John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Division of Planning and Budget

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: December 1, 2020

In accordance with Louisiana Revised Statue 36:8, the Louisiana Department of Health is submitting its annual Management and Program Analysis Report (AMPAR) for the 2020 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 2019-2020

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

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

Undersecretary: **Ruth Johnson**

Executive Director: **Alicia English Rhoden**

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

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

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

Accomplishment #1: Achievement of Full Reaccreditation without Findings or Recommendations

A. What was achieved?

During Fiscal Year 2019-2020, JPHSA achieved full reaccreditation from the Council on Accreditation (COA) with no findings or recommendations.This achievement was the culmination of four years of preparation and planning, as well as "living" JPHSA's Mission and service statement on a daily basis.

The accreditation evaluated JPHSA's performance in seventeen key competencies spanning all of JPHSA's business and service delivery areas. Specifically, the areas evaluated included: Administration and Management; Ethical Practices; Financial Management; Human Resources Management; Performance and Quality Improvement; Risk Prevention and Management; Administrative and Service Environment; Behavior Support and Management; Client Rights; Personnel Development and Supervision; Counseling, Support and Education; Housing Stabilization and Community Living Services; Vocational Rehabilitation Services; Services for Mental Health and/or Substance Use Disorders; Integrated Care/Health Homes; Primary Care Services; and Services for Individuals with Developmental Disabilities Services.

Each competency area is rated by COA on a score of 1 (highest) to 4 (lowest). Not only did JPHSA achieve reaccreditation with no findings or recommendations as stated above, but JPHSA received a score of 1 in every single category. JPHSA's reaccreditation date was February 29, 2020, and will end after four years on February 29, 2024. This is the longest reaccreditation cycle COA awards to any agency.

B. Why is this success significant?

JPHSA's high scores across all areas of the evaluation are significant because they signify JPHSA is performing optimally, delivering high quality services, and maintaining strong internal controls. Maintaining an active accreditation is vital to JPHSA's long-term sustainability; it underscores a strong and positive reputation in the community and meets a requirement for third party Managed Care Organizations, including Louisiana Medicaid and other external payors JPHSA bills for reimbursement for services. This self-generated revenue helps support JPHSA in its Mission to serve the residents of Jefferson Parish.

Moreover, as stated above, JPHSA achieved a full four-year accreditation, the longest available from COA. By not having to assume costs for more frequent reaccreditation cycles, both in fees and in significant investments in staff time, JPHSA is able to direct resources where they matter most: to services and supports.

C. Who benefits and how?

The COA mark provides assurances to the public that JPHSA's services have been judged by its peers to be of the highest quality in the behavioral healthcare and the intellectual/developmental disabilities industries. The intensive reaccreditation process benefits individuals served by JPHSA because it requires JPHSA to closely examine and evaluate its practices and policies across the entirety of its business and service delivery areas on an ongoing basis. In doing so, JPHSA is able to more easily identify areas in need of improvement and implement Performance and Quality Improvement (PQI) activities, or conversely, identify the areas in which it is performing strongly, which may be deserving of further investment or expansion. All of these activities contribute to the overall PQI process and ultimately serve to increase service quality.

Similarly, staff members benefit from this achievement through the evaluation of JPHSA's human resources and staff development practices. Again, the intensive examination that occurs as part of the reaccreditation process naturally results in identification of PQI opportunities, including those that benefit staff members.

D. How was the accomplishment achieved?

For each competency area described above in Section A, COA has standards which describe the activities an agency must conduct in order to be considered competent and the types of corresponding evidence acceptable to prove the activities. While COA operates in a contextual milieu, meaning they offer consideration to the organization being evaluated to reasonably interpret the standards and set policy, they do expect that the evidence submitted for every standard is comprehensive and addresses all requirements and sub-requirements. As there were seventeen competency areas, each with several standards and subcomponents, JPHSA ultimately submitted over five hundred pieces of evidence. This included a lengthy narrative for each competency area.

The JPHSA Accreditation Coordinator is responsible for managing the process of evidence collection in every reaccreditation cycle, which begins about 18 months prior to the reaccreditation deadline. For the most recent reaccreditation, the Accreditation Coordinator began the process of soliciting and managing evidence in Fiscal Year 2018-2019. However, the majority of the work was completed in Fiscal Year 2019-2020.

Specifically, during Fiscal Year 2019-2020, the Accreditation Coordinator met with all key staff members on an ongoing basis to ensure expectations were understood and to answer questions regarding the reaccreditation process. She also communicated with all staff regularly, both in person during quarterly Division and Department meetings, as well as weekly through JPