs themselves.

Bureaus of Planning and Performance (BP2)/Health Informatics (BHI): Accomplishment #6: Publication of Public Facing Informational Dashboarding

A. **What was achieved?**

The Office of Public Health (OPH) worked to create a culture of public transparency by developing dashboards to provide timely and relevant information for members of the public. Two examples of this are the creation of the Louisiana Coronavirus (COVID-19) Case Tracking and Vaccine Information Dashboards, and the Louisiana State Health Assessment Dashboard. The COVID-19 dashboard integrates information from a number of OPH organizations to publish data on COVID cases, tests, cases, deaths, hospitalizations, and vaccination administration, with demographic and geographic details. Data processing to support the dashboard also produces data products used by the LDH contact tracing effort, researchers, and the public. The SHA Dashboard shares information about the health of Louisianans and to show where health inequities exist

with regard to health outcomes and the determinants of health.

B. Why is this success significant?
The COVID-19 dashboard is the official tracking and reporting record for LDH and its partners, the accuracy of which was confirmed by the Louisiana Legislative Auditor. It was launched within days of the first positive case in the state, and is maintained by existing Bureau of Health Informatics (BHI) and Infectious Disease Epidemiology (ID Epi) staff at a minimal cost, using technologies currently deployed across the agency. Innovative approaches allow us to provide a level of demographic completeness lacking at the national level and across the US.

The degree that a community enjoys good health has been correlated to social determinants that are not equitable in all communities. The SHA Dashboard provides the data behind the various factors. This dashboard has provided needed data for organizations working to drive change, including the Governor's COVID-19 Health Equity Task Force. The Task Forces was charged with creating a health equity dashboard for Louisiana and this tool met that need. Feedback is that organizations are using the data from the dashboard to apply for funding opportunities for additional initiatives targeting health equity. The State Health Assessment Dashboard also fulfills an important requirement for public health accreditation. The Louisiana Department of Health (LDH) became accredited in 2019 and will apply for reaccreditation in 2024.

C. **Who benefits and how?**

LDH's COVID-19 dashboard is a public-facing dashboard, available to decision-makers and members of the public. Various downloadable datasets are made available for use by the public and researchers. To date, the COVID-19 dashboard has been viewed over 45 million times.

Data from the SHA dashboard will be used to inform health improvement efforts across the state and as a foundation for the creation of the Louisiana State Health Improvement Plan over the coming year. Therefore, this will ultimately result in more effective health improvement initiatives and better, more equitable health outcomes for Louisianans. From its launch in March 2021 through June 2021, the dashboard has garnered 8,842 total page views from 2,826 unique visitors.

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

The COVID-19 dashboard is designed, implemented, and supported entirely with existing staff and technologies, and represents a collaboration of BHI, ID Epi, Bureau of Media and Communications (BMAC), and the Office of the Secretary. While some level of automation has been incorporated in the dashboard and associated processing, at least 10 staff are involved in the data processing and updating of the dashboard every reporting day. BHI and ID Epi continuously review the dashboard to identify relevant information to add to reporting, such as the comparison of COVID-19 cases, deaths, vaccinations, and populations by race by parish and vaccination demographic information.

OPH leveraged block grant federal funding and partnered with data firm mySidewalk to

create the site. A health equity framework described in the Prevention Institute report *Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health* (2015) was utilized to inform the dashboard's rationale, design, and indicator selection. Inspired by this framework, the dashboard was designed to portray health-related data in three main categories: foundations of community health, behaviors and exposures, and medical outcomes. A rigorous process, including expert review and bivariate analyses to determine statistical significance, was then conducted on more than 120 health-related indicators to inform which to portray on the dashboard and how to visualize them. This process identified indicators that elucidate racial and urban/rural inequities at the structural level that, in turn, drive inequitable health outcomes throughout the state.

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?**

Yes, transparency of data provides the public we serve the information they need to have confidence in government. In addition, having a common place where accurate data is displayed reduces the occurrence of miscommunication and ensures all members of an initiative are informed and collaborating with the same information. The first step to improving a problem is to assess the problem and analyze the data. Dashboards provide a common, visual and easy to understand, platform to make that first step easier to accomplish.

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

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

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

The Office of Public Health (OPH) consistently implements effective strategies to improve the health of Louisianans. We have a long and impressive list of achievements even beyond what is mentioned in this report that our dedicated staff have worked hard to achieve. OPH has played a central role in Louisiana's response to the COVID-19 pandemic. Since COVID-19 emerged in Louisiana, we have had to adapt and shift our priorities, while doing our best to continue longstanding programs. With the unprecedented nature of the COVID-19 pandemic, it is unclear how long this will affect our organization.

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

  While COVID-19 has impacted progress on strategic goals, programs have still made significant advancements in some areas; particularly in communications. One of the objectives of the 2017 Revised Strategic Plan was to develop and implement a community-focused public health marketing campaign to convey the value of public health. The process to develop public health campaigns became even more critical during the COVID pandemic, as OPH was required to communicate relevant information while addressing the concerns of vaccine hesitant populations.

  OPH was called to convey complex information to the public that was changing very quickly. There were several strategies used to accomplish the messaging, some of which are used during disaster responses and some were newly developed. Establishing a 211 hotline for information and issuing Health Alert Notices (HANs) are two methods that are used during disasters to relay critical information. Those methods have been a mainstay during the pandemic response. Publishing data to a web-based dashboard on the LDH website is a new tool used to convey the current state of infection and transmission, with filters that an individual can use to assess their specific geographic location and the specific data for their area. In addition, the website was used to convey ever-changing guidance from the health officials and the Centers for Disease Control. Operational information on where to receive a COVID test or vaccine was also messaged using the Department's website. The methods of communication continue to evolve as we work through new information and the public has new questions.

  Another area where progress has been made is the strategic goal to increase financial stability by more efficient utilization of resources and increased revenue. In order to efficiently utilize and be good stewards of state funds, OPH has been advocating for and leveraging federal dollars and supplies for COVID, using fellows from the CDC to assist in technical projects, and billing insurance for COVID testing. OPH has is also auditing grant billing to reveal any payer opportunities to have CDC pay instead of the state. During COVID response OPH has also used the Louisiana National Guard (LANG) for staffing critical functions related to the response, and leveraged Louisiana Volunteers in Action (LAVA) to reduce staffing demands, Several of the accomplishments mentioned in Section 1 have also helped to reduce costs (e.g. lab expansion reduces courier costs to balance out staff costs, SANs VR training to reduce hours spent on training and reduce travel dollars, and retention efforts which reduce the admin cost of turnover, mitigating WIC's USDA grant issues).

  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.

Due to the volume of the workload associated with Communications, some communication efforts have been contracted. Having vendors and internal Communication staff collaborating with our Epidemiologists, the source of the data, has been critical in us receiving accurate and effective communications.

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

   This progress was forced by the pandemic and the need to provide public information to reduce transmission and spread of disease. However, we have established some successful work strategies that will allow future endeavors to progress more quickly.

- **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 of Public Health (OPH) did not revise its 5-year strategic plan but did participate in the LDH planning that began September 2020. A business plan is forthcoming and many initiatives are being launched.

- **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 late 2019, workgroups were formed, at the agency level, to develop and implement work plans to advance these strategic aims. In addition, in January 2020, each bureau went through a process of identifying how the work of that bureau could align with and contribute to achieving the strategic aims. While many aspects of strategic aim implementation have been on hold due to COVID-19 response efforts since March 2020, some of the work has been able to progress, such as development of an agency-wide onboarding system to promote employee retention, as well as activities at the bureau level to advance organizational effectiveness. Once the Secretary's business plan is released, we will be resetting to continue implementation of the strategic aims.

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

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

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

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

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

B. Corrective Actions

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

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

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

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

5. Do corrective actions carry a cost?

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

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

A. Problem/Issue Description #1: <u>Inadequate Public Health Infrastructure</u>

1. What is the nature of the problem or issue?
   The COVID-19 pandemic response has challenged the Office of Public Health's (OPH) infrastructure in unpredictable ways. Internally, it has been difficult to allocate staff at a sufficient level to address the enormity of the response, while simultaneously ensuring there is enough staff capacity to continue the required normal operations. One challenge in particular has been developing and maintaining the infrastructure to manage large sums of federal funding. The lack of infrastructure has necessitated handing over additional responsibilities to staff in middle management positions, which has led to overload, turnover, and loss of critical leadership at this level.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   The first goal of OPH's strategic plan is to "Increase financial stability by more efficient utilization of resources and increased revenue." With over $880 million in federal grants now available, OPH has certainly increased the availability of resources. However, without the adequate infrastructure in place to manage the grants or their deliverables it is increasingly difficult to meet the requirements of the grants and efficiently leverage those resources.

3. What organizational unit in the department is experiencing the problem or issue?
   This is experienced across the entire agency.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   This affects external customers and the public at large as it is a barrier to more effectively addressing public health needs, which impacts public health outcomes. It is an obstacle to providing excellent customer service levels. Internally, it taxes our managerial capacity and staff morale as existing staff continue to be stretched and overworked. Typically, it is our more tenured staff who are tasked with more activities within their current schedule requiring many hours of K-time and lack on any work life balance. When low morale leads to staff turnover, the agency loses institutional and job-related knowledge and capacity which is costly to replace. In most technical areas, there is a two-year training period to train new staff. In the highly specialized areas, that training period can be up to five years to fully replace the knowledge lost.

5. How long has the problem or issue existed?

Expanding staffing to meet new initiatives is not a new challenge; however, the number of tasks and the workload from a pandemic has meant that the number of staff needed to accomplish the work is far greater than ever experienced before. However, though OPH's budget and responsibilities have quadrupled, its staff has increased less than 5%.

6. What are the causes of the problem or issue? How do you know?
   The problem has been caused by the lack of TO and JA positions, and the risk has been highlighted by the ongoing pandemic, and the influx of federal funds. Attempts to address the gaps using contract positions have not been sustainable, and it has been difficult to attract workers willing to accept temporary positions, nor does contracting build infrastructure for the long term. State positions are more attractive to potential applicants than contract positions. In addition, contracting or outsourcing the work requires another process of procurement, oversight, management and auditing, i.e. more work, that is not required when using state positions.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   With regard to emergency response, a consequence is that we are restricted in our ability to mobilize our staff to engage in emergency response efforts. The burden of emergency response falls unevenly on our staff members, with permanent TO positions required to be activated but not most contract positions, which affects morale of those who are required to respond. The pandemic response, has extended for over 16 months with no end in sight, further taxing exhausted staff.

   OPH has utilized external contracted positions and internal temporary positions to meet the need for these programs and services, but that is not sustainable, nor does it provide a long term solution. It also handicaps the agency's ability to compete with private industry for top talent in these forward initiatives.

   There is also the risk of financial consequences due to the lack of a grants management infrastructure. Without proper management of funds we not only limit our the ability to efficiently and effectively implement federal grant requirements, but we also run the risk of losing the funding and handicapping future attempts to obtain additional funding. OPH's budget has increased by 900 million (75%), however, staffing has only increased by 56 JAs (5%).

B. Corrective Actions

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

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

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?

    Yes, leadership is considering a large request for additional Job Appointment state staff, as well as outsourcing support services.

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.
        Estimates as much as 2% of the overall grant funding level have been projected in outsource services.
        b. How much has been expended so far? No dollars have been expended.
        c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

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

A. Problem/Issue Description #2: <u>Staff Retention</u>

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

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   While we are able to make progress on strategic plan objectives, the issue directly affects Strategic Question 3 of the OPH Revised 2017 Strategic Plan, which is focused on attracting and retaining and competent and diverse workforce.

3. What organizational unit in the department is experiencing the problem or issue?
   This is experienced across our agency.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   The ability to retain staff directly impacts the degree to which we can respond to the public health needs of our community members. Internally, this creates gaps in institutional knowledge, and increases the workload of the remaining staff.

5. How long has the problem or issue existed?
   This has been an ongoing issue which has been impacted further due to the pandemic.

6. What are the causes of the problem or issue? How do you know?
   This problem is caused by many factors, some of which have been made more impactful due to the ongoing COVID response. An example is the increased workload and stress being placed on current staff due to pandemic response and the inability to obtain additional TO and JA positions (OPH's turnover for FY21 was 15.1%).

   Turnover within the Office of Public Health is a three prong challenge: compensation, job demands, and culture. While efforts have been made to balance job demands, staff continue to be overwhelmed and stressed by the demands placed on them. While these are magnified by the pandemic, the core issues existed before the pandemic. They have only been exacerbated by the responses that LDH, and more specifically, OPH has been asked to lead and execute. The result is that some employees, particularly in OPH are asked to do more than others particularly in other LDH Offices, while the remuneration is not correlated to those demands or efforts. This leads to a challenging culture where staff feel overworked and underappreciated.
   We have offered the cost-free soft solutions such as free counseling, health habit

recommendations for both mental and physical health, and other helping hands through leadership support. While these are helpful, they pale in comparison to the demands and the inability to flex in compensation benefits or to provide any work–life balance in a meaningful way that could lead to a sustainable workforce that balances the stress across a suitable workforce. The result will continue to be high turn-over and an OPH that loses capacity and ability to continue to respond to this pandemic or any other emergency response required in the coming year.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   The inability to retain staff hinders our efforts to build a competent and diverse workforce, decreases our efficiency and effectiveness, and limits our ability to respond to the public health needs of our communities. This is further exacerbated by external factors such as weather-related emergencies and the ongoing COVID-19 pandemic. Future emergency responses will be impacted by the loss of institutional knowledge that is resulting from the exit of burned out middle management.

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?
   Support the public health funding with state positions to accomplish the work, even if they are temporary job appointment positions. Create a "premium pay" attached to the pandemic response to compensate for the urgent and temporary appointment.

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?
  OPH has requested positions and supplied the duties that would be assigned to the requested number of job appointment positions.

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

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

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

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

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

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

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

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

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

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

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

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

1. **Title of Report or Program Evaluation #1:**
   Integrated HIV Surveillance and Prevention Programs for Health Departments, Louisiana OPH STD/HIV/Hepatitis Program; year 3 end of year progress report (RFA PS18-1802).

2. **Date completed:**
   Mar 30th 2021.

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
   Annual progress report required by federal funding agency and notice of award.

4. **Methodology used for analysis or evaluation:**
   The STD/HIV/Hepatitis Program is fortunate to have a longstanding Research and Evaluation Unit that works across all units and is available to assist in evaluating all interventions and funded program efforts including reduction of new HIV diagnoses strategies outlined in RFA 18-1802. HIV Integrated Prevention and Surveillance evaluation efforts are described in their SHHP-Wide Evaluation Plan. This tool is designed to act as a comprehensive reference for internal monitoring, evaluation, and research related to SHHP interventions, programs, and projects, consolidate and describe monitoring and evaluation activities, as well as function as tool for supervisors and managers to monitor program performance and anticipate grant reporting deadlines. Additional required and optional evaluation projects and studies are outlined in the Louisiana HIV Integrated Prevention and Surveillance Evaluation and Performance Monitoring Plan submitted as a CDC grant requirement. HIV surveillance and programmatic data were used to compute all indicators and performance measures and assess progress towards all grant objectives and goals.

5. **Cost (allocation of in-house resources or purchase price):**
   Cost is in-kind and allocated as part of grant activities and deliverables.

6. **Major Findings and Conclusions:**
   All Standards and Evaluation Report goals were met, with the exception of 5 specific activities related to 1) Completeness of Initial Viral Load or CD4 Count, 2) Previous Negative HIV Test History, 3) Perinatal HIV Exposure Reporting, 4) Annual Testing Targets, and 5) Annual Linkage to Care Targets for Newly Diagnosed Clients.

   The report goes on to cite several specific factors related to these missed targets. Of primary note was the impact of COVID-19 and emergency lockdowns and restrictions on traditional public health activities. Because HIV testing activities associated with this grant are traditionally conducted within community based settings, where services were limited there was an impact on HIV testing and subsequent linkage to care. Additionally, specific limitations with the documentation within the health system itself for these other variables listed in SER 1-3, were outlined.

7. **Major Recommendations:**
   After federal review of the report there were few major recommendations with the exception of one single recommendation to “Develop an action plan for increasing partner services activities and ensuring data entry completeness that follows the state’s required mitigation

practices."

8. **Action taken in response to the report or evaluation:**
   In response to this recommendation, a technical response was developed and sent to CDC detailing an action plan to increase telehealth activities to remove barriers due to COVID-19 in the workplace as well as to increase partner services. In addition, plans to increase completeness of HIV surveillance data including a DIS webinar and better integration of HIV surveillance data with partner service activities was described.

   Additional plans are being created to increase community engagement. These strategies include, but are not limited to, community engagement through increased use of online platforms, implementing drive-through STI testing, and adopting HIV self-testing as a means to screen community members while adhering to COVID-19 safety measures.

9. **Availability (hard copy, electronic file, website):**
   Electronic file available on request.

10. **Contact person for more information:**
    Name: Samuel Burgess, Director, STD/HIV/Hepatitis Program and DeAnn Gruber, Director, Bureau of Infectious Diseases
    Agency & Program: LDH, OPH, Bureau of Infectious Diseases, STD/HIV/Hepatitis Program
    Telephone: (504) 568-7474
    E-mail: samuel.burgess@la.gov and deann.gruber@la.gov

1. **Title of Report or Program Evaluation #2:**
   Tuberculosis Trends in Louisiana 2010 to 2020

2. **Date completed:**
   04/21/2021

3. **Subject or purpose and reason for initiation of the analysis or evaluation**
   This report includes TB surveillance data and published annually to inform internal and external program partners on the status of TB in Louisiana.

4. **Methodology used for analysis or evaluation**
   Data were collected in IDRIS and the patient management program webLATB and analyzed using SQL. Data from CDC and Census Population data were also used.

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

6. **Major Findings and Conclusions:**
   TB case count and rates have been steadily decreasing since 2010. Case rates were higher among men than women, Black/African Americans and Asians than Whites, and Hispanic/Latino than non-Hispanic/Latino. The majority of TB cases in Louisiana are pulmonary and had diagnosis confirmed by AFB culture identification.

7. **Major Recommendations:**
   Louisiana ranks in the top 20 for TB burden in the United States. Continued innovation to increase for treatment initiation and completion must be explored.

8. **Action taken in response to the report or evaluation:**
   These results are being used to inform 2021 program activities.

9. **Availability (hard copy, electronic file, website):**
   This report is available on the program website and was shared with community partners as a PDF attachment. The document can be found here: https://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/tuber/AnnualTBReportLA2020.pdf

10. **Contact person for more information:**
    Name: Kathryn Yoo
    Title: Assistant Director and Epidemiologist
    Agency & Program: OPH, BID, TB Control Program
    Telephone: 504-568-8122
    E-mail: Kathryn.yoo@la.gov

1. **Title of Report or Program Evaluation #3:**
   Video/electronic Directly Observed Therapy (VDOT) Analysis

2. **Date completed:**
   07/14/2021

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
   This analysis was done to evaluate the effectiveness of the program after one full year of statewide implementation.

4. **Methodology used for analysis or evaluation:**
   Data were collected in the patient management software webLATB and analyzed using SQL and Excel.

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

6. **Major Findings and Conclusions:**
   While treatment outcome data is incomplete, there was an increased utilization of VDOT compared to traditional Directly Observed Therapy (DOT) and an increase in patients with TB infection initiating treatment. There was also demonstrated cost savings.

7. **Major Recommendations:**
   Continue to encourage patients to utilize VDOT and provide incentive funds for phones and data.

8. **Action taken in response to the report or evaluation:**
   Review CQI and program evaluation process.

9. **Availability (hard copy, electronic file, website):**
   This report has been distributed to program staff as a pdf attachment.

10. **Contact person for more information:**
    Name: Kathryn Yoo
    Title: Assistant Director and Epidemiologist
    Agency & Program: OPH, BID, TB Control Program
    Telephone: 504-568-8122
    E-mail: Kathryn.yoo@la.gov

1. Title of Report or Program Evaluation #4:
   USDA/Food and Nutrition Service (FNS) – Management Evaluation of the Commodity Supplemental Food Program (CSFP)

2. **Date completed:**
   3/19/2021

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
   Cyclical federal review of the management of the Louisiana CSFP Program by the Office of Public Health Bureau of Nutrition Services (OPH/BONS). Periodically, USDA/FNS will evaluate states on their administration of federal programming.

4. **Methodology used for analysis or evaluation:**
   FNS evaluated OPH/BONS on their performance in 13 functional areas (listed in CSFP State Plan). This involved submitting responses to FNS surveys and meeting with USDA staff to review program management practices in Louisiana's administration of the CSFP Program.
5. **Cost (allocation of in-house resources or purchase price):**
   $0

6. **Major Findings and Conclusions:**
   USDA reported five findings and three observations. One of these findings is a repeat from 2016, however the 2016 CAP was approved by USDA.
   1. Forms in use by Louisiana CSFP do not include full/up to date food safety/recall and Civil Rights statements.
   2. Eligibility notifications do not include a date and timeframe of certification.
   3. Late submissions of required reports to USDA, in particular, the FNS-153.
   4. All CSFP staff did not complete Civil Rights trainings.

5. When OPH/BONS reviews the contract Local Agency's (PHILMAT) performance, they do not currently document the "ask" about Civil Rights training for CSFP staff. Repeat finding from 2016.

The three observations include:

1. USDA's concern that Louisiana CSFP is not reaching enough eligible seniors.
2. USDA's concern that the Louisiana CSFP State Plan is too lengthy – a lot of the information contained would be better suited for a standard operating procedures (SOP) or internal policy.
3. USDA's concern that training was not conducted for CSFP staff that handle food safety/recalls on proper USDA policies/procedures.

7. **Major Recommendations:**

The following are recommendations from USDA/FNS. They are in the respective order of the findings/observations listed above:

- Update CSFP forms and documents to include full, updated Civil Rights statement.
- Update eligibility notifications to include length and window of time for program participation certification.
- Develop SOP's to get the FNS-153 report turned in a timelier manner.
- OPH/BONS needs to provide training to all CSFP staff as soon as possible and ensure this training happens in the future.
- OPH/BONS should document the "ask" about Civil Rights training for CSFP staff.
- OPH/BONS should look at additional contract agencies to increase the reach of the Louisiana CSFP Program.
- OPH/BONS should update and shorten the Louisiana CSFP plan in order to reduce confusion and make updating plan contents easier and more understandable.
- OPH/BONS should conduct and document food safety training for procedures and protocols surrounding food recalls.

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

The following actions taken are in the respective order of the findings/observations/recommendations listed above:

- Updated CSFP forms and documents to include full, updated Civil Rights statement.
- Updated eligibility notifications to include length and window of time for program participation certification.
- Developed SOP's and partnered with the Local (contract) Agency to get the FNS-153 report turned in a timelier manner in the future.
- Local (contract) Agency provided training to all CSFP staff and documented process to ensure this training happens in the future.
- OPH/BONS changed Local Agency review forms to document the "ask" about Civil Rights training for CSFP staff.
- OPH/BONS is currently looking at additional contract agencies to increase the reach of the Louisiana CSFP Program. Additionally, OPH/BONS has begun

working on project planning with the Local Agency to increase outreach and service delivery networks for seniors in Louisiana.

- OPH/BONS has updated and shortened the Louisiana CSFP State Plan in order to reduce confusion and make updating plan contents easier and more understandable. This is at USDA now for review/approval.
- Local Agency conducted and documented food safety training for procedures and protocols surrounding food recalls. OPH/BONS is also working to update the contract agreement to ensure this training continues to happen in the future.

Overall, the corrective action plan Louisiana CSFP staff submitted to the USDA/FNS office is pending their approval.

9. **Availability (hard copy, electronic file, website):**
   Electronic File – can be emailed upon request

10. **Contact person for more information:**
    Name: Tamara Dangerfield
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Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department: **Louisiana Department of Health (LDH)**
09-330 Office of Behavioral Health

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

Undersecretary: **Ruth Johnson**

Assistant Secretary: **Karen Stubbs Church, J.D.**

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

Accomplishment #1: Department of Justice (DOJ) Agreement

A. **What was achieved?**

The Office of Behavioral Health (OBH), in conjunction with the Office of Aging and Adult Services (OAAS), has continued transition coordination efforts, transitioning individuals with Serious Mental Illness (SMI) who meet the DOJ Agreement's Target Population criteria into the community. Additionally, OBH has a number of efforts underway associated with the implementation of various other aspects of the Agreement, including the development of additional services and supports intended to improve the overall system of care allowing for the diversion from inappropriate placement within nursing facilities. Specifically this has included the following:

- December, 2020 - Hiring of a Peer Support Program Manager with oversight of a cadre of Peer InReach Specialists who will work in tandem with Transition Coordinators throughout the state.
- June, 2021 - Hiring 5 PIRS working in various regions throughout the state
- March, 2021 - Implementing a stand-alone Medicaid reimbursable peer support specialist service
- May, 2021 - Designing a model for a Community Case Management program

- June, 2021 - Designing and obtaining funding for a variety of Medicaid-reimbursable services including a crisis continuum of care. This includes:
  - Mobile Crisis Intervention (MCI)
  - Community Brief Crisis Support (CBCS)
  - Behavioral Health Crisis Care (BHCC) Centers

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

This success is significant in that it allows for individuals throughout Louisiana to be served in community-based settings appropriate to their needs, thereby ensuring the state's compliance with the Americans with Disabilities Act (ADA) and Olmstead.

C. **Who benefits and how?**

Constituents throughout Louisiana through the ability to access quality care appropriate to their needs.

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

These accomplishments have been achieved through cross office collaboration both in regards to the identification and transition of individuals into the community, the implementation of diversion efforts, and the development of services necessary to ensure a robust system of care.

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 cross-office collaboration is a model which should be shared with others.

Accomplishment #2: SUD Initiatives – Increasing Access to Services

A. **What was achieved?**

Effective September 29, 2021, OBH was awarded the Louisiana State Opioid Response Grant (LaSOR 2.0). This grant seeks to enhance prevention, treatment and recovery services by expanding education, outreach and Medication for Opioid Used Disorder (MOUD) treatment availability statewide, by building and expanding services capacity within the states (10) Opioid Treatment Programs (**OTPs**) and increasing the number of Office Based Opioid Treatment (**OBOT**) providers through a Hub and Spoke model, allowing increased access to care, expansion of community outreach mobile teams, and increase recovery supports, with the ultimate goal of reducing overdose death rates. In addition, this grant seeks to expand MOUD services to persons that are incarcerated

and approaching reentry into the community.

Additionally, OBH has continued to work towards increasing access to Medication for Opioid Use Disorder (MOUD) by increasing the use of evidence-based behavioral health treatment services. Therefore, OBH will expand the number of OTPs from 10 to 12 and thereby increasing the number of persons that can access treatment services.

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

There has been a steady incline in the number of fatal overdoses involving opioids in Louisiana. According to recent 2019 data from the state's vital records database which is used by coroners, opioid-involved deaths increased by 25%, from 470 in 2018 to 588 in 2019. From 2012 to 2019, opioid-involved deaths increased 267%. According to U.S. Department of Health and Human Services (HHS) guidelines, to combat the overdose crisis, people with opioid use disorders need better access to evidence-based treatments, which are often scarce. MOUD is the gold standard for treatment of opioid use disorder and the LaSOR grant will allow more access to prevention, intervention, treatment and recovery support services.

Regarding MOUD, the opioid crisis has resulted in approximately 450,000 deaths nationwide since 1999[1]. Expanding the number of OTP's in the state will increase the availability of needed services in the states opioid hotspots.

C. **Who benefits and how?**

Persons that are between 201% - 300% poverty level that access treatment within community outpatient treatment programs, which are comprised of screening, assessment and a comprehensive treatment plan, which includes counseling and other behavioral health therapies to provide individuals with a whole-person approach. The treatment plan helps individuals achieve and sustain recovery and to reclaim active and meaningful lives. Women who are pregnant or breastfeeding can also safely receive MOUD to better manage their OUD while avoiding health risks to both mother and baby.

Medicaid members eligible for treatment in an OTP must be at least 18 years old, unless the member has consent from a parent or legal guardian, if applicable, and has been addicted to opiates for at least one year or meets federal exceptions, as determined by a physician. Methadone is one component of a comprehensive treatment plan, which includes counseling and other behavioral health therapies to provide members with a whole-person approach. The treatment plan helps individuals achieve and sustain recovery and to reclaim active and meaningful lives. Women who are pregnant or breastfeeding can also safely take Methadone to better manage their OUD while avoiding health risks to both mother and baby.

[1] The Centers for Disease Control (CDC; 2020) and National Institute on Drug Abuse (NIDA; 2020)

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

OBH has partnered with multiple stakeholders to plan, implement and execute a multifaceted approach to expanding education, outreach, treatment and recovery support services targeting persons with MOUD. See partners below:

- Opioid Treatment Programs (OTP) – HUB(s)
- LSU-Health Science Center, Department of Psychiatry, New Orleans. – Spokes, Clinical Consultation, Spoke Care Teams
- Local Governing Entity (LGE) – Prevention, Intervention, Crisis Mobile Teams, and Spokes
- Tulane University – ECHO (Extension for Community Healthcare Outcomes) Training, clinical consultation, and academic detailing
- LSU – Social Research and Evaluation Center/Baton Rouge – Tribal Needs Assessment, Evaluation, Data Collection
- Department of Corrections- Education, Treatment, Training and Referral to Recovery Supports
- Oxford Recovery Home Re-entry Initiative – Recovery Housing
- Participation with Office of Public Health – NOWS initiative (Neonatal Opioid Withdrawal Syndrome) and Opioid Prevention Outreach Coordinators (OPOCs)
- Faith Based Communities
- Louisiana Community and Technical College System (Prevention)-Educational Outreach

Concerning OTP expansion efforts, OBH will partner with two OTP stakeholders to plan, implement and execute the expansion plan to increase MOUD services. An average OTP serves 400-1,200 individuals monthly. To implement this goal, we plan to increase availability and accessibility to 400 and up to 1,200 patients per month at two new clinics, which includes geographic access to care and service availability at times that are convenient to patients. Continuity of care is critical because increased time in treatment strengthens long-term recovery. Long-term recovery improves productivity and employability, reduces criminal activity, and improves family functioning. If individuals are productive and self-sufficient, this improves the overall community health and economic sufficiency.

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

Providing MOUD is one of the approaches used to expand evidence-based treatment services, which impacts the goal to increase quality of and access to OUD treatment.

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 population of focus touch multiple departments and agencies because of the severe nature of OUD. Collaboration and a reduction of duplicative efforts among agencies will help provide more efficient and quality services to this vulnerable population.

Accomplishment #3: Peer Support Specialists (PSS) Expansion

A. **What was achieved?**

During SFY21, an additional 112 peers successfully completed the two-week long Peer Employment Training (PET) to become recognized as Peer Support Specialists (PSS). Due to the COVID-19 Pandemic, all Peer Trainings were successfully conducted virtually via Zoom. On March 1, 2021, the first phase of Medicaid reimbursement for Peer Support Services as a standalone Medicaid service was initiated. With this initial phase, the local governing entities (LGEs) are the provider type allowed to bill Medicaid for this service in the initial phase.

Information obtained for the Peer Stakeholders Workgroup established in 2020 and responses from a Request for Information (RFI) released in September 2020 have provided valuable feedback and information with structuring the Medicaid service definition and phases of implementation for Medicaid reimbursement of Peer Support Services. During SFY21, LDH/OBH continued discussions with national subject matter experts, Peers, partners and other stakeholders to obtain input to guide next steps in the statewide expansion of peer services. LDH/OBH has continued to work closely with national subject matter experts and engage in discussions with other states to obtain additional feedback regarding how the expansion of peer services has occurred in other areas of the country and to help shape the future of this service in Louisiana.

During SFY21, LDH/OBH also obtained approval to create ten additional Peer Support Specialists positions with the My Choice Louisiana initiative that was developed in response to the DOJ agreement. These ten additional positions included a Peer Supervisor and nine (9) regional Peer Support Specialists to support the target population of the DOJ agreement with successfully transitioning from a nursing facility to the community.

While there have been many challenges with the transitions needed during the COVID-19 Pandemic, the transition to virtual trainings has been beneficial to increased participation in comparison to the previous state fiscal year when all trainings were conducted in-person. Please see data below regarding Peers trained and active in Louisiana. Active Peers refers to those trained Peer Support Specialists who have continued to obtain the minimum of ten continuing education units annually and submit their annual training reports to LDH/OBH.

- Peers Trained in SFY20 - **57**

- Peers Trained in SFY21 - **112**
- Total Peers Trained to Date - **704**
- Total Active Peers - **401**

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

This success is significant for numerous reasons. These additions of Peer Support Services are critical to compliance with Senate Concurrent Resolution 84 (SCR84), which requested the Louisiana Department of Health take all steps necessary to approve peer support services as a Medicaid covered service. These steps also comply with the federal Department of Justice (DOJ) Agreement, which requires Louisiana to expand PSS to the target population identified in the Agreement. Peer Support Services are also recognized by the federal Substance Abuse Mental Health Services Administration (SAMHSA) as a best practice in the provision of behavioral health services.

C. **Who benefits and how?**

The expansion of Peer Support Services (PSS) benefits those served through behavioral health programs. Peers can relate to others in a non-clinical, more personal way as they have a similar lived experience. Peers are positive role models and offer hope to others, demonstrating by their own life that recovery is possible. As PSS is recognized by SAMHSA as a best practice, research studies have demonstrated improved engagement and retention of service recipients when PSS are a part of the treatment team.

The transition of the Peer Employment Training (PET) training to virtual to comply with COVID-19 safety protocols has continued to demonstrate the benefit of increased participation in the training, as participants are not required to leave their homes and families for a two-week period. The LDH/OBH contractor that manages the Peer Trainings has reported that the most common reason for "no-shows" with the in-person training has been the inability to coordinate childcare arrangements for a two-week period. The virtual trainings have allowed for more flexibility with supporting Peers to obtain the training necessary to become an approved Peer Support Specialist. The transition from in-person to virtual trainings has also reduced the costs for the training and will allow LDH/OBH to increase the training capacity. The goal is to provide a minimum of nine trainings in SFY22, which will allow LDH/OBH to train a minimum of 110 Peers.

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

These accomplishments were achieved through collaborative efforts with partners, stakeholders and contractors. Support from community partners, stakeholders, legislature and LGEs led to the passage of SCR84 and the Legislature's approval of funds to support the addition of PSS as a Medicaid reimbursable service. During SFY21, LDH/OBH also continued to work closely with national subject matter experts on the development of the Medicaid service definition, as well as identifying additional training curricula for Peer Support Specialists and Supervisors of Peer Support Specialists. National subject matter expert in the field of Peer Services, Dr. Peggy

Swarbrick, has continued to assist Louisiana with further development of training curricula and growth of Peer services.

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

Yes, this accomplishment contributes of the agency's strategic plan by:

- Contributing to the plan to expand Peer Support Services;
- Complying with the DOJ Agreement;
- Complying with SCR84;
- Further development and implementation of SAMHSA recognized best practices with behavioral health services

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

Yes, while the utilization of Peer Support Specialists is primarily associated with behavioral health programs, the use of Peers has also been identified as helpful with many populations and programs, such as Veterans/service Members, individuals with chronic health conditions, parents of children with behavioral health conditions, and child welfare systems.

Accomplishment # 4: COVID-19 Emergency Response for Suicide Prevention

A. **What was achieved?**

A case management intervention model was developed for individuals at risk for suicide. OBH partnered with Mental Health Association of Greater Baton Rouge (MHAGBR) to provide case management for individuals who have attempted suicide or experienced a suicide crisis. Individuals are at an increased risk of suicide after discharge from emergency departments and inpatient psychiatric facilities. The program offers rapid follow-up of adults who have attempted suicide or experienced a suicidal crisis after discharge from emergency departments and inpatient psychiatric facilities. Follow-up and care transition protocols were developed to ensure safety, especially among high risk adults.

Suicide prevention, intervention, and postvention trainings have been provided statewide to community members, health and behavioral health providers, Peer Support Specialists, and service member veterans and their families (SMVF) to increase awareness of suicide and help individuals recognize when someone is struggling with their mental health.

Protocols were developed to provide case management, support groups and psychoeducation to domestic violence survivors. Relationships have been established with shelters and other domestic violence coalitions and resources to address trauma of domestic violence survivors.

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

The program supports the state/communities during the COVID-19 pandemic in advancing efforts to prevent suicide and suicide attempts. This program utilizes Peer Support Specialists to provide case management, follow-up and transitional care to individuals receiving the case management intervention. Peer Support is an evidenced-based practice for individuals with mental health conditions or challenges. Peer support improves quality of life, increases and improves engagement with services and increases whole health and self-management. Providing statewide suicide prevention, intervention and postvention trainings increases the awareness of suicide and warning signs of someone who may be experiencing a mental health crisis and connecting them to services.

C. **Who benefits and how?**

Individuals ages 25 and older who have attempted suicide or experienced a suicide crisis will benefit from the program. MHAGBR employed a case management intervention utilizing Peer Support Specialists as the case managers with supervision provided by a clinical psychologist. The case manager interaction includes the following elements: screening, assessment, safety planning and means restriction, discharge planning, transition care, warm hand off to treatment or community organizations as needed, information sharing and caring contacts.

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

OBH was awarded the SAMHSA grant for COVID-19 Emergency Response for Suicide Prevention authorized under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Protocols were developed based on best practices in suicide care to provide rapid follow-up and care transitions.

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

Yes, this accomplishment contributes to the agency's strategic plan:

- Contributing to the strategic plan to expand the use of peers to keep individuals at risk for suicide connected and engaged over a continuum of care.
- Providing education and increased awareness of the risks and warning signs of an individual experiencing a mental health or suicide crisis and how to support someone after a suicide loss by offering statewide suicide prevention, intervention, and postvention trainings.

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

No.

Accomplishment #5: Zero Suicide:

A. What was achieved?

LDH/OBH provides leadership to decrease suicide deaths and suicide attempts of adults aged 25 or older within behavioral healthcare systems through the following objectives:

LDH/OBH is collaborating with 4 designated Local Governing Entities (LGE) and two state psychiatric hospitals to pilot the SAMHSA Zero Suicide framework.

- The initiative must include the following components: leadership development, healthcare provider training, identification of suicide risk factors, patient engagement, access to treatment, health system transition, and health system quality improvement.
- Training will be provided through a Zero Suicide Academy for the workforce of professionals who are addressing suicide prevention in local communities.

B. Why is this success significant?

Zero Suicide is a transformation Framework for health and behavioral health care systems. The foundational belief of Zero Suicide is that suicide deaths are preventable for individuals under the care of health and behavioral health systems. By addressing all elements of the Zero Suicide Framework, health care providers will transform their health system to one that is ready to identify, treat, refer, and ensure continuity of care for individuals at risk for suicide and suicidal behaviors. Organizations that have used this approach found a 60-80% reduction in suicide rates among those in care.

C. **Who benefits and how?**

The program implements suicide prevention and intervention programs for individuals who are 25 years of age or older. The program is designed to raise awareness of suicide, establish referral processes and improve care and outcomes for such individuals who are at risk for suicide.

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

This goal and aspirational challenge will be accomplished with a 5-year grant from the Substance Abuse Mental Health Services Administration (SAMHSA) to implement the Zero Suicide Framework.

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

Yes. The goal of the state suicide prevention plan is to reduce the incidence of suicide in Louisiana through system-level implementation of strategies in criminal justice and health systems throughout Louisiana, including behavioral health systems. House Bill 148 required the Office of Behavioral Health (OBH) to establish the Zero Suicide

initiative statewide to bring awareness to suicides, and enhance awareness by creating and administering focus on zero suicide.

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

Yes. The Zero Suicide model is a key concept within the 2012 National Strategy for Suicide Prevention (NSSP), a priority of the National Action Alliance for Suicide Prevention.

Accomplishment #6: 988 Planning & Implementation Initiative

A. **What was achieved?**

The 988 Implementation Planning Grant is allowing LDH/OBH to plan for the implementation of a new nationwide three-digit number for mental health crisis and suicide response (988). The goal of this plan is to develop and plan to address key coordination, funding, capacity, operational and other key considerations which are necessary to implement 988 by July 16, 2022. This plan will also focus on a long-term plan to improve in-state answer rates for Lifeline calls, texts and chats. The 988 Implementation plan will provide for the planning of LDH/OBH to establish a robust call system in which two (2) certified Lifeline call centers will serve as back-up to each other to increase the in-state answer rate for Lifeline calls, texts and chats.

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

In July 2022, 988 will become the national three-digit code for the National Suicide Prevention Lifeline, replacing the current phone number of 1-800-273-TALK (8255). The 988 Implementation Planning Grant will allow for the development of clear roadmaps for how LDH/OBH will address key coordination, capacity, funding and communication strategies that are foundational to the launching of 988 which will occur by July 16, 2022. With an easy to remember and dial number like 988, the Lifeline hopes to reach many more people in emotional crisis. 988 represents a long past due opportunity to shift from a law enforcement and justice system response to one of immediately connecting to care for individuals in suicidal, mental health and substance use crises. The number is the first step to make a fundamental shift in how people in crisis are engaged in our communities.

C. **Who benefits and how?**

The Lifeline is the nation's public safety net for all American residents in emotional distress or suicidal crisis. Specifically, Louisianans will benefit by being served by their local crisis centers. Expanding the call system to include a second certified Lifeline Contact Center will establish a robust call system with two (2) certified Lifeline contact

centers serving as back-up to each other, which will increase the number of calls answered in-state. Callers to the National Suicide Prevention Lifeline are better served by their local crisis centers. The plan will also expand the state's capacity to answer text and chat for the Lifeline. Local Lifeline crisis centers reduce the burden on our emergency rooms, police, and emergency responders, as well as our behavioral healthcare providers, who often must step in when emotional crises escalate. The centers also provide a safety net in the absence of other affordable community resources. A 988 Crisis line that is effectively resourced and promoted will be able to:

- Connect a person in a mental health crisis to a trained counselor who can address their immediate needs and help connect them to ongoing care.
- Reduce healthcare spending with more cost-effective early intervention.
- Reduce use of law enforcement, public health, and other safety resources.
- Meet the growing need for crisis intervention at scale.
- Help end stigma toward those seeking or accessing mental healthcare.

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

The 988 Implementation Plan is being developed as part of a technical assistance grant that was received from Vibrant Emotional Health, who is the administrator of the National Suicide Prevention Lifeline**.** The Louisiana 988 Implementation Plan is being developed in collaboration with a multi-stakeholder coalition. The 988 Coalition began meeting monthly in May 2021. Membership in the coalition represents a wide range of stakeholders including Lifeline contact center staff, providers, advocates, peers, and representatives from the state 911 administrators. The initial meetings were an opportunity for OBH to present information about the new three-digit number and for the current certified Lifeline centers and the 211 providers to present critical information on how the centers currently operate. Workgroups have been developed to focus on drafting and finalizing the Louisiana 988 Implementation Plan.

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

Yes. Lifeline centers reduce suicidal and emotional distress in callers. People in crisis can easily use hotlines to access help when other mental health, substance abuse, and social services have eligibility restrictions, are unavailable in rural areas, are inaccessible during late-night hours, or no longer operate because of budget cuts.

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

No, not at this time as the initiative is still in the planning stage gearing up for implementation. Nonetheless, the methodology and activities of the planning process may be useful for future projects.

Accomplishment #7: Center for Evidence to Practice (CE2P)

A. **What was achieved?**

OBH directs the work of the Center for Evidence to Practice, housed at Louisiana State University – Health Sciences Center (LSU-HSC), which serves Louisiana as a hub for training and implementation of Evidence-Based Practices (EBPs) within Medicaid-funded behavioral health services for youth. OBH and Medicaid launched the Center for Evidence to Practice in 2018; SFY 2020-2021 was the Center's second full year of operation.

For SFY21, despite the barriers presented by the COVID pandemic, the Center for Evidence to Practice initiated five (5) training cohorts to train Medicaid-serving behavioral health practitioners in EBPs, training a total of 163 behavioral health practitioners. In addition, there were 531 participants in research-informed practices trainings such as Motivational Interviewing. The Center for Evidence to Practice has continued to develop and refine their website to provide user-friendly information to consumers and stakeholders on EBPs and how to access them. In addition to continuous updates to the interactive map of LA Medicaid EBP providers across the state, the Center's website also now features additional community resources such as the "EBP referral guide/decision tree" that assists stakeholders in identifying an appropriate EBP program for a child based on age and area of treatment focus.

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

This initiative expands and increases access to evidence-based practices in behavioral health for LA Medicaid member youth. This increases the quality and effectiveness of behavioral health services for youth in the Medicaid system.

C. **Who benefits and how?**

Behavioral health providers in LA benefit through access to intensive, high-quality training and consultation leading to national certification in high quality therapeutic interventions.

Medicaid eligible children, adolescents, and families benefit by access to high-quality, evidence-based care with proven outcomes.

The Medicaid program benefits through efficient use of Medicaid resources; evidence-based programs have been shown to deliver better outcomes for youth when compared to treatment-as-usual, and can prevent the need for more lengthy, less effective, and more expensive behavioral health treatments. Many of the therapeutic interventions being expanded in LA have been nationally recognized as showing proven outcomes in

preventing children's entry into foster care, so are expected to produce downstream benefits to LA DCFS as well. (Resources are available if needed.)

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

Medicaid and OBH jointly fund the work of the Center for Evidence to Practice, under the CHVE. OBH closely collaborates with and directs the Center's work. The Center for Evidence to Practice accomplishes their work through extensive and broad engagement with stakeholders across the state, including behavioral health providers, state agencies, MCOs, and juvenile courts.

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

Yes; specifically, this accomplishment contributes to OBH's strategic plan transformational priority of "Access to Behavioral Health Services" including access to high-quality evidence-based behavioral therapies for young children, and workforce development efforts [that] 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.

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

No.

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

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

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

The Office of Behavioral Health (OBH) is on target, however, there are areas that due to fluctuating trends of the current pandemic have been or may be affected. The public health emergency and/or weather-related incidents that have occurred has caused delays in particular areas of implementation of several of our initiatives relative to our agency's strategic plans. Nonetheless, we are moving in a forward direction anticipating positive outcomes regarding any impacted initiatives. We have resumed most of the operations of our office, and those functions that were impacted were studied to develop alternative methods to continue operations with the least functional impact. Our strategies appear to be effective and rooted in evidence-based techniques and practices. We are consistently attempting to

identify the potential outcomes and anticipate yielding positive returns.

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

In 2014, the Department of Justice (DOJ) initiated an investigation into the state of Louisiana's mental health service system to assess compliance with Title II of the Americans with Disabilities Act (ADA). Following this investigation, in 2016, the DOJ concluded that Louisiana unnecessarily relies on nursing facilities to serve people with serious mental illness (SMI) instead of serving them in the most integrated setting appropriate to their needs as required by the ADA.

In June 2018, the State of Louisiana and LDH signed an agreement with the DOJ to help ensure compliance with the ADA, which requires that the State's services to individuals with mental illness be provided in the most integrated setting appropriate to their needs.

The first of the two main components, that we have already begun, is the diversion and pre-admission screening piece, which requires the State to develop a plan for a diversion system that will identify individuals in the target population seeking admission to nursing facilities and provide intervention and services to prevent unnecessary institutionalization. Specifically:

LDH has implemented changes to the screening process for nursing home admissions and is now authorizing more temporary stays rather than long-term "permanent" stays. This means that the need for continued stay in a nursing facility will have to be justified and will come under review more often.

OBH has formally standardized the utilization of temporary authorizations. For pre-admission Preadmission Screening and Resident Review (PASRR) Level II requests, authorization request will not exceed 90 days (or 100 days for persons approved for convalescent care by LDH). Additionally, all individuals will receive a new PASRR Level II evaluation annually. This increase in evaluations has resulted in a substantial increase in the number of Level II evaluations conducted annually.

1) PASRR Level II Referrals Received (SFY 2019): 7,134
2) PASRR Level II Referrals Received (SFY 2020): 7,146
3) PASRR Level II Referrals Received (SFY 2021): 6,779
4) Requests for Independent Assessments (SFY 2019): 2,903
5) Requests for Independent Assessments (SFY 2020): 3,367
6) Requests for Independent Assessments (SFY 2021): 3,743

Finally, LDH Transition Coordinators have been performing face-to-face transition assessments with members of the target population. As of June 30, 2021, My Choice Louisiana

OBH Transition Coordinators have transitioned 69 individuals. Additionally, activities have been undertaken to conduct in-reach activities to individuals with serious mental illness residing in nursing homes to gauge their interest in transitioning into the community. These activities, especially when coupled with the integration of Peer In-reach Specialists (PIRS) are expected to result in more transitions being facilitated.

Other areas of notable success are the expansion of services to Louisiana citizens regarding: substance use disorders treatment and prevention; suicide prevention and crisis services; PSS, and continued development of training for competent practitioners for children, youth and families (i.e., CE2P). For purposes of this section, we will highlight the success of the My Choice Initiative (i.e., DOJ Agreement) success.

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

The success of this effort lies on the willingness of LDH to work with the DOJ to correct this issue efficiently and effectively. LDH has partnerships with the MCOs and the LGEs that also assist. The Department, and state, has recognized the importance of this program and have been supportive of activities undertaken as a result given their positive impact to the state and its constituents.

My Choice Louisiana: This effort – as mentioned earlier – has been a joint effort by all LDH agencies, with OBH and OAAS as the leading entities. OBH has contributed to the successful implementation of the planning and the achievement of goals. Progress is determined through the attainment of goals associated with the projects overall implementation and adherence to timelines and targets established within the annual implementation plans.

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

OBH anticipates that progress will continue. The LDH/DOJ project will continue through 2023. The first phase of implementation ran through December 6, 2018 and Phase Two was released in December 2019 along with a crisis plan, diversion plan, and a housing plan. Annual implementation plans will be updated and released each December moving forward for the duration of the project. Staff are currently implementing critical activities necessary to move the programs forward and outlining activities for future years, 2022 and beyond.

- **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 COVID-19 public health emergency has impacted certain initiatives. Specifically, though COVID-19 had impacted the ability of Transition Coordinators to go into Nursing Facilities to transition individuals into the community, work has begun more recently to restart these activities with the number of transitions occurring increasing since June, 2020. Additionally, OBH has spearheaded the attainment and utilization of technology intended to further improve in-reach activities within nursing facilities, which enable additional transitions into the community. These impacts continued to be felt through SFY21 as the COVID cases in Louisiana continued to rise periodically with various waves of cases. Adding to the impact due to COVID, a number of weather events impacted the state during this period with two direct hits to the Southwestern portion of the state. These impacts resulted in disaster declarations, which impacted the Pre-Admission Screening Resident Review (PASRR) process and our ability to conduct pre-admission reviews for nursing home placement.

While the scope of the project is vast, with multiple moving parts, OBH is working diligently to adhere to timelines within the implementation plans; onboarding and enlisting the assistance of staff and outside consultants to ensure targets are achieved.

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

OBH is not significantly behind on any individual component related to the implementation of activities associated with the DOJ Agreement. In fact, despite the multiple external barriers which have affected the state (malware, COVID-19, hurricanes); OBH has worked diligently to ensure activities are kept current. As indicated earlier, hiring of additional staff will allow for a more focused and targeted approach to implementation of the various components of the Agreement.

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

As noted above, the multiple external barriers which have affected the state (i.e., COVID-19, hurricanes, and other weather-related events) have contributed to the delays in progress of some efforts.

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

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

OBH was in the progress of revising and updating the strategic plan until the COVID-19 Pandemic occurred. Nonetheless, we are preparing to revise the plan in the near future.

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

Agency-level goals and objectives included in the strategic plan are further translated into comprehensive work plans which describe the action steps that will be taken to accomplish the objective, associated timelines, and person responsible for each action step; these work plans are reviewed and updated on a regular basis by gathering input from all levels of the agency's functional areas. Discussions are conducted with Team Leaders and participants representing functional areas essential to support agency priorities. Further, agency goals and objectives are embedded in the performance planning and evaluation process for employees.

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

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

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

A. Problem/Issue Description

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?

Department Issue #1: Continuity of OBH Operations During the COVID-19 Pandemic Spikes

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

Operational methodologies and overall continuation of operations were dramatically impacted with the onset of the COVID-19 pandemic and the nearly immediate shift to moving all of our in-field and headquarters' staff to telework, in the event that it was appropriate and that staff had the capability. Further our critical missions and the goals of our 24/7 facilities were negatively impacted due to the nature of, and residual impacts of this event.

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

As noted earlier, OBH's mission and goals were initially impacted by the pandemic. While we worked, and continue to work, toward implementing processes to ensure that our goals are advanced, this unprecedented event has curbed our ability to achieve these ends, as efficiently as originally intended. While still experiencing some delays in areas, we have resumed most operations as noted earlier.

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

All units within OBH have been impacted by the impediments that have resulted from this event. Administration has had to account for variations and accommodations related to purchasing, contracting and resource deployment. Staff who work with strictly hard copies; work in-person with program staff; work with receiving physical deliverables, paper checks and shipments; as well as the necessity for specifically procuring resources related to shifting to telework have all resulted in a need for additional time and dedication with our limited staffing in this area. Accommodations that were immediately required, specific to the pandemic, include the following resources required for an effective transition to telework status: Mandatory mobile office functionality, namely – laptops, internet access, printing capability when necessary, telephone access and necessary supplies and resources otherwise available in house. Clinical staff had to also move to a telework capacity, and were impacted by all of the above noted issues. Additionally, clinical staff were pulled out of the field, which impacted their ability to adequately

meet the needs of the community and toward the projects that they are working to advance and achieve the associated goals set by the office and department, as a whole.
Health Management staff had to address regulations such as those associated with telework capacity of providers, in order to ensure continued access for Medicaid Managed Care recipients. Additional allowances offered via CMS and waiver recipient accommodations had to be accounted for, and implemented with an extremely short turnaround time.
Further we had to ensure access to Medication Assisted Treatment through the state's Opioid Treatment Programs so that patients had access to the appropriate dosing and continued support and therapeutic services.

Our 24/7 inpatient facilities had to work to ensure appropriate coverage, as staffing was impacted by the pandemic, and issues with placement and compliance with the Cooper vs. Jackson lawsuit were being adhered to, in light of the impact experienced based on necessitated quarantine guidelines and discharge protocol.

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

This pandemic has not only affected our staff and all of the Louisiana Department of Health staff, but also the recipients of our efforts, the providers of behavioral health services, and our contractors and managed care entities working to provide the services needed by the citizens of Louisiana in need of behavioral healthcare.

5. How long has the problem or issue existed?

The impact was most significantly realized as of March 22, 2020, when state employees were notified that, ultimately, telework was required, per policy, and as the norm. While there have been alternative ways to continue functioning as the pandemic persists, the above mentioned date remains accurate.

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

The pandemic known as COVID-19 was the immediate cause to the operational issues that OBH experienced in SFY20 and SFY21. Our reaction to, and responsive associated with the operational adjustments necessitated by the national requirements and guidance, as well as the Governor's directives, initiatives and mission, further supported our acknowledgment of the impact of the pandemic and our ensuing response.

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

Consequences include inability of staff to ensure completion of their assigned tasks, ability of OBH to respond to our goals of initiatives such as transitioning recipients to the most appropriate level of care within our 24/7 facilities per Cooper vs. Jackson which requires the timely processing of clients to the least restrictive level of care in the event that the recipient is deemed to be incapable of being restored to competency or not guilty by reason of insanity – meaning

they are available to be transitioned to a civil placement versus a forensic placement. The Office of Public Health has required ELMHS to quarantine patients for 14 days which has impacted their ability to transition recipients to the appropriate level of care within the allotted period of time. This backlog impedes our ability to appropriately adhere to the guidelines provided for in the agreement.

Additionally, we are currently under a Settlement Agreement with the Department of Justice which requires certain activities related to the assessment of residents of nursing facilities in light of any behavioral health issues or disorders, and ensures that recipients that may appropriately transition to a community residential setting, and who are in support of such transition, are provided the assistance and support to necessarily do so, and to successfully integrate into their community. The inability of our Transition Coordinators to go out in to the community and meet with the residents in these facilities causes the process to be impeded, but not terminated. Staff have worked diligently to implement alternate processes in order to continue this effort for the duration of the limitations of social distancing and in order to comply with health and safety issues that have arisen with the COVID pandemic.

From a headquarters perspective, we had numerous operational processes and allocation resource issues that had to be addressed, in order to ensure the successful continuity of operations for OBH. Steps were taken to update our Continuity of Operations Plan to account for pandemic related issues such as office wide telework and resource allocations, as well as implementation of our COOP team and purchasing and processes to accommodate our staff's ability to work remotely. OBH also assessed our resources and proceeded with purchasing of Personal Protective Equipment, mobile printers, cellular phones and Mifis to ensure that all of our staff were equipped to continue their daily tasks in support of the mission of OBH. We also crafted an emergency telework agreement in order to support staff that didn't have an existing agreement in place. All scheduled meetings were shifted over to web-based meetings through ZOOM functionality, and All Staff meetings were set up each week in order to keep OBH staff abreast of the status of the office protocol and in order to provide support and resources to ensure they were comfortable as to their status and aware of how the pandemic would impact them as employees of OBH.

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?

<u>Department Issue #2: OBH Organizational Structure</u>

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

The organizational structure of OBH does not align with our subject matter areas, and is deficient in certain areas of priority.

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

This issue does impact our efficiency, which ultimately reduces our ability to most effectively

progress with our strategic plan.

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

This issue impacts all of the units within OBH.

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

Due to the decentralized nature of staff working within the same subject matter areas, communications with outside stakeholders such as other LDH offices, LGEs, providers and other state agencies, are at risk of not being transparent or consistent.

5. How long has the problem or issue existed?

This issue has existed, to some degree, since OMH and OAD were merged in FY11.

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

Some of the causes leading to OBH's organizational structure issues include the merger of the former Office of Mental Health (OMH) and Office of Addictive Disorders (OAD), the decentralization of administrative control of regional behavioral health services from OBH to the 10 LGEs, the implementation of Medicaid managed care for the provision of behavioral health services and an increasing prevalence of opioid abuse and the resulting need for treatment. An overarching issue is the loss of state general fund dollars over the last several fiscal years, and the increased need to pursue other funding sources.

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

We need to build capacity in certain core areas, as well as streamline and centralize processes that are currently scattered as well as duplicated, across the Office. Without rectifying these issues with our current organizational structure, we will not be able to address OBH's priorities in the most effective and efficient manner.

B. Corrective Actions

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

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

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

A business reorganization through Civil Service.

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

Yes. This was presented in one previous AMPAR submission as an issue, with additional progress having been made in the interim.

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

Our goal is to successfully implement by the fall of 2021.

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

With the assistance of a national consultant, we have developed a set of targeted priorities for the office, and identified where our current organizational structure is not in line with those priorities. While there have been delays due to a number of new grants and initiatives, as well as the impact of COVID-19, we hired a former LDH HR staff person to lead this project as a WAE. She has reviewed all of our SF-3s, revised our org- chart and initiated our submission to Civil Service. This has resulted in significant progress with this action, even in light of the pandemic. Our goal was to have the plan ready for presentation to Civil Service no later than the spring of 2021. We have met with Civil Service, and subsequently submitted our plan for reorganization and are currently awaiting feedback from Civil Service.

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

5. Do corrective actions carry a cost?

☒ No. If not, please explain.

Our business reorganization does include requests for additional TO or other resources, so we don't anticipate any significant cost.

☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
    a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
    b. How much has been expended so far?
    c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

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

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

A. Check all that apply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Title of Report or Program Evaluation:
   Prevention Management Information System Reporting on Prevention Services (Quarterly and Annual)

2. Date completed:
   July 1, 2019 – June 30, 2020
   This data is from FY20 AMPAR report. FY21 data available August 5, 2021.

3. Subject / purpose and reason for initiation of the analysis or evaluation:
   The Office of Behavioral Health (OBH) is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the SAPT which is the primary funding source for prevention services. It requires 20% of the grant be set aside for primary prevention services. An important issue for prevention services is consumer confidence and transparency of our use of available resources. It is our challenge to be efficient in the use of these resources. This report

is a continuing process to measure the number of services we provide and the populations that are served.

4. Methodology used for analysis or evaluation:
   The data in this report is from the Prevention Management Information System (PMIS), the primary reporting system for the SAPT for prevention services.

5. Cost (allocation of in-house resources or purchase price):
   There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from PMIS to generate this document. Data is entered into PMIS by the Local Governing Entity (LGE) prevention staff, their contract providers statewide and OBH staff.

6. Major Findings and Conclusions:
   During FY 2020, Prevention Services provided evidence-based services to 78,106 enrollees.

   FY 2020 block grant funded one-time services provided to the general population reached 9.1 million participants. This number reflects the number of individuals that are impacted by PSAs, billboards, and other media campaigns. This number included the combined services provided by Prevention Staff and Prevention Contract Providers.

7. Major Recommendations:
   The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.

8. Action taken in response to the report or evaluation:
   No actions other than the recommended (above) were pertinent.

9. Availability (hard copy, electronic file, website):
   The report is distributed via e-mail and is available by hard copy upon request.

10. Contact Person:
    Name: Dr. Leslie Brougham Freeman
    Title: Director of Prevention Services
    Agency & Program: LA Department of Health, Office of Behavioral Health
    Telephone: 225.342.5705
    Email: Leslie.BroughamFreeman@la.gov

1. Title of Report or Program Evaluation:
   Synar Report: Youth Access to Tobacco in Louisiana

2. Date Completed:
   December 17, 2020

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 $ $82,200.00 ($100.00 per compliance check x 822 checks). The total cost to prepare and complete the Annual Synar Report was $70,000.00.

6. Major Findings and Conclusions:
   The objective of this study was to estimate the non-compliance rate for tobacco sales in Louisiana among youth under age 18. Annual targets were established to decrease the state's non-compliance rate to 20% by FFY 2002. However, Louisiana achieved 20.3% non-compliance in FFY 1999, only two years after the start of the Louisiana Synar Initiative, and three years ahead of the scheduled target date. The current rate of tobacco sales to minors in FFY 2021 is 8.0%.

7. Major Recommendations:
   OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2021 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). Louisiana was ranked among the top states in

compliance, in the FY 2013 report (most recent on file). The SAMHSA report can be viewed at https://store.samhsa.gov/shin/content//SYNAR-14/SYNAR-14.pdf. Our goal is to continue implementing current strategies since they've proven to be successful.

9. Availability (hard copy, electronic file, website):
   The FFY 2021 Annual Synar Report is available by hardcopy, and may be accessed online at https://ldh.la.gov/index.cfm/newsroom/detail/1390.

10. Contact Person:
    Name: Dr. Leslie Brougham Freeman
    Title: Director of Prevention Services
    Agency & Program: LA Department of Health, Office of Behavioral Health
    Telephone: 225.342.5705
    Email: Leslie.BroughamFreeman@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department: **Louisiana Department of Health (LDH)**
09-340 Office for Citizens with Developmental Disabilities

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

Undersecretary: **Ruth Johnson**

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: Supporting Individuals with Intellectual/Developmental Disabilities, Families, and Providers through Multiple Emergency Events:

A. **What was achieved?**

During the 2020-2021 fiscal year Louisiana experienced several weather-related disasters, in addition to the COVID-19 Public Health Emergency. The active summer hurricane season, the February ice storm, and the spring flooding all affected Office for Citizens with Developmental Disabilities (OCDD) participants. OCDD worked to develop emergency processes and procedures to keep participants safe during the

weather-related emergencies. OCDD continued to complete Screenings for Urgency of Need (SUN) virtually, to ensure that people who had urgent and emergent needs could continue to receive Home and Community Based Waiver offers. OCDD worked with Intermediate Care Facilities for Individuals with Intellectual/Developmental Disabilities (ICF/IIDs) to coordinate vaccinations, with over 86% of residents having received at least an initial dose. OCDD was able to assist in maintaining the health and safety of participants during a very challenging year.

In August OCDD Waiver and the OCDD ICF/IID Programmatic Unit worked collectively to assist individuals at the Robinswood School after the abrupt closure of the facility. Following Hurricane Laura, the Robinswood School was forced to evacuate to Pinecrest Supports and Services Center. While residents were evacuated, Robinswood de-activated its license, and OCDD's ICF/IID Programmatic Unit worked to move over 60 individuals to private ICF providers within 30 days—all but one of these individuals has maintained their placement to date. OCDD's Waiver unit worked to offer community-based placement to those who wished to be served in the community. OCDD's ICF/IID Programmatic Unit also worked to develop a Cooperative Endeavor Agreement (CEA) to serve the remaining high-risk Robinswood residents who could not be supported in a traditional ICF/IID facility.

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

OCDD's efforts helped to keep participants safe during multiple disasters. COVID-19 presented challenges to OCDD's usual planning and preparedness efforts; however, OCDD managed to succeed in supporting participants in spite of the challenging circumstances.

C. **Who benefits and how?**

OCDD participants, families, support coordinators, and direct support workers all benefited from OCDD's disaster planning relief efforts.

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

OCDD's units worked cooperatively to make sure that all waiver participants had the necessary information to keep them safe during weather-related emergencies. OCDD's waiver activities included:

- Sharing important health and safety information including generator safety, and carbon monoxide warnings;
- Collaborating with the Governor's Office of Homeland Security and Emergency Management (GOHSEP), Federal Emergency Management Agency (FEMA), and other national organizations to maintain the health and safety of waiver participants;
- Increasing trainings on planning and preparedness;
- Checking evacuation plans and working with support coordinators to make sure all safety plans were feasible;
- Tracking short term, middle, and long term housing needs for those displaced by weather-related disasters;
- Assisting community homes in emergency situations and where emergency plans had failed;

- Leveraging technology to continue screening participants for urgent and emergent unmet needs,
- Assisting those displaced out of state with local resources in their evacuation area, and
- Support coordinators maintaining communication and providing assistance for those displaced out of state.

OCDD's ICF/IID Programmatic Unit was also active in assisting those affected by COVID-19, and those in weather-affected regions. OCDD's ICF/IID Programmatic Unit activities included:

- Acting as the sole point of contact and data collection for COVID-19 testing in the ICF/IIDs,
- Coordinating, administering, and tracking vaccine percentage rate,
- Providing transition and technical assistance for all individuals moving from Pinecrest Supports and Services Center to private ICF/IIDs to ensure needed supports and services were in place and the transitions were successful, and
- Linking ICF/IID to resources during weather-related emergencies.

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

Yes, one of OCDD's strategic plan goals is to provide a system that affords participants access to information about supports and services, and to give them access to those supports and services. OCDD's actions during the multiple emergency situations ensured that OCDD participants could continue to access services safely. OCDD's enhanced communication with providers, participants, families, and support coordinators provided additional access to information about supports and services, and emergency preparedness and response.

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

Yes, Emergency Preparedness and Planning is essential in the State of Louisiana and should be encouraged in all departments and agencies.

Accomplishment #2: Successful Implementation of Emergency Changes to Home and Community Based Services (HCBS) to Support Participants, Families, and Providers during the COVID-19 Pandemic:

A. **What was achieved?**

At the beginning of the COVID-19 pandemic, OCDD developed and Centers for Medicaid and Medicare Services (CMS) approved an emergency amendment to our four Home and Community Based waiver programs (Appendix K). The Appendix K waiver flexibilities enables participants to continue to receive the most appropriate services in a way that protects their own health and safety, and the health and safety of those providing the services. The following exceptions were approved:

- Allowed telehealth for visits (Support Coordination (SC), local governing entities (LGE), and Home and Community Based Service (HCBS) Providers;
- Allowed 30 day timelines for needs based assessments;
- Allowed revisions to the participant's plan of care (POC) with verbal approval;
- Allowed annual plan of care extensions;
- Allowed sharing across waivers;
- Allowed conversions of day habilitation, pre-vocational hours to in-home supports;
- Allowed staff to reside in the home of the waiver participant and provide supports;
- Allowed waiver participant to reside with staff;
- Allowed legally responsible family to be paid staff;
- Allowed 20 additional hours per week for Children's Choice waiver;
- Allowed 16 and 17 year olds to be hired as paid staff;
- Allowed Supervised Independent Providers to conduct virtual visits instead of face to face visits;
- Allowed Monitored In-Home Caregiving (MIHC) for two OCDD waivers.

Office for Citizens with Developmental Disabilities (OCDD) kept participants and stakeholders informed about waiver flexibilities by issuing guidance throughout the pandemic.

To help address workforce issues OCDD also developed a hazard rate of pay for Direct Service Workers (DSWs) who worked with individuals with COVID-19, and a retainer payment for agencies to bridge financial gaps during the required program closures. OCDD linked individuals and providers with personal protective equipment (PPE) and delivery options. An internal tracking system was developed to identify waiver participants or participant's family members, who tested positive and to identify trends and patterns of individuals testing positive in a group setting.

OCDD issued memorandums to provide vaccine guidance and training to HCBS providers and SC agencies, as well as training to HCBS providers and Support Coordination Agencies regarding COVID-19 response efforts. OCDD developed a phone script and a tracking system to identify individuals requesting a vaccination in the home or community. Once vaccination began, OCDD shared the eligibility criteria and documents for waiver participants to take to the vaccination locations.

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

OCDD serves an extremely vulnerable population, and worked to ensure that services continued safely during the public health emergency. OCDD's emergency response helped to ensure health and safety of our vulnerable populations and reduced the exposure of COVID-19.

C. **Who benefits and how?**

These efforts benefited all OCDD waiver participants, their families, and those that support our participants. Waiver flexibilities allowed participants to continue to receive necessary services while keeping them safe from COVID-19.

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

At the beginning of the COVID-19 Public Health Emergency OCDD submitted

emergency waiver amendments to CMS for approval. Those waiver flexibilities allowed OCDD to continue to support participants despite the challenges posed by the public health emergency. OCDD provided webinars, memorandums, and frequently asked questions for participants, families, Support Coordination, HCBS providers, and stakeholder groups. OCDD worked to stay updated on the virus and the latest information and trends.

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

Yes. OCDD's strategic plan aims to help provide participants with access to information about supports and services available to them, and how to access those services. Throughout the COVID-19 public health emergency our office addressed the concerns of OCDD waiver participants, and provided them with information and assistance with waiver flexibilities that ensured that their needs were met despite the challenging circumstances.

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

Yes. OCDD reviewed state and national level trends to inform actions that were taken.

Accomplishment #3: Ongoing EarlySteps Response to the COVID-19 Pandemic:

A. **What was achieved?**

EarlySteps—under the leadership of OCDD—is Louisiana's Individuals with Disabilities Education Act (IDEA), Part C early intervention system. The EarlySteps service system is designed to support infants and toddlers with disabilities, and their families and caregivers, in *natural environment* settings. In Louisiana, 99% of service delivery occurs in these settings, typically family homes and child care centers. When the first COVID-19 restrictions were issued in March 2020, EarlySteps staff worked with the LDH Office of Public Health (OPH) to design and implement a responsive hybrid service delivery model so that appropriate service delivery could continue regardless of the phase of the COVID-19 requirements. In addition, staff collaborated with the Louisiana Department of Education Early Care and Education (LDE) staff to monitor changing requirements for child care centers and to develop and update requirements for service delivery in child care settings.

- In March 2020, CMS issued flexibility guidance, allowing for reimbursement for virtual services provided through a telehealth model. EarlySteps staff worked with Louisiana Medicaid and OPH to develop procedures that allowed virtual services to be provided to families, and reimbursed to providers. These procedures included guidance documents, links to platforms (Zoom, Microsoft Teams, etc.) including training in their use, procedure billing codes, and guidance for conducting virtual eligibility evaluations.
- As each phase of the pandemic was implemented, staff worked with OPH and LDE to solicit input on service guidance and implement changes matched to each phase:

  - March 20, 2020: virtual-only services were allowed. Guidance, a family letter, and FAQs were shared with stakeholders.
  - August 2020: Face-to-face visits in child care centers were allowed. A Telephone Screening process was developed to determine the level of risk for the family, child care, and the provider based on COVID-19 risk factors (symptoms, temperature, exposure to COVID-19, vaccination, etc.).
  - September 2020: Up to two home visits per day were allowed. Child care center visits were allowed in parishes with < 5% positivity rates, resulting in a combination or home and virtual visits for provider caseloads.
  - November 2020 to June 2021: A combination of home and virtual visits were allowed up to four home visits per day in parishes whose weekly positivity rates were < 5%. If positivity rates were greater than 5% home visits were limited to two per day.
  - June 1, 2021: The positivity rates across the state were consistently < 5%, so the daily limit of four home visits per day was removed. The Telephone Screening was updated and simplified with more current Centers for Disease Control (CDC) guidance and the expansion of vaccine availability.
  - EarlySteps has a cost participation requirement (FCP) where families pay a portion of their cost for services based on their income. EarlySteps developed a process for suspending FCP when a family's income was negatively impacted by the pandemic. The suspensions were also applied to families in regions 5 and 6 following the effects of the two hurricanes in the summer 2020.
- EarlySteps staff continue to monitor COVID-19 positivity rates weekly and review CDC, CMS, IDEA-Part C guidance and other resources to make ongoing decisions about service delivery to eligible children and families as the pandemic changes or resolves. In addition, FCP suspensions are reviewed at the annual Individual Family Service Plan (IFSP) meeting based on changing family circumstances, which allow for families to resume FCP assignment and payments.

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

The COVID-19 pandemic is unprecedented for its impact worldwide. The lives of families with eligible infants and toddlers and those of EarlySteps providers were significantly impacted very quickly. Some families chose to refuse referrals to EarlySteps, to withdraw from the program, or to reduce the number and type of contacts with the program. These decisions, although understandable, impacted income for thousands of early interventionists across the state.

EarlySteps was committed to meeting child, family, and provider needs as quickly and effectively as possible, with little to no break in service delivery and support to minimize these impacts as much as possible.

C. **Who benefits and how?**

Eligible children and families benefitted from a flexible service model which allowed for minimum to no breaks in service, and which evolved as the conditions of the pandemic changed over time. Providers benefited from the ability to continue to provide services as the different phases evolved, minimizing impacts to their income.

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

The successful implementation of the evolving service delivery model resulted from ongoing use of the continuous quality improvement model that EarlySteps uses to accomplish any system improvement activity: the National Implementation Research Network (NIRN) Implementation Science methodology.

- Research was conducted from many national and resources to explore options for continuing service delivery based on the COVID-19 phase and used for decision-making.
- Service Data was constantly reviewed to monitor entry to- and exit from- the program, service utilization, issues with billing and reimbursement.
- Stakeholder input was collected and used to make ongoing decisions. 782 families and 588 early interventionists responded to one of the EarlySteps surveys about their experience and preferences regarding EarlySteps service delivery. The system improvement stakeholder workgroups provided input on resources and service delivery tools specifically for use during virtual service delivery, and to ensure services continued according to EarlySteps practices.
- EarlySteps staff monitored state and national resources for changing recommendations as needs during the pandemic changed and collaborated with OPH to get feedback on updating guidance.

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

Yes. The outcomes achieved to date contribute to ongoing success, as shown by the performance measures from the state's Annual Performance Report and other program data:

- Two indicators most likely to be impacted by COVID-19 were maintained or showed slight improvement for the 2019-2020 reporting period: Services provided within 30 days of the IFSP development improved from 90% to 93.66% and IFSP development within 45 days of referral was maintained at 99%.
- Feedback from EarlySteps families and other stakeholders:
    - 782 families responded to a survey about service delivery during COVID-19. Approximately 82% responded that they felt supported by EarlySteps during the pandemic and 74% responded that they were able to participate in virtual service delivery between 70-100% of the time.
- 588 providers responded to a survey about LDH decisions regarding service delivery. Approximately 76% felt that EarlySteps was responsive to changing needs and 75% agreed with decisions regarding continuation of virtual service delivery as the COVID-19 impact changed despite preferences for resuming home visits over virtual visits. Reviewing data regularly provided information

regarding referrals, eligibility determination and child count.

- EarlySteps refocused on referral source outreach due to a 15% decrease in referrals once face-to-face contacts were determined to be safe. These efforts resulted in a 10% increase compared to the same period in 2020.
- After a 7% decrease in child count and as a result of outreach efforts, the child count has increased each month beginning March 2021.

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

Yes. EarlySteps used specific components of the NIRN model to implement changes and aligned with its evidence-based practice: the Division of Early Childhood Recommended Practices (DECRPs). This methodology posits that effective practice change depends on the key features of: stakeholder involvement and communication, careful practice selection and design, adult professional development practices including coaching, and ongoing measurement for fidelity of implementation.

Accomplishment #4: Stakeholder Engagement with Advocates and Providers during the COVID-19 Pandemic:

A. **What was achieved?**

Throughout the COVID-19 Pandemic OCDD engaged in robust stakeholder outreach and engagement aimed at ensuring the transparent and meaningful sharing of information and resources to keep our vulnerable population safe, and to promote advocacy.

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

OCDD management was able to gain insight into how we were reaching our participants, what their needs were and how to best address those needs. This strategy gave OCDD an opportunity to explore what Appendix K flexibilities were working for families, participants, and providers, and assisted staff in planning and expanding waiver services going forward. OCDD was able to give participants a balance for the need for in-person collaboration and connection with staff. OCDD will continue to use these technologies and means of communication to emerge stronger in our post-pandemic recovery.

C. **Who benefits and how?**

Self-advocates, family members, providers, and the direct support workforce all benefited from having a forum to report strategies and practices to assist in meeting the needs of all waiver recipients. OCDD was also able to provide additional resources to help identify and implement best practices in slowing the spread of COVID-19.

OCDD benefited from the additional stakeholder input by being able to gather the necessary information needed to focus on improving our ability to advocate for the specific healthcare initiatives and resources that were important to those providing and receiving services.

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

Early in the COVID-19 pandemic OCDD's Waiver leadership team, along with their staff, identified the need for enhanced communication. Once identified, OCDD implemented strategies that included:

- A COVID-19 webpage to raise awareness and disseminate safety guidelines and guidance quickly and effectively to reach those recipients who may otherwise have missed OCDD communications.
- Ongoing surveys aimed at capturing information related to:
  - the effectiveness of the service delivery system and flexibilities;
  - the health status of household members and direct support workers; and
  - vaccination willingness and outreach.
- Reporting tools that capture COVID-19 specific health and safety data of individuals with intellectual and developmental disabilities.
- Public facing reports that provide a snapshot of COVID-19 positivity, hospitalization, and recovery data for waiver recipients and ICF/IID residents.
- Public facing reports that provide an overview of vaccination rates for waiver recipients and ICF/IID residents.
- Virtual stakeholder forums to share information and solicit feedback on the COVID-19 flexibilities that OCDD put in place to address the needs of individuals during the public health emergency.
- Participation in national panels to communicate the successes and barriers experienced by the Intellectual and Developmental Disabilities (IDD) population in the state of Louisiana.

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

Yes, OCDD's strategic plan recognizes that promoting stakeholder engagement and advocacy efforts is an important component of our overall strategic plan.

OCDD was able to create experiences and platforms that allowed the OCDD team to gather and promote consistent and effective communication practices with stakeholders. By creating this open communication environment with stakeholders the OCDD team was also able to impact outcomes and build support for upcoming initiatives.

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

Yes, using stakeholder input via listening sessions and surveys is a Best Management Practice according to the CMS, and the methodology will be shared with other states and departments to illustrate how stakeholder input can be used to impact outcomes and support for upcoming initiatives.

Accomplishment #5: Engagement in Person-Centered Initiative:

A. **What was achieved?**

The Office for Citizens with Developmental Disabilities (OCDD) clinical services and

waiver division partnered to implement a core onboarding training series with certification requirements for all new support coordinators for OCDD waiver services. Ten modules were developed, consistent with national best practices and OCDD waiver expectations.

- Modules 1-3: Person-centered thinking and tools to aid in discovery,
- Module 4: Preparing for planning discussions and using PC tools,
- Modules 5-7c: Facilitating planning discussions and building a PC plan,
- Module 8: Plan review and quality outcomes.

Modules were delivered to an initial group of newly hired support coordinators; those modules were recorded and distributed to all support coordination agencies. These onboarding modules will be required training for all new support coordinators hired to provide case management for any individuals receiving OCDD waiver services. A certification process was developed with homework linked to each of the 4 core sections noted above. Certification is underway for the initial group of support coordinators with significant positive progress occurring: 67% of support coordinators completing training are progressing through certification in the first core areas [certification occurs sequentially through the four core areas], with 16% completing certification in the first core area, and working on the second core area. Certification requirements will also be implemented as a core component of initial support coordination onboarding in conjunction with the recorded modules.

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

National experts, federal regulation agencies, and LDH/OCDD leadership have long-recognized that person-centered practices represent a best-practice approach to supporting individuals with intellectual or developmental disabilities (IDD). Implementation to scale of person-centered practices take years and multiple efforts. Multiple large state-operated facilities existed between 1960 and the early 1990s due to the large imbalance in Louisiana's support system; consequently, OCDD's initial efforts were linked to reforms associated with the impact of the Olmstead decisions and the Americans with Disabilities Act (ADA). The effort was initially focused on its Supports and Services Center (SSCs), with primary goals of supporting individuals to be more involved in the local community, and to move from larger congregate living situations to smaller, more community-based living. The Office achieved success in these efforts beginning with the initial accreditation of Greater New Orleans (GNO) SSC (formerly Metropolitan Developmental Center) by the Council on Quality and Leadership and continued its success with the Department of Justice (DOJ)-informed improvements at two of its SSCs (NLSSC achieved an increase from 0% to 42% of individuals moving to work or educational activities daily within the local community between 2003 and 2007; achieved 98% of individuals participating in preferred community recreational activities at least monthly by 2007; and transitioned individuals to smaller living arrangements—ultimately downsizing to closure via privatization in 2012).

Between 2003 and 2012, OCDD successfully downsized and closed nine larger congregate SSCs, and achieved a significant rebalancing of supports with more individuals receiving supports via Home and Community Based Services over this time period. Due to the increased demand for services in community-settings, and the growing

costs within the comprehensive waiver, mid-way through the transitional efforts OCDD also turned its attention to resource allocation—another nationally-growing effort. Between 2005 and 2008 OCDD convened a large stakeholder group and worked with national consultants to develop an approach to balancing the need to allocate resources effectively with the need to attain important positive outcomes for individuals. OCDD was recognized nationally for its development of the *Guidelines for Support Planning*, which combined a person-centered approach to planning and the delivery of supports with the important consideration of a more equitable distribution of resources to support the most people with available dollars. By implementing an intensive training and monitoring approach to planning, OCDD successfully implemented resource allocation within its New Opportunities Waiver (NOW) and decreased the annual average waiver cost per participant while serving more people (Section A refers to some of this data) — with no increases in critical incidents and no individuals losing their ability to live in an HCBS setting due to this implementation. Additionally, plan goals shifted to:

- Support for independence (32% of plans to 71%);
- Support for desired community involvement (44% of plans to 84%);
- Planned supports to maintain social connections (22% of plans to 54%);
- Involvement of natural supports (56% of plans to 80%) and
- Use of typical community or technology supports (9% of plans to 52%).

These efforts were recognized at the 2015 National Association of States United for Aging and Disabilities (NASUAD) HCBS conference. The growing waiting list for the New Opportunities Waiver (NOW) shifted OCDD's focus to effectively reforming the waiver screening and implementation process following the 2012-2014 system transformation input. An evaluation of the Request for Services Registry (RFSR) occurred, and stakeholders engaged in planning changes to the waiver screening and access process. These changes were implemented beginning in 2017, and OCDD successfully moved to a prioritized process where individuals no longer wait for currently needed services. OCDD presented this success at the 2019 ARC National Convention. The significant turnover in support coordination agencies, new requirements to allow additional support coordination agencies to enroll to provide OCDD case management services, and the growing numbers of individuals being supported across multiple OCDD waivers, drew a new focus to the need for additional person-centered practice reforms.

The National Association of State Directors of Developmental Disabilities Services (NASDDDS) data suggests that all states continue to struggle with bringing person-centered practices to scale system-wide. Person-centered practices have been shown to improve the planning process and waiver recipient outcomes within specific providers– both as noted above in some Louisiana efforts and in recent presentations nationally from specific providers (for example, a Minnesota provider presenting at the HCBS conference related to person-centered organizational changes noted positive impacts on satisfaction of recipients with services and improved outcomes along with decreased injuries/incidents, decreases staff turnover and staffing needs, and decreased emergent situations). One challenge in taking these practices to scale has been the lack of shared expectations, core competencies and outcome measures. The National Center for Advancing Person-Centered Practices and Systems (NCAPPS) was launched in 2019 and the collaborative recently published self-assessment and core competency areas for plan

facilitation and implementation. Additionally, the increased adoption of technology to adapt during the COVID-19 emergency as a means of engagement and education has offered OCDD a new opportunity to leverage limited existing expertise within the state to initiate this effort in a way that improves sustainability. This initiative focuses on developing competency-based core onboarding modules for support coordination, and the merging of data on plan quality and individual outcomes into existing support coordination monitoring with a co-occurring provider tool-kit and competency approach at the supervisory level within provider organizations. This effort represents the foundational stage of scaling up person-centered practices in the state of Louisiana's IDD system. Initial outcomes will focus on plan improvement and success in accessing individualized, varied supports. This success sets the stage for OCDD to move ahead in future years to the use of meaningful outcome data to guide both evaluation of service provision, and areas for improved quality aimed at supporting independence, social and community connections, employment, and varied social roles.

C. **Who benefits and how?**

Self-advocates, families, providers, and advocacy groups all acknowledge OCDD has good person-centered planning resources (e.g. guidelines for support planning). However, they have also shared that there needs to be a way to ensure person-centered practices are being implemented at the planning level, that providers are exposed to person-centeredness at the service delivery level, and that person-centered practices are reflected in key performance measures.

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

OCDD's clinical services division reviewed and updated person-centered training content and developed 10 core modules.

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

Yes. OCDD has specific goals to increase the use of community-based care (and decrease reliance on institutional care), focus on person-centered practices, and to increase the capacity of community providers to support individuals.

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

Yes. The approach OCDD is undertaking is consistent with national standards and trends using the NCAPPS resources and guidance.

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

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

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

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

The Office for Citizens with Developmental Disabilities (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 funding enabled Office accomplishments in FY 2020-2021. OCDD's progress on objectives remained steady, despite setbacks posed by the COVID-19 Public Health Emergency, and current strategies were effective. OCDD continues to build on successes in the areas of customer responsiveness, waiver reform, person-centered thinking, early intervention, supports for people with complex behavioral needs, and employment. The success of these initiatives in FY 2020-2021 has moved the Office toward goals/objectives outlined in OCDD's Strategic Plan.

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

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

results have been generated without specific department action?

- Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
- Other? Please specify.

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

Supporting Individuals with Complex Behavioral Health Needs to Live in their Community

The The Office for Citizens with Developmental Disabilities (OCDD) Resource Center has continued to shift to supporting individuals with the most complex behavioral needs, and currently acts as a service of last resort. The presentation of behavioral health needs and/or legal involvement, are the primary reason(s) for high-cost institutionalization within the OCDD system. A performance indicator (#24259) is included in OCDD's Strategic Plan and Operational Plan to monitor the success of this initiative. This year the OCDD Resource Center Behavioral Health staff supported over 250 individuals referred with complex behavioral health needs; this support resulted in 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 has implemented triage initiatives, and they have been able to provide services to a greater number of individuals and provider agencies. Resource Center professionals, in collaboration with the Local Governing Entities, have implemented crisis/diversion initiatives, and can initiate a consultation prior to escalation of a crisis to ensure one's community connection is maintained, or within a time-frame that increases the likelihood of diversion to the most integrated setting.

Enhanced Training for Community Professionals and Providers to Improve Capacity to Support Individuals with Complex Needs

The OCDD Resource Center uses the professional expertise of staff to develop and conduct training and technical assistance activities with community providers and professionals to enhance the ability of these providers and professionals to support individuals with complex medical and behavioral support needs. These activities are initiated by the office and by provider/professional request. A performance indicator (#24696) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative. While this fiscal year's efforts were challenged due to the public health emergency, the Resource Center was able to conduct 299 training activities in FY 21, with the majority of these being focused on medical/nursing related activities impacted by the public health emergency. The Resource Center was also able to continue *Operation House Call* activities virtually in the New Orleans area (to continue training of medical residents in meeting the needs of individuals with IDD), and face-to-face activities resumed in both New Orleans and Shreveport locations before year's end. Additionally, during this fiscal year OCDD's Resource Center Team developed resources for educating behavioral health professionals on the efficacy of existing behavioral health evidenced-based practices (EBPs) for individuals with IDD and co-occurring behavioral health needs.

OCDD's clinical director participated as a member of the virtual conference committee for the National Association on Dual Diagnosis (NADD)'s annual conference, which represented an international collaborative addressing the impact of the public health emergency for individuals with IDD and behavioral health needs. The clinical director and associate clinical director also presented at the conference. With regard to dental needs, OCDD continued formal outreach and coordination with Medicaid health plans and stakeholder groups and served as a member of the dental task force.

1. To what do you attribute this success?

   OCDD employs clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral and medical support needs. OCDD and the Office of Behavioral Health (OBH) have developed more formal partnership approaches to address the needs of individuals with co-occurring needs.

2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

   Progress is expected to continue. The OCDD Resource Center and Clinical Staff have adapted trainings by offering virtual alternatives to in-person training, and learning from the virtual options will be used in future planning for hybrid approaches to maximize providers/professionals the Resource Center can reach and impact. Feedback is obtained from customers at the time of each training event; this feedback and suggestions for additional training allow OCDD to be responsive to customers' training needs. OCDD and OBH will continue to use the Transformation Transfer Initiative (TTI) grant outcomes to develop joint proposals for training and certification of community professionals. Professional continuing education and discipline-specific outreach events will continue, with planning done each fiscal year.

Development of OCDD Process for Implementation of Act 421 (Children's Medicaid Option/TEFRA-Like Program)

1. **To what do you attribute this success?**
   During the 2019 Regular legislative session the Legislature passed Act 421—Children's Medicaid Option (CMO), which required the Department to implement a TEFRA-like program to allow children with exceptional needs to be eligible for Medicaid state plan services regardless of parent income. OCDD and Medicaid worked cooperatively to develop a program for medically complex children to access Medicaid-funded services regardless of their parents' income. Initially implementation was set to begin January 1, 2021, however implementation was delayed due to the COVID-19 public health emergency, and subsequent delays in Centers for Medicare and Medicaid approvals. However, progress was necessary to be prepared for CMS approval, and the anticipated implementation of the Act 421-CMO program.

   Although approval from CMS has not yet been received, OCDD has completed processes including Intergovernmental Agreements with all 10 Local Governing Entities, OCDD staff onboarding, development of an Act 421-CMO database, and development of OCDD notification letters. OCDD is ready to implement Act 421-CMO upon CMS approval.

   The development of the Act 421-CMO program is a joint effort with OCDD and Medicaid. Outstanding agency communication and cooperation contributed to the success in this program's development.

2. **Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?**

   The development of the Act 421-CMO is a one-time gain, however once CMS approves the program OCDD and Medicaid will shift to implementation, and additional progress on implementation is expected.

Working with National Subject Matter Experts and Relevant Stakeholders to Develop Consistent Service Definitions and Rates for Vocational/Day Program Services

On March 17, 2014, Centers for Medicare and Medicaid Services finalized The Home and Community Based Services Settings Rule. The final rule addresses several sections of Medicaid law which allows states to use federal Medicaid funds to pay for home and community-based services. The rule supports enhanced quality in HCBS programs, adds protections for individuals receiving services, and reflects CMS's intent to ensure that individuals have full access to the benefits of community living and are able to receive services in the most integrated setting (including employment).

In July 2019, OCDD re-joined the State Employment Leadership Network (SELN), in an effort to gain technical guidance and assistance as OCDD makes the shift to become an *Employment First* state, as well as meet compliance with the HCBS

Settings Rule. These changes will lead to the implementation of services within the HCBS waivers that will support each individual to actively participate in their community—including individual employment—and with the expectation that each individual will be making choices that will provide them with their expectations for a meaningful life.

1. **To what do you attribute this success?**

   In October, 2019, OCDD held a Service Redesign meeting to discuss the expectations from the HCBS Settings Rule, as well as the vision for Employment and Community Day services. "***The end goal for each person who receives OCDD waiver services will be individual, fully integrated, community employment in typical businesses working alongside coworkers, interacting with customers and vendors to the same extent as employees without disabilities and where advancement and wages are similar to those without disabilities."***

   A provider workgroup was formed following the meeting using volunteers from each region of the state. Over the course of the year, the workgroup discussed each of the current waiver services, and changes that would be made to those waiver services. The group also discussed new service definitions and how those would be operationalized. A rate project was also completed by a few providers who volunteered.

   OCDD has been having ongoing discussions with the SELN for each service that was developed with the workgroup, and has continued to receive at least monthly (sometimes bi-monthly) one-on-one guidance and direction from the SELN. If changes occurred, the definitions were returned to the workgroup and OCDD received provider feedback. SELN has provided guidance, including rate studies from other states, as service rates are developed within our service selection. The SELN has been available via email, has provided monthly meetings with other state members, has continued to provide resources, and has provided OCDD ongoing assistance as requested to meet our goals and deadlines.

   OCDD has completed final definitions for all of the Employment and Community Day Services. Currently, OCDD is working to finalize rates for each of the amended services, and the newly created services.

   Once these tasks are completed, OCDD will begin amending the HCBS waiver applications to include the new service definitions and rates.

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 once the final rates are determined, and OCDD presents Employment and Community Day services to the workgroup and the larger stakeholder group for feedback on the final plan of action.

   After these tasks have occurred, OCDD will align and add the new service definitions across the three OCDD adult HCBS waivers, which will allow providers to deliver services and supports that are in alignment with the OCDD vision and the HCBS Settings Rule.

Maintenance of Most Appropriate Waiver Process to Allow Those with Urgent/Emergent Unmet Needs to Receive Waiver Opportunities

In 2017 OCDD—in collaboration with community partners—began screening potential OCDD waiver recipients using the Screening for Urgency of Need (SUN) tool. The screenings were face-to-face meetings with individuals and family members who are on the Request for Services Registry (RFSR) list. The SUN was designed to identify any needs a person may have, review current supports a person has and uses now, and to determine the urgency of any unmet needs. During the COVID-19 Public Health Emergency OCDD made a shift from face-to face screenings to virtual visits to ensure the health and safety of individuals, families, and SUN staff. OCDD continued to screen individuals throughout the public health emergency to address emergent and urgent needs that would result in a waiver offer.

1. **To what do you attribute this success?**

   The number of screenings increased during the public health emergency. OCDD was able to contact and complete more screenings due to decreased travel times. OCDD was also able to reduce the costs for rental vehicles, gas, and hotel stays that were incidental to screenings. OCDD implemented the use of FaceTime, Duo, and Zoom for virtual visits.

   OCDD designed an expedited process form for the Local Governing Entity to complete at the initial onset of immediate needs expressed by the individual or family member. This process has been successful in addressing immediate needs, and tracking the request by Local Governing Entity offices.

2. **Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?**

   This progress will continue outside of the public health emergency. The screening team is expected to expand in an effort to address individuals statewide who are requesting a screening to identify their support needs.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

  1. To what do you attribute this lack of progress? For example:
     - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
     - Is the lack of progress due to budget or other constraint?
     - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
     - Other? Please specify.

2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

Development of an Integrated, Full-Scale Data-Driven Process

1. To what do you attribute this lack of progress?
   OCDD is in the process of developing a full scale data-driven quality database. OCDD must resolve many issues before the database is complete. One primary obstruction has been lack of resources for developing a full scale data-driven process. Currently OCDD has one available programmer who has the full time responsibility for modernizing all of OCDD's databases. OTS is currently working on upgrading its Information Technology Structure, and this must be completed before OCDD can move forward with the database. Over the past year OCDD has updated two of the databases that will become a part of the full scale data-driven database. The implementation of SIMS took place in 2019, and staff are continuing to update and refine the system so it is complete and responsive to the needs of the users of this system. Finalizing the electronic Individual Support Plan (eISP) will also be tied to this system.
2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

   The lack of progress on a quality integrated database is due to a lack of resources, both in terms of funding to create the singular data system and infrastructure (i.e. concerns for server space, web-based capabilities) and adequate personnel to develop and administer the system. Modernization of all IT infrastructure has had a significant impact on progress.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☒ Yes. If so, what adjustments have been made and how will they address the situation?
  ☐ No. If not, why not?

  Yes. OCDD's Strategic Plan was updated for FY 2020 through 2025. Updates included revisions to Office goals, program objectives, strategies and indicators to reflect Office direction, to build on successes, to provide strategies in areas where success has not been as substantial or where changes in program direction indicate such, and to improve performance assessment.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

  On a department-wide level, Performance-Based Budgeting activities (including, but not limited to, strategic planning, operational planning, and the Louisiana Performance

Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. Recommendations are made directly to the Assistant Secretaries or the Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

Within OCDD objectives are assigned to specific staff members who are responsible for management and oversight of the accomplishment of each objective and related performance indicators. A variety of management tools (i.e., databases, project charters, etc.) and task/initiative specific workgroups/committees are used to track, review, and provide feedback for use in decision making and resource allocation. Progress, or lack of progress, (along with support/resources needed to achieve assigned objective) is reported to OCDD Executive Management. Performance data is also reported in Louisiana Performance Accountability System (LaPAS), and is available for both management and stakeholder review.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description

1. What is the nature of the problem or issue?
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
3. What organizational unit in the department is experiencing the problem or issue?
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
5. How long has the problem or issue existed?
6. What are the causes of the problem or issue? How do you know?

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

☐ No. If not, skip questions 2-5 below.

☐ Yes. If so, complete questions 2-5 below. Do not delete any questions.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

4. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
      - How much progress has been made and how much additional progress is needed?
   b. If not:
      - Why has no action been taken regarding this recommendation?
      - What are the obstacles preventing or delaying corrective actions?
      - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☐ No. If not, please explain.

☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:

   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of financing for any additional funds.
      - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

Problem/Issue #1: Information Technology (IT) Upgrades/Modernization Project

A. Problem/Issue Description

1. What is the nature of the problem or issue?

OCDD's Information Technology (IT) software and equipment are out-of-date and in need of system upgrade and modernization. Many applications/databases need redesign and/or major revision; equipment needs to be updated. Modernization is needed to allow for automation of processes requiring access by multiple internal and external users. The Office's system transformation efforts are being hindered by the lack of up-to-date IT equipment and programming.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)

Yes, in some way all of the six goals are negatively impacted by OCDD's outdated IT system due to a need for resources to make improvements. Goal V (To implement an integrated, full-scale data-driven quality enhancement system) is especially hampered by this problem.

3. What organizational unit in the department is experiencing the problem or issue?

While to varying degrees, this problem affects all units within the Office. IT upgrades and modernization would improve the efficiency of all work units within the Office.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)

The people supported by the Office and their families, providers, support coordination agencies, and other stakeholders are indirectly affected. The Office is unable to fully implement an updated person-centered planning process without the ability to allow for multiple users and storage for automated assessments and plans of support.

5. How long has the problem or issue existed?

The problem has existed for a number of years but has exacerbated in the past year due to the need for higher system requirements to accomplish major initiatives.

6. What are the causes of the problem or issue? How do you know?

The OCDD Information Technology (IT) Upgrades/Modernization projection has been significantly hampered by the lack of funding.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

Development and implementation of person-centered software such as OCDD's electronic Individual Support Plan (eISP) and the Office's Quality Enhancement system remain priorities and are critical to the OCDD's next steps in system transformation. These efforts will be delayed and will significantly affect progress

in meeting established OCDD goals and objectives if additional funding is not secured.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

☐ No. If not, skip questions 2-5 below.

☒ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

Funding is needed to implement, test, correct, and maintain the data infrastructure necessary to implement the eISP, build a proposed electronic developmental disability health record, and re-design the current quality enhancement integrated database. The ability to fill the vacant full-time programmer and funding to replace older equipment is needed to address efficiencies. Funding to address larger systemic issues is needed to fully implement major initiatives related to the planning process for individuals with developmental disabilities being served in Home and Community-Based Services waivers.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

Yes.

4. Are corrective actions underway?

Funding was requested in the FY 2020-2021 budget.

5. Do corrective actions carry a cost?

☐ No. If not, please explain.

☒ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)
Yes, salary for another full-time programmer, and funding for equipment upgrades and system modernization are required. This cannot be managed with current TO and budget.

Problem/Issue #2: 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 persons with autism, and (2) services and supports, including skilled nursing service and community nursing service, to individuals who are medically fragile

A. Problem/Issue Description

1. What is the nature of the problem or issue?

There continues to be a lack of adequately trained professionals and direct

support staff to deliver needed behavioral and medical/nursing services to individuals with complex needs in community settings, including a lack of qualified professionals to deliver applied behavior analytic therapies to persons with autism. There is a shortage of trained staff to provide services and supports for individuals with significant medical needs, including a shortage in skilled nursing services, and a shortage of trained nurses who work either full-time, part-time, and contract for the agency/provider for individuals who are medically fragile and reside in community settings.

Adequate behavioral supports can be very effective in improving quality of life, and reducing behavioral symptoms/challenges for individuals with intellectual/ developmental disabilities. Applied behavior analysis can be very effective and can significantly alter the course of autism for many individuals. Complex medical support needs, particularly those requiring nursing supports throughout significant periods of the day, can be managed in community settings; however, it is very difficult to locate and secure trained staff to meet these needs. Continued challenges in this area contribute to institutional admissions, hospital admissions, emergency room use, increased illnesses, increased medication usage and costs, and other negative health outcomes.

There have been specific departmental and OCDD initiatives introduced during this fiscal year to continue addressing this barrier—and improvements have occurred in some areas—however the general problem still exists. A multi-faceted and multi-year approach is likely required to resolve the problem.

2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)**

   Yes. Lack of professional supports in community settings has continued to be the primary contributor to admissions to the supports and service center and other more restrictive settings. Requests for admissions happen when community providers are unable to meet behavioral and psychiatric needs of people whom they are serving in community settings and (in smaller numbers) those with complex medical needs. The lack of trained autism professionals negatively impacts the ability to develop new autism services, which could prevent more severe negative developmental outcomes. The inability to adequately teach functional behavioral skills detracts from community participation objectives (i.e., that individuals with disabilities are participating fully in communities). The continued movement from Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) settings to community-based living arrangements is also hampered due to the challenges in securing needed behavioral and medical/ nursing supports for individuals with complex needs.

3. **What organizational unit in the department is experiencing the problem or issue?**

   OCDD and the Local Governing Entities have been impacted by the lack

of professional support in the community for many years. The Office of Behavioral Health (OBH) and Medicaid are also experiencing some impact due to this problem.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**

   Individuals supported and their families, support coordinators, and private providers who serve persons with intellectual/developmental disabilities in community homes, family homes, and supported independent living settings are all impacted by this problem. Hospitals are impacted when individuals with co-occurring needs present at the emergency room due to difficulty accessing other needed services. Behavioral health professionals and agencies are impacted because they are now receiving referrals for individuals with co-occurring needs for whom they may not feel adequately trained to deliver treatment. Managed care organizations are also impacted due to expectations related to developing a network of providers for the provision of needed health and behavioral health services in an environment where access to needed specialized training is a challenge.

5. **How long has the problem or issue existed?**

   The problem has been longstanding over many years.

6. **What are the causes of the problem or issue? How do you know?**

   Many factors contribute to the problem beginning with a historic lack of training of persons equipped to deliver these services. Many professional training programs offer no training in intellectual/developmental disabilities. National reports continue to indicate that there is a general shortage of behavioral health professionals in many areas of the country with access for those with co-occurring developmental disabilities and behavioral health needs even more challenging. The cost of providing nursing services in individual settings—and challenges in terms of isolation in these arrangements—negatively impact the access to needed medical/nursing supports. Both the increasing number of persons with intellectual/ developmental disabilities now being served in the community, and the downsizing of institutional services (generally considered to be positive and progressive developments in developmental disabilities services) have contributed to an increased need for medical/nursing and behavioral/psychiatric supports in the community. In addition, private Supported Independent Living (SIL) providers serving persons in waiver settings and private community home providers generally do not conduct, and are not required to conduct, training with direct support staff on positive behavior supports and medical/nursing needs.

   Factors specific to calendar year 2021 include the COVID-19 global pandemic, two major hurricanes disrupting services in the State, and historically significant ice damage and flooding in large sections of the State. These public health disasters affected the provision of community-

based services and resulted in the temporary relocation of many people with developmental disabilities. Additionally, issues related to availability of direct service workers (DSWs) is likely to continue or worsen due to changes in the general economy subsequent to COVID-19. Many entry-level jobs are reimbursing new hires at rates significantly higher than DSWs. Therefore, we may have a shrinking workforce of qualified DSWs to support people in the community, resulting in increased utilization of more restrictive, high-cost alternative.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?

Consequences include:

- a significant number of people with intellectual/developmental disabilities having unmet needs,
- a continued need for costly institutional admissions to the higher treatment cost supports and service center,
- continued high utilization of high-cost acute services, and
- an inadequate number of practitioners to positively impact the developmental trajectories of children with autism, other behavioral challenges and/or complex medical needs leading to increasing service costs over the course of their lifespan.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

☐ No. If not, skip questions 2-5 below.

☒ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

The following are recommended actions to alleviate the problem:

- Evaluate benefits of the inclusion of behavioral and medical therapeutic respite options via the OCDD consolidated waiver, and research development of specialized shared living waiver models for individuals with complex medical and behavioral needs.
- Continue implementation of opportunities for partnering with university programs that provide training, as well as individual clinicians, resulting in additional needed professionals and growing the service provider pool.
- Continue OCDD developed and sponsored professional continuing education opportunities.
- Develop statewide guidelines for meeting complex health, behavioral health and allied health needs for individuals with intellectual/developmental

disabilities.

- Continue to evaluate other state's practices in areas like the START model, which may offer opportunities for new and expanded services.
- Continue and enhance nursing and dental outreach efforts to improve outcomes for individuals with complex medical/dental needs.
- Continue collaboration with OBH on development of crisis framework and services and other opportunities for partnership with shared stakeholders.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

   Yes. A recommendation has been included in this annual report since FY 2007-2008. Some recommendations have been implemented, and new recommendations are included. Many of these recommendations require sustained implementation over a period of time to effect needed systems issues and improve outcomes.

4. Are corrective actions underway?

   Yes. The following actions are underway:

   - OCDD continues implementation of the complex care supplemental option within the waiver services and implementation of an Emotional Wellness Guide in its HCBS program.
   - OCDD has developed core training related to trauma-informed and wellness supports for support coordinators and providers and will be implementing trauma and wellness focused efforts this fiscal year.
   - OCDD continues its statewide offering of Medical/Nursing DSW training via Money Follows the Person (MFP) Rebalancing Demonstration.
   - OCDD continues to offer Board Certified Behavior Analysts (BCBA) continuing education opportunities, as well as other behavioral and psychological continuing education options.
   - OCDD continues professional continuing education opportunities across disciplinary areas.
   - OCDD continues to provide consultation and technical assistance via the OCDD Resource Center.
   - OCDD has implemented routine outreach to full-time, part-time, and contract nurses for HCBS providers via the OCDD Resource Center.
   - OCDD continues to work with Medicaid to support Applied Behavior Analysis (ABA) services via the State Plan and has increased routine coordination with Office of Behavioral Health (OBH) related to mental health needs for individuals with intellectual/developmental disabilities.
   - OCDD has proposed implementation of a pilot with the Center for START services beginning this fiscal year using some of the additional Federal Medical Assistance Percentages (FMAP) funds.
   - OCDD is in discussion with stakeholders and the Louisiana State University (LSU) Dental School to design a dental component of Operation House Call.
   - OCDD is collaborating with OBH on development of a liaison program with Managed Care Organizations (MCOs) and key hospitals to address

the co-occurring IDD and behavioral health needs of recipients who access services across systems.

5. Do corrective actions carry a cost?

☒ No. If not, please explain.

Most of these actions do not carry a cost. The training and capacity building efforts approved in the Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana) Operational Protocol are funded with federal demonstration dollars through fiscal year 2023. While other corrective actions could carry a cost insofar as additional clinicians and/or technical assistance staff are recruited into state service systems, they do not carry a cost as most new positions in OCDD are existing positions diverted from institutional services. They do not incur a cost when the focus is on community, non-public capacity building. Costs are associated with new services such as ABA, START and enhanced waiver services. However, those costs are likely offset by costs associated with failure to implement corrective actions such as: 1) failure to intervene at the community level can result in extensive additional institutional treatment costs, and 2) failure to intervene with persons with autism at an early age does result in extensive lifelong service costs that are estimated at over one million dollars per person and incurred by families and the taxpayer.

☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:

a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
b. How much has been expended so far?
c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
d. Will additional personnel or funds be required to implement the recommended actions? If so:
    - Provide specific figures, including proposed means of financing for any additional funds.
    - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

Problem/Issue #3: Ongoing cost associated with facilities that have been closed, vacated or privatized

A. Problem/Issue Description

1. **What is the nature of the problem or issue?**

Over the last fifteen years, eight former state-operated, supports and services centers for people with developmental disabilities have either privatized their operations or closed in ongoing efforts to serve people in the least restrictive

settings in their communities. OCDD continues to bear responsibility for the ongoing costs associated with four of these eight facilities. These costs generally include:

- Acquisitions and major repairs, the payment of risk management premiums, building and grounds maintenance, utilities, and/or loss prevention/ security,
- Ongoing, or legacy costs, including the employer share of group insurance benefits for retirees, and
- The supports and services offered through statewide Resource Center operations that formerly ran from each facility.

Some of these services have been refined to include the ICF/IID Programmatic Unit and Monitoring and Analytical Support activities. OCDD continues to be responsible for the maintenance of the grounds of North Lake Supports and Services Center facility, Leesville Residential and Employment Services, and the grounds of the state owned property located in Belle Chasse. None of these expenditures are part of the cost reporting used to determine the per diem for the facilities. As these facilities either privatized or closed over the years, the expenditures were collapsed under the appropriation to the Pinecrest Supports and Services Center. The activities are funded from a combination of both a significantly reduced State General Fund appropriation and pooled Interagency Transfer (IAT) Revenues derived from any over-collections that may be available from the Pinecrest Supports and Services Center operations. Pinecrest has continued to absorb the expenditures that were once spread across nine facilities and their respective revenue streams. As facility operating expenditures increase, the ability of Pinecrest to support these statewide non-facility activities is diminished or eliminated moving forward. During FY 2020, the Central Louisiana Supports and Services Center was transferred to OCDD at mid-year resulting from Act 411 of the 2019 Regular Session.

2. **Is the problem or issue affecting the progress of your strategic plan?**

   Yes. Although indirectly, this issue affects agency progress in implementing its Strategic Plan. Fiscal and human resources are necessary to manage vacated properties and to support critical, non-facility activities. These resources could be better utilized to further progress toward one or more of its Strategic Plan goals. The non-facility activities have no dedicated funding stream and require the use of funds designed for use by Pinecrest. Any available pooled revenues from Pinecrest are subject to reduction based on the operational needs of the facility. As these operational expenditures have increased at Pinecrest over the last several years, the amount of available pooled revenues to subsidize the non-facility activities has decreased significantly.

3. **What organizational unit in the office is experiencing the problem or issue?**

   OCDD is managing the problem by continuing to allocate any available resources to the costs necessary to maintain the properties and fulfill both Office of Risk Management (ORM) and other state requirements.

4. **Who else is affected by the problem?**

The Pinecrest facility budget is impacted. The mandated expenditures made through this appropriation from Pinecrest pooled revenues impact the cash flow at the facility. There are also additional indirect impacts of these required expenditures on participants/families in that resources are diverted away from service delivery.

5. **How long has the problem or issue existed?**

   This issue was identified in 2010.

6. **What are the causes of the problem or issue? How do you know?**

   The problem is caused by the mandatory expenditures associated with duties and costs for state-owned property insured by Office of Risk Management (ORM), mandated group insurance costs for retirees from now closed institutions, and statewide Resource Center operations. These costs, once funded from eight state-run facilities which are no longer in operation, are now subsidized solely by the operation of the Pinecrest revenue stream. Though vacated or operating with significantly reduced occupancy, the properties require appropriate effort to keep the physical plant in good condition and to prevent theft or destruction of property. The retirement benefit absorbed in the Pinecrest revenue stream includes medical coverage for employees who retired under one of the qualifying retirement systems. The benefit paid by the state for participating retirees depends upon a number of factors based on their participation in the Group Benefits program.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**

   The consequence of this issue is the continued expenditure of funds to maintain properties that are no longer used by OCDD. These expenditures may cause cash flow shortfalls in future fiscal years.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your office?

   ☐ No. If not, skip questions 2-5 below.

   ☒ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   LDH should pursue an alternative use for the facilities, including, but not limited to, the following: 1) the transfer of state-owned property to other state, parish, or local governing departments/offices for an alternative public good; and/or 2) the utilization of state-owned property as revenue generating property. If not, the state may propose to sell the properties. Note that sections of all facilities contain asbestos that will require abatement. All such actions above may require an amendment to rule or law.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

   Yes. Similar recommendations have been made in this annual report since the FY 2009-2010 submittal.

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?

Yes, corrective actions are underway.

- Closed Facilities. With respect to ongoing facility maintenance and upkeep at closed facilities, in accordance with the ORM guidelines, OCDD is working to identify potential alternate uses for all properties not occupied or those planning to be vacated due to ongoing downsizing efforts.
  - During the fiscal year, action was taken on three closed facilities:
    - Leesville: OCDD continues expending toward the upkeep of this facility during the fiscal year upon expiration of a cooperative endeavor agreement with the Town of Leesville. Act 342 of the 2019 Regular Session of the Legislature authorized the transfer of certain parcels of land that include the former Leesville Residential and Employment Services facility to the Museum of America's Training Ground. However, the transfer and sale of the Leesville property did not occur. The property has storm and freeze damage. Claims for the repair of this damage were filed with the ORM, and repairs are underway.
    - Southwest: The responsibility for the property has been transferred from OCDD-Pinecrest Supports and services Center to OBH-Eastern LA Mental Health System (ELMHS). The property continues to be maintained by ELMHS for evacuation destination for its patients should the need occur.
    - Belle Chasse: OCDD is responsible for the upkeep of property located at 251 F. Edward Hebert Blvd., Belle Chasse, Louisiana. The property and buildings had been part of the Metropolitan Developmental Center. The facility was previously sold to

Plaquemines Parish by the Office of State Lands, however the 22-acre property was not included in the sale; OCDD remains responsible for the upkeep. The property and buildings were damaged during hurricane Zeta, and a claim was made with ORM. Repairs are currently under way.

- Updates on previously reported efforts to find a proposed best use for former facilities:
  - Acadiana: Act 142 of the 2017 Regular Session of the Legislature authorized LDH to transfer land and improvements occupied by the former Acadiana Employment Services Center in Opelousas to the St. Landry Parish School Board. To date, this property remains under OCDD as no sale has taken place.
  - Northwest: Act 350 of the 2017 Regular Session of the Legislature authorized the transfer of certain parcels of the former Northwest Supports and Services Center in Bossier Parish. The annual Risk Management premium allocations have been actuarially reduced through the normal underwriting cycle for these facilities. To date, this property remains under OCDD as no sale has taken place, however the sale of the property is imminent. The facility has storm and freeze damage, and a claim was filed with ORM. Repairs are nearly complete.

- Legacy Costs. Regarding ongoing legacy costs associated with mandated group insurance premiums for employees who retired from now closed institutions, Act 1 of 2020 1st Extraordinary Session appropriated a reduced amount of State General Fund in FY 2021 placing a greater burden the revenue stream at the state operated facilities. The appropriated amount represented the gap between the estimated ability of state facilities to meet these obligations from its own revenue stream and the mandated expenditure obligation.

5. Do corrective actions carry a cost?

☒ No. If not, please explain.
☐ 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?

No. There are no anticipated direct costs related to researching and developing amendments to existing legislation, as these actions would be completed by existing staff. Failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings/facilities. Additional resources are necessary to the extent that the revenue stream at Pinecrest is unable to fund.

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste and abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

Internal Audit also provides management with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The LDH has a designated Audit Coordinator for financial audits. The Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

☐ Policy, research, planning, and/or quality assurance functions in-house

☐ Policy, research, planning, and/or quality assurance functions by contract

☐ Program evaluation by in-house staff

☐ Program evaluation by contract

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

☒ **In-house performance accountability system or process**
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

☒ **Benchmarking for Best Management Practices**
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

☒ **Performance-based contracting (including contract monitoring)**
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

☐ Peer review

☐ Accreditation review

☐ Customer/stakeholder feedback

☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☒ Yes. Proceed to Section C below.

☐ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

1. **Title of Report or Program Evaluation: <u>National Core Indicators Project</u>**

   The National Core Indicators (NCI) Project is co-sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). Forty-eight states and the District of Columbia contribute survey data on individualized cycles for each NCI annual survey period.

2. **Date completed:**

   NCI made the final reports for the survey cycle that ended June 30, 2020 available to the State by HSRI and the NASDDDS in January 2021.

   The 2020/2021 survey cycle began in December 2020, with pre-survey activities that included:
   - Pulling the survey respondent sample,
   - Cleaning the data to obtain usable contact information,
   - Obtaining a bid from Office of State Printing for mass printing and mailing of the survey invitations,
   - Preparing the State Work Plan for NCI,
   - Customizing the survey tool for Louisiana and preparing LDH reviews, and
   - Approvals for printing.

   Letters were mailed to respondents on June 17, 2021. OCDD asked respondents

to enter survey data directly into the NCI on-line database until June 30, 2021.

NCI extended the due date for final response entries for the Child Family and the Adult Family Surveys from June 30, 2021 to July 6, 2021. NCI also extended the final response entries for the Staff Stability Survey from June 30, 2021 to July 31, 2021.

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**

The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and their families. Indicators address key areas of concern including employment, rights, support planning, community inclusion, choice, and health and safety. Surveys were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. Survey questions concerned satisfaction, quality of care and quality of life. Analyses compared Louisiana statewide results with results of other states participating in the National Core Indicators Project. During the 2020/2021 cycle, OCDD chose to conduct the Child Family survey and the Adult Family survey. The Family Guardian survey and the In-Person Interview survey were not conducted for this cycle.

OCDD participated in the 2020/2021 NCI Staff Stability Survey (NCI-SSS) for the third consecutive year. NCI instituted this survey to address the concerns surfaced in HSRI and NASDDDS about the instability of the direct care service work force. Concerns that are being explored include wages, benefits, career opportunities, work environment, and educational opportunities for the work force of caregivers. The NCI-SSS is an on-line survey through an NCI database accessed by licensed service provider administrators of agencies supporting adults with DD/IID in residential, employment, day services and other in-home or community inclusion programs. The survey captures information about wages, benefits, and turnover of the direct support staff hired by the agencies. Respondents participate on a voluntary basis, but are strongly encouraged by OCDD leadership to complete the survey in order to obtain the most comprehensive data about the conditions that exist in Louisiana. OCDD only has access to the aggregate data collected and reported by NCI.

4. **Methodology used for analysis or evaluation:**

The Child Family Survey was the primary tool used to evaluate service participant satisfaction for the 2019/2020 cycle (prior year). The analysis of this survey reports both the number and percentage of responses to each question. The NCI averages contained in the national report are weighted means; their calculations reflect the relative population sizes of all participating states, as well as the sample size. The weights used in the calculations of this report were developed by NCI using each participating state's number of survey respondents, and its total survey-eligible population. NCI tests for statistical significance as well as effect sizes. Effect sizes are used in addition to statistical significance because statistical significance of a state's result depends, in part, on the size of the state's sample. NCI compiles comparisons in an NCI national report that includes all of the participating states who submit a minimum of 400

surveys. NCI produces state reports for each participating state; if a state is not eligible to be included in the national report, that state will still have a state report available.

In FY 2020/2021, OCDD mailed a letter to all of the families of individuals with developmental disabilities who were participating in Medicaid wavier developmental disability programs, as well as families who were participating in the EarlySteps program on July 1, 2020. The survey respondent must reside in the same household as the participant, and there must be in-home direct service work being provided by Medicaid or Early steps. NCI offers a web-based survey response site that provides families who were participating in one of the family surveys the opportunity to respond via direct entry into the NCI database. OCDD provides a unique survey code on each survey for respondents to use to access the database to assure anonymity. OCDD has experienced a diminishing rate of return of surveys, which has resulted in this Office pulling larger samples and mailing more survey invitations in order to achieve the target of a minimum of 400 completed Family Surveys per targeted population. OCDD did not conduct the In-Person Survey that directly interviews adults with a developmental disability participating in services through OCDD-managed programs. This decision was the result of OCDD's need to re-establish procedures after significant changes in Resource Center management, as well as the need to more thoroughly analyze the data and develop improvement strategies before the beginning of another survey cycle.

Final reports from NCI on the aggregated 2019/2020(previous year) data were available in January 2021.

Reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services and delivered to OCDD in 2020:

- *National Core Indicators Child Family Survey 2020 Final Report:* This report provides an aggregated summary of the results of the survey which was mailed to families of children living and receiving developmental disability services in the family home and provides comparisons between Louisiana and the national average of other participating states.

OCDD concluded the Child Family survey on July 7, 2021 with a return rate of approximately 3%. The Adult Family survey was concluded on July 7, 2021 with a return rate of 10%.

OCDD used the NCI web-based survey response format exclusively for the 2020/2021 surveys for the first time; hard copy surveys were not sent to the sample survey recipients. This decision was made as a result of LDH and OCDD initiatives related to COVID-19 response, such as essential personnel who assist with the NCI surveys being detailed to state COVID-19 special projects during a period that was critical to finalizing the mail sample. The efficiency of sending only an invitation letter to families to participate in the NCI survey not only saved valuable time and expense, but offered families a

more contemporary way to complete the survey. The Quality section used this experience as a pilot for future NCI survey invitations which will continue to rely more extensively on electronic responses to family surveys, but with additional back-up strategies such as a family's ability to contact OCDD to request a paper copy of the survey if they cannot complete the survey electronically.

5. Cost (allocation of in-house resources or purchase price):

   The Child Family mail-out letters were printed by State Printing for $934.11 and the Adult Family mail-out was $937.24.

6. **Major Findings and Conclusions:**

   Family survey findings for the 2019/2020 cycle were extensive. OCDD is working on a final analysis of the reports produced by NCI. A Preliminary review suggests feedback from family members of service participants remains consistent with previous years. OCDD Performance Review Committee will continue to analyze the data to establish potential focus points for Office initiatives.

7. **Major Recommendations:**

   OCDD should tie participant feedback to Office initiatives designed to strengthen the system to demonstrate to participants/families that feedback is used constructively, and does impact state and federal decisions regarding the direction of services. OCDD should consider contracting out the mail return processing of surveys, and the In-Person Survey activities, to an entity that would remove any conflict of interest concerns that occur with OCDD surveying its own services.

8. **Action taken in response to the report or evaluation:**

   Information from the surveys was cross-walked to Centers for Medicare & Medicaid Services (CMS) measures for the Home and Community-Based Services (HCBS) Settings Rule, which addresses community participation and employment goals for persons with developmental disabilities who are receiving HCBS.

   OCDD's quality improvement process includes a review of NCI data—as well as data from other sources—such as data on regional performance indicators as part of the Human Services Accountability Plan, and data from EarlySteps and HCBS waiver performance indicators. The data is reviewed by an OCDD workgroup consisting of programmatic and quality staff. When trends and patterns are noted, quality improvement projects are developed and implemented upon approval of the OCDD Executive Management Team.

9. **Availability (hard copy, electronic file, website):**

   Available in electronic file on the National Core Indicators website:

   www.nationalcoreindicators.org

10. Contact person for more information:

Name: Dolores Sarna
Title: Program Manager 2
Agency & Program: Office for Citizens with Developmental Disabilities, Quality Management Section
Telephone: 225-342-5714
E-mail: Dolores.sarna@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department: **Louisiana Department of Health (LDH)**
09-375 Imperial Calcasieu Human Services Authority

Department Head: **Dr. Courtney N. Phillips**
LDH Secretary

Undersecretary: **Ruth Johnson**

Executive Director: **Tanya McGee**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?
For each accomplishment, please discuss and explain each item below.

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Hurricane and Other Weather Disaster Response

A. **What was achieved?**
Southwest Louisiana endured an unprecedented number of federally declared weather disasters resulting in widespread, catastrophic devastation to property and infrastructure, which included back-to-back major hurricanes, a record-setting freeze, and back-to-back flood events. Imperial Calcasieu Human Services Authority's (ImCal) swift and effective emergency response to Hurricane Laura, the first and most devastating of the disasters, allowed us to maintain clinical and administrative operations with only minimal interruption. Email communication and vital IT services were restored within days of landfall, allowing ImCal to immediately begin inspecting, repairing, and safely reopening clinical offices. During the time that many roads were

impassable and persons served were evacuated, ImCal provided counseling and medication management services via telehealth to assure community behavioral health needs were met. The DD Division worked to re-establish evacuees back into their homes and community. ImCal maintained its operations in a similar fashion through Hurricane Delta six weeks later, as well as during the freeze when many community members were enduring water and electrical outages. In spring, two back-to-back flood events occurred, which impacted our newly relocated Developmental Disabilities office. With no disruption to DD services, staff members were relocated to other office areas around the district and transitioned to working-from-home.

B. **Why is this success significant?**
In the wake of the COVID pandemic, where Lake Charles and surrounding areas were a national hot spot during multiple surges, the need for behavioral health services has never been more evident. SWLA has experienced continually increasing overdose deaths and suicide rates since the beginning of the pandemic. Loss of behavioral health services during the time following the hurricane would have been detrimental to the wellbeing of an already traumatized community.

C. **Who benefits and how?**
Consumers of behavioral health and developmental disability services within ImCal HSA benefit from readily available services. In addition, ImCal provided support to community partners and other service providers, which benefits the community at large.

D. **How was the accomplishment achieved?**
This accomplishment was achieved through effective disaster planning and preparedness, and immediate response as soon as possible following the disasters.

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: Pandemic Response

A. **What was achieved?**
Upon the onset of the COVID pandemic, Imperial Calcasieu Human Services Authority (ImCal) quickly implemented procedures to reduce spread and protect staff members and persons served, in accordance with recommendations of federal, state, and local public health officials. Within its clinics and offices, ImCal implemented mitigation measures such as screening for exposure and symptomology, enhanced cleaning, social distancing, and masking. ImCal promptly purchased IT equipment and the software systems needed to allow employees to work from home and transitioned in person

meetings, and events to Zoom. Essential clinical and Developmental Disabilities (DD) services were also transitioned to Zoom to protect persons served. ImCal encouraged and enforced the use of Families First Coronavirus Response Act (FFRCA) Leave for employees to stay home when sick or after exposure to COVID in order to reduce spread. The Disabilities Division partnered with the LDH Office for Citizens with Developmental Disabilities (OCDD) and the Region V Office of Public Health to conduct COVID-19 testing in intermediate care facilities. When the vaccine became available, ImCal collaborated with the Region V OPH in distribution to behavioral health providers in the private sector. ImCal HSA offers vaccine administration to its staff, persons served, other behavioral health and developmental disabilities providers, as well as to the community at large through the Genoa Pharmacy located within ImCal HSA Lake Charles.

B. **Why is this success significant?**
ImCal's adaptability and prompt response ensured that essential BH and DD services are available to the community.

C. **Who benefits and how?**
All ImCal persons served and staff members benefit from an appropriate COVID response with regard to education, mitigation measures, and vaccination.

D. **How was the accomplishment achieved?**
ImCal adhered to the mitigation standards outlined by the Governor's Office, Office of State Fire Marshal, and Office of Public Health to prevent the spread of COVID-19.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes.

<u>Accomplishment #3: Opioid Epidemic Response</u>

A. **What was achieved?**
Imperial Calcasieu Human Services Authority (ImCal) is involved in multiple initiatives to respond to the opioid epidemic. ImCal purchased and distributed nearly 1000 naloxone nasal spray (Narcan) kits to local providers, law enforcement, college campus personnel, individuals in treatment for opioid use disorders and active opioid users. In addition, we partnered with the Southwest Louisiana Area Health Education Center (SWLAHEC) to provide Narcan kits, as part of their ongoing HIV/IVDU outreach efforts which have targeted our growing homeless population. ImCal has also partnered with Odyssey House of Louisiana to provide substance use navigators/peer support case

managers to local area hospital emergency departments to assist patients in need of substance use supports and services. Treatment access was also enhanced through the continuation of a contract with a local Suboxone provider. Suboxone contains a combination of buprenorphine and naloxone; it is used to treat narcotic (opiate) addiction. Under this contract, ImCal was able to continue to fund MAT clinical services for individuals with opioid use disorder (OUD). In addition, ImCal HSA funded the training of two of their own psychiatric prescribing practitioners in order to provide MAT services in-house. ImCal is also registered as an Office Based Opioid Treatment (OBOT) provider with LSU under the SOR grant. This has increased the availability of MAT services in the SWLA community.

B. **Why is this success significant?**
As a result of the COVID-19 pandemic, stay at home orders and job losses, as well as several natural disasters, we have seen a 140% increase in opioid overdose deaths in SWLA.

C. **Who benefits and how?**
Individuals and families struggling with opioid use disorders, as well as our community partners, have benefited from our work to combat the opioid epidemic.

D. **How was the accomplishment achieved?**
ImCal HSA worked collaboratively with the SWLAHEC, the Office of Public Health, Calcasieu Parish Coroner's Office, and Acadian Ambulance to address the growing number of opioid related deaths in SWLA.

E. **Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)**
Yes.

F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?**
Yes.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

Imperial Calcasieu Human Services Authority's (ImCal) is on time and on target to meet the

goals and objectives set within our 5 year strategic plan. The mission of ImCal HSA is that citizens with mental health, addictions, and developmental challenges residing in the parishes of Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis are empowered, and self-determination is valued such that individuals live a satisfying, hopeful, and contributing life. This mission is accomplished through ImCal's Administrative, Behavioral Health and Developmental Disability Activities. ImCal HSA makes use of best practices in implementing, evaluating, monitoring, modifying existing services so that quality is assured; services meet the needs of those served; and the variety of services available adequately address the range of behavioral health issues identified and are further developed to address service gaps.

ImCal Agency Goals:

I. To increase public awareness and to provide access to care for individuals and their families who are in need of behavioral health and developmental disabilities services.

II. To ensure that services provided are responsive to client needs, based on evidence-based best practices, and that programs afford the client a continuum of care taking into consideration cultural diversity and abide by all State and Federal guidelines.

III. To promote healthy, safe lives for people by providing leadership in educating the community on the importance of prevention, early detection and intervention, and by facilitating coalition building to address localized community problems.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

    1. To what do you attribute this success? For example:
        - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
        - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
        - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
        - Other? Please specify.
    2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

ImCal HSA continues to make steady progress in all three Program Activity areas. Outside of the three accomplishments described in Section I. above, while ImCal has not significantly exceeded any stated objectives and strategies, we have made steady and efficient progress in

all objectives and strategies as indicated in our 5 year plan which gets more and more difficult to accomplish with continuous budget cuts every fiscal year.

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

    1. To what do you attribute this lack of progress? For example:
        - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
        - Is the lack of progress due to budget or other constraint?
        - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
        - Other? Please specify.
    2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

None.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

    ☐ Yes. If so, what adjustments have been made and how will they address the situation?
    ☒ No. If not, why not?

    ImCal has made steady and efficient progress in all objectives and strategies as indicated in our 5-year strategic plan, despite no increase in our budget.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

ImCal Executive Management Team utilizes the 5-year strategic plan to develop ImCal HSA's annual operational goals and objectives within the Annual Business Plan as well as develop its annual budget. Performance measure data outlined within the 5-year strategic plan is collected quarterly and shared with the Executive Management Team; performance measures are adjusted as needed.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

<u>Problem/Issue #1:</u> Five federally declared disaster events, four of which were major weather disasters that occurred during the COVID-19 global pandemic

A. Problem/Issue Description

1. **What is the nature of the problem or issue?**
   In the midst of the global COVID-19 pandemic, SWLA endured four unprecedented and catastrophic weather disasters. Hurricane Laura made landfall on August 27th dealing devastating damages to all of SWLA. Hurricane Delta followed six weeks later. In February of 2021, a record-breaking freeze occurred, damaging hurricane-battered homes and infrastructure. In the month of May, the area endured two major flood events causing more damage to homes and businesses. The Admin and DD divisions became displaced after Imperial Calcasieu Human Services Authority's (ImCal) building suffered major damage from Hurricane Laura. The DD Division is again displaced from its temporary post-hurricane location due to flooding. ImCal maintained both clinical and administrative operations throughout all of the disasters with very minimal disruption; however, many challenges have emerged: 1) loss of staff which are difficult to recruit and replace, 2) loss of community providers and contractors, 3) loss of housing for both BH and DD clientele, and 4) increased rates of suicide and overdose within the community.

2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)**
   The number of persons served overall decreased, which negatively impacted some of our operational goals. Despite these temporary setbacks, we continue to make progress toward our 5-year strategic goals and objectives.

3. **What organizational unit in the department is experiencing the problem or issue?**
   All departments and divisions have been affected.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   The entire community has been affected to include clients, partners, stakeholders, staff members, businesses, schools, etc. The destruction of property and infrastructure has led to lack of housing and other vital resources for individuals served. Many of ImCal's community partners are displaced or services have been reduced, negatively impacting the established continuum of care. Many SWLA residents remain displaced which reduces not only the individuals we would serve, but also our pool of potential staff members.

5. **How long has the problem or issue existed?**
   The COVID-19 pandemic arrived in March of 2020. The hurricanes hit the area in the fall of 2020. In February of 2021, the freeze occurred. Back-to-back floods occurred in the spring of 2021.

6. **What are the causes of the problem or issue? How do you know?**
   The COVID-19 pandemic led to a decrease in service provision in the early months of the pandemic. Large-scale displacement of residents has led to challenges in recruiting and hiring staff members, providers, and contractors to address the increasing needs of the community. Continued traumatic stress from COVID-19 and major weather events has led to unprecedented increases in overdose rates as well as increased suicide rates.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   Community continues to struggle in recovery efforts, in most part due to the high demand for federal disaster relief funding for housing and infrastructure repairs.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

   ☒ No. If not, skip questions 2-5 below.
   ☐ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?

4. Are corrective actions underway?
    a. If so:
        - What is the expected time frame for corrective actions to be implemented and improvements to occur?
        - How much progress has been made and how much additional progress is needed?
    b. If not:
        - Why has no action been taken regarding this recommendation?
        - What are the obstacles preventing or delaying corrective actions?
        - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☒ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
    a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
    b. How much has been expended so far?
    c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
    d. Will additional personnel or funds be required to implement the recommended actions? If so:
        - Provide specific figures, including proposed means of financing for any additional funds.
        - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

Problem/Issue #2: Recruitment and retention of professional and qualified staff under a Civil Service System and limited budgetary resources

A. Problem/Issue Description
1. **What is the nature of the problem or issue?**
Imperial Calcasieu Human Services Authority (ImCal) struggles with recruitment and retention of licensed professional staff and limited access to funds to compete with the private sector, complicated by lack of qualified staff due to hurricane and other disasters. Under a behavioral health Managed Care environment, ImCal HSA is expected to operate similar to the private sector in order to generate revenue to support the budget.

2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)**
   Not at this time.

3. **What organizational unit in the department is experiencing the problem or issue?**
   The Behavioral Health Division within ImCal is experiencing the problem.

4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)**
   The individuals served by ImCal are affected by waiting lists to access services.

5. **How long has the problem or issue existed?**
   The problem has existed since ImCal's inception.

6. **What are the causes of the problem or issue? How do you know?**
   The cause of the problem appears to be recruitment and retention of licensed professional staff and limited access to funds to compete with the private sector.

7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
   ImCal will continue to struggle in filling vacancies and providing needed services to the community.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

   ☒ No. If not, skip questions 2-5 below.
   ☐ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
   a. If so:
      - What is the expected time frame for corrective actions to be implemented and improvements to occur?
      - How much progress has been made and how much additional progress is needed?
   b. If not:
      - Why has no action been taken regarding this recommendation?
      - What are the obstacles preventing or delaying corrective actions?

- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

☒ No. If not, please explain.
☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
   a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
   b. How much has been expended so far?
   c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
   d. Will additional personnel or funds be required to implement the recommended actions? If so:
      - Provide specific figures, including proposed means of financing for any additional funds.
      - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
The 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**
ImCal HSA participates in the Office of Behavioral Health Peer Review process annually. This fiscal year an administrative and clinical peer review was conducted with Acadiana Area Human Services District.

☒ **Accreditation review**
ImCal HSA is accredited by CARF, International. Quality of conformance is reviewed annually and a full re-accreditation on-site survey is conducted by CARF every three years.

☒ **Customer/stakeholder feedback**
ImCal HSA participates in the C'est Bon program in the Office of Behavioral Health through the State Behavioral Health Planning Council. The program employs a specially trained team of behavioral health peers and family members who evaluate services from the persons served point of view. The team interviews some of those served at the clinic regarding the quality of services. The team then analyzes the information obtained. The data is reviewed by the Office of Behavioral Health and then presented in a report as feedback to facility managers and their staff. The purpose of the *C'est Bon* survey is continuous quality improvement of both services and facilities. Our greatest goal is to help the behavioral health system work for all by encouraging those involved to work together.

☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☐ Yes. Proceed to Section C below.
☒ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation

2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department:	**Louisiana Department of Health (LDH)** 09-376 Central Louisiana Human Services District
Department Head:	**Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Executive Director:	**Rebecca Craig**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain each item below.

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Initiation of New Supports and Services

A. What was achieved?

Initiation of new supports and services, specifically, supports for persons suffering with Opioid Dependence. The supports include, but are not limited to, the use of Buprenorphine/Naloxone Maintenance Treatment, outreach to persons with Opioid Dependence, and Crisis Support Services for the Central Louisiana Human Services District (CLHD) geographic area.

B. Why is this success significant?
According to National Institute for Health (NIH) in 2019, nearly 50,000 people died from opioid-involved overdoses in the United States. The situation is defined as an Opioid Overdose Crisis. The services implemented by the CLHSD are focused services and supports that are recommended by NIH and result in overdose prevention and reversal interventions to save lives and support recovery.

C. Who benefits and how?
The overall social welfare within CLHSD and, specifically, persons with opioid misuse disorders. Overall, the social effects of the crisis impact multiple areas such as the criminal justice system and health care system. The interventions are expected to be beneficial by reducing involvement in the criminal justice system, reducing healthcare involvement such as emergency services, neonatal abstinence syndrome, and reduce the spread of HIV and hepatitis C resulting from injecting drug use related to opioid use.

D. How was the accomplishment achieved?
Grant funding furnished to the CLHSD was utilized. The LaSOR Prevention- Crisis Mobile Team hire specialized staff trained to augment treatment services to persons identified with opioid dependence and utilize outreach staff who provide education to the public in a non-traditional forum. Treatment is augmented by offering the use of Buprenorphine/Naloxone Maintenance services.

E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
Yes.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
The services implemented are recommended by the NIH and are considered Best Practice.

Accomplishment #2: Rapid Expansion of Telehealth Services During the CV-19 Pandemic

A. **What was achieved?**
Rapid expansion of Telehealth services during the CV-19 Pandemic including related safety health precautions.

B. **Why is this success significant?**
Although tele-health has been utilized by CLHSD prescribers to provide access to rural areas prior to the pandemic, routine care by clinical staff did not offer telehealth services. Due to the pandemic, it was necessary to expand use of telehealth for routine care provided by mid-level therapists following social restrictions enacted due to the declared pandemic. Prior to the pandemic, technological supports necessary to provide telehealth were not available. Particularly, the expansion increased access for people

living in the most rural areas of CLHSD who previously were unable to receive services due to transportation and limited financial resources.
CLHSD coordinated an emergency response team, and with the State EOC to successfully expand services. Support was provided to clinical staff including issuing lap-tops, providing information and education regarding licensing changes, insuring protected internet communications, and other technological supports that permitted clients to continue with safe, therapeutic services.

C. **Who benefits and how?**
Active clients who receive services from the CLHSD programs, and other new persons who were able to access care through tele-health services.

D. **How was the accomplishment achieved?**
This achievement was achieved through staff Coordination Meetings
- Education for staff on use of current e-conferencing system (Zoom)
- Establishment of business agreements with e-conferencing system selected (Zoom)
- Provide staff with technological supports to work from home (issuance of computers, web cams, laptops, printers, supplies, etc.).
- Establish VPN connections for employees working remotely.
- Review of new rules and guidelines established for Licensed Professionals who would be working remotely.
- Review and update the coding and billing established in the electronic health record

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?**
With consideration of the pandemic situation, it is considered the best practice given the risks and benefits for persons served by the CLHSD.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

Central Louisiana Human Services District (CLHSD) reviews input from internal and external sources in order to develop the strategic plan. The input includes a review with consideration of legal mandates and needs assessment results. Ultimately, the strategic plan insures the operation of programs to provide quality services and supports to the public while meeting legal mandates of the agency. CLHSD has been successful in providing oversight and program support for maintaining service provision for mental health services, addiction services, and developmental disabilities services. CLHSD measures its success by positive treatment outcome measures and satisfaction surveys administered to program participants. CLHSD success for fiscal year 2021 was achieved using technological supports for telemedicine, electronic health records, and billing.

- **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.

    Central Louisiana Human Services District (CLHSD) achieved success by interdepartmental efforts. The Administrative program provides the leadership, support, and oversight to insure the effective implementation of the behavioral health and developmental disabilities programs. The behavioral health and developmental disability programs put into action quality services for the public in a manner that has provided positive outcomes and client satisfaction. Significant progress has been accomplished this year in the areas of Access to Care utilizing technology. The challenges during the COVID-19 Pandemic restrictions has accelerated the utilization of technologies in providing access to the most rural areas of the CLHSD geographic area. Face-to-face services are a preferred method of treatment delivery. However, a large number of persons served by the district are from lower socio economic groups, and struggle with transportation to programs that primarily offer clinic based, face-to-face services. The expansion of telehealth services has permitted increased access for this particular population.

    2. Is this significant progress the result of a one-time gain? Or is progress expected

to continue at an accelerated pace?

CLHSD achieved significant progress in technological supports advancing increased access to care. Technological supports are necessary for the delivery of services to remote areas of the CLHSD, and with future ability to complement the access to care by people who may be home bound or unable to access care face to face. It is not expected the progress will continue at the same rate as FY2020.

- **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.

Forward movement of the CLHSD strategic plan is impacted by limited staffing resources, particularly Licensed Mental Health Professionals (LMHPs). Clinical services are needed most and are critical to the function of the District. The critical clinical services can only be provided by LMHPs as indicated by training and license type. Shortage areas include Psychiatrists, Medical Psychologist, Clinical Social Workers (LCSW's), Professional Counselors (LPC's), and Addictions Counselors (LAC's).

In the area of reimbursements, federal third party payers are not allowed by all LMHP's (i.e. Licensed Professional Counselors and Licensed Addictions Counselors). The reimbursement restrictions affect billing and reimbursement for claims, issues with scheduling, issues with access to care, and other organizational problems.

In addition, the constraints on staffing limits our progress in implementing new programs, contracting for programs, staffing clinics and crisis teams as well as limits to obtaining financial reimbursement for services.

2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

Reimbursement and staffing issues are a continuing problem. Staffing issues are related

to the reimbursement by third party payers and Federal payers for Licensed Mental Health Professionals (LMHPs), and the availability of the LMHPs who specialize in providing behavioral health services. Efforts have been made to maximize the available resources; however, programs continue to be impacted by staffing shortages.

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☒ Yes. If so, what adjustments have been made and how will they address the situation?
  ☐ No. If not, why not?

  CLHSD utilizes all disciplines (LMHP's) allowed by third party payers to provide services to program participants. We have made efforts to attract providers from outside of the CLHSD defined geographic area, and Telehealth is used to expand access to providers.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

  Currently, our strategic plan objectives and strategies continue to be appropriate to the overall success and improvement of the quality of services offered to the citizens of Louisiana. CLHSD shares its strategic plan with the community, advocates, internal personnel, as well as stakeholders.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   Shortages of Licensed Mental Health Professionals (LMHPs).

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   Yes, we have experienced problems filling vacancies with LMHPs for Behavioral Health Clinics and programs.

3. What organizational unit in the department is experiencing the problem or issue?
   Clinical Services Programs that provide direct care for persons experiencing mental health and substance use disorders, contract programs that provide direct clinical services, contract programs that provide crisis services, and our billing department are all experiencing this problem.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Customers, internal functions, and personnel are directly affected.

5. How long has the problem or issue existed?
   This is a longstanding problem.

6. What are the causes of the problem or issue? How do you know?
   Rural areas have few LMHPs. In addition, federal payers provide reimbursement to certain LMHPs, but not all in Louisiana.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? In light of the current Opioid Crisis and Mental Health concerns, staffing of essential programs has been difficult.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department?

   ☐ No. If not, skip questions 2-5 below.
   ☒ Yes. If so, complete questions 2-5 below.

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
   Raise awareness of the critical needs of the CLHSD geographic area.
   Advocate at a Federal level for reimbursement of Licensed Professionals within Louisiana that are not currently included in the Centers for Medicare & Medicaid Services (CMS).

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?

Untreated or inadequately treated behavioral health issues result in increased costs that are incurred within the criminal justice system, judicial system, and Hospital systems. Therefore, addressing current concerns in behavioral health care would ultimately lead to a decrease overall costs to the health care system.

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply. Add comments to explain each methodology utilized.

☒ **Internal audit**
The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste and abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

Internal Audit also provides management with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The LDH has a designated Audit Coordinator for financial audits. The Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal c communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

☐ Policy, research, planning, and/or quality assurance functions in-house
☐ Policy, research, planning, and/or quality assurance functions by contract
☐ Program evaluation by in-house staff
☐ Program evaluation by contract

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

☒ **In-house performance accountability system or process**
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

☒ **Benchmarking for Best Management Practices**
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

☒ **Performance-based contracting (including contract monitoring)**
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

☐ Peer review
☐ Accreditation review
☐ Customer/stakeholder feedback
☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☐ Yes. Proceed to Section C below.
☒ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)

6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail:

Annual Management and Program Analysis Report
Fiscal Year 2020-2021

Department:	**Louisiana Department of Health (LDH)** 09-377 Northwest Louisiana Human Services District
Department Head:	**Dr. Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Executive Director:	**Doug Efferson**

I. What outstanding accomplishments did your department achieve during the previous fiscal year?

For each accomplishment, please discuss and explain each item below.

A. What was achieved?
B. Why is this success significant?
C. Who benefits and how?
D. How was the accomplishment achieved?
E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

Accomplishment #1: Re-Opened the Many Behavioral Health Clinic:

A. What was achieved?
The Many Behavioral Health Clinic was re-opened on April 14, 2021.

B. Why is this success significant?
The Many Behavioral Health Clinic was closed May 1, 2016 due to budget cuts. While clients were able to be served by other providers in the area or by our Natchitoches Behavioral Health Clinic, the travel distance significantly limited client access to services. Re-opening the clinic improves client access to services.

C. Who benefits and how?
The clients of Sabine Parish now have access to behavioral health services without the need for significant travel. The health and welfare of our clients has been significantly improved by access to a local Behavioral Health clinic.

D. How was the accomplishment achieved?
The legislature increased our district funding by one million dollars for Fiscal Year 2020. This additional funding allowed us to upgrade the state-owned building and hire the staff needed to operate the clinic. With the Covid-19 pandemic receding this spring, opening up the clinic became safe for clients and staff.

E. Does this accomplishment contribute to the success of your strategic plan?
Yes. Expansion of Behavioral Health Services is a significant part of our 5-year strategic plan.

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
No.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

Yes.

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

Adjusting our business practices to accommodate the Covid-19 pandemic assisted us in maintaining our strategic progress. In additional to following the state-mandated response guidelines, our district implemented weekly viral load reduction cleaning, transitioned services to telehealth where possible, and restricted building access during the worst of the pandemic. These efforts helped us to maintain services at a significant level throughout the pandemic and keep us on track to achieving our five-year strategic plan goals and objectives.

- **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:

None.

1. To what do you attribute this success? For example:
    - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
    - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
    - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
    - Other? Please specify.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

- **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

  None.

  1. To what do you attribute this lack of progress? For example:
      - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
      - Is the lack of progress due to budget or other constraint?
      - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
      - Other? Please specify.

  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

- **Has your department revised its strategic plan to build on your successes and address shortfalls?**

  ☐ Yes. If so, what adjustments have been made and how will they address the situation?
  ☒ No. If not, why not?

No adjustment was needed this year. There were no significant successes or shortfalls to address and the strategic plan remains relevant in its current form.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**

The areas of focus for the strategic plan were based on stakeholder input and the District's End Statement developed by the Northwest Louisiana Human Services District (NLHSD) Board of Directors. The NLHSD Senior Leadership Team then adjusted the goals and objectives of the plan based on input from management staff. The final draft has been disseminated to staff via e-mail and posted on the NLHSD shared folder for all staff to reference when needed. Review of the plan is set to occur twice a year with a summary report to the Board of Directors for their review and input.

III. What significant department management or operational problems or issues exist? What corrective actions (if any) do you recommend?

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in administrative and management oversight that hinder productivity, efficiency, and effective service delivery. "Problems or issues" may be related to external factors—such as demographics, economy, fiscal condition of the state, federal or state legislation, rules, or mandates—that are largely beyond the control of the department but affect department management, operations, and/or service delivery. "Problems or issues" may or may not be related directly to strategic plan lack of progress.)

None.

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description

1. What is the nature of the problem or issue?
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
3. What organizational unit in the department is experiencing the problem or issue?
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
5. How long has the problem or issue existed?
6. What are the causes of the problem or issue? How do you know?
7. What are the consequences, including impacts on performance, of failure to

resolve the problem or issue?

B. Corrective Actions
   1. Does the problem or issue identified above require a corrective action by your department?

      ☐ No. If not, skip questions 2-5 below.
      ☐ Yes. If so, complete questions 2-5 below.

   2. What corrective actions do you recommend to alleviate or resolve the problem or issue?

   3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   4. Are corrective actions underway?
      a. If so:
         - What is the expected time frame for corrective actions to be implemented and improvements to occur?
         - How much progress has been made and how much additional progress is needed?
      b. If not:
         - Why has no action been taken regarding this recommendation?
         - What are the obstacles preventing or delaying corrective actions?
         - If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

   5. Do corrective actions carry a cost?

      ☐ No. If not, please explain.
      ☐ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.) Please discuss the following:
         a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
         b. How much has been expended so far?
         c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
         d. Will additional personnel or funds be required to implement the recommended actions? If so:
            - Provide specific figures, including proposed means of financing for any additional funds.
            - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests?

IV. How does your department identify, analyze, and resolve management issues and evaluate program efficiency and effectiveness?

A. Check all that apply.

☒ **Internal audit**
The LDH Office of the Secretary ensures ongoing monitoring of programmatic and administrative functions.

The Internal Audit function, within LDH Office of the Secretary, appraises activities within the Department to safeguard the Department against fraud, waste and abuse by conducting risk-based audits and compliance investigations. The Internal Audit function ensures that transactions are executed according to management's authority and recorded properly; that operating efficiency is promoted; and that compliance is maintained with prescribed federal regulations, state laws, and management policies.

Internal Audit also provides management with evaluations of the effectiveness of internal controls over accounting, operational and administrative functions.

☒ **External audits (Example: audits by the Office of the Legislative Auditor)**
The LDH has a designated Audit Coordinator for financial audits. The Audit Coordinator is the designated point of contact for all correspondence and communication related to financial audits of LDH agencies. The Audit Coordinator is involved all written communication related to audits and is kept informed about all relevant verbal communication between agency personnel and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities.

The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

☐ Policy, research, planning, and/or quality assurance functions in-house

☐ Policy, research, planning, and/or quality assurance functions by contract

☐ Program evaluation by in-house staff

☐ Program evaluation by contract

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for all LDH agencies. Explanatory notes are provided for positive or negative variances greater than 5% from quarterly performance indicator targets. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if significant variances occur, or if modifications and additions are needed.

☒ **In-house performance accountability system or process**
Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the LDH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are made at monthly expenditure analysis meetings directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed. In addition, at the close of a fiscal year, agencies and programs review and evaluate their performance in order to determine if the information gained from this review should be used to improve strategic and operational planning, or strengthen program management initiatives.

☒ **Benchmarking for Best Management Practices**
The LDH Division of Planning and Budget reviews, researches and develops objectives, performance measures and strategies for the Office of the Secretary, as well as each LDH agency. Recommendations are compared to benchmarks from leading states involved in performance-based budgeting activities. Recommendations are made directly to the agency's assistant secretary or the Department's undersecretary, if modifications or additions are needed.

☒ **Performance-based contracting (including contract monitoring)**
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan.

☐ Peer review

☒ Accreditation review
Northwest Louisiana Human Services District (NLHSD) currently operates under a 3-Year CARF (Commission on Accreditation of Rehabilitation Facilities) Accreditation. This accreditation includes an annual conformance review process.

☒ Customer/stakeholder feedback
Northwest Louisiana Human Services District (NLHSD) solicits input from

LaPAS and C'est Bon surveys, comments on the NLHSD website, verbal and written comments during public forums, and stakeholder surveys distributed during the NLHSD Board's annual strategic planning process.

☐ Other (please specify):

B. Did your office complete any management reports or program evaluations during the fiscal year covered by this report?

☐ Yes. Proceed to Section C below.
☒ No Skip Section C below.

C. List management reports and program evaluations completed or acquired by your office during the fiscal year covered by this report. For each, provide:

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
    Name:
    Title:
    Agency & Program:
    Telephone:
    E-mail: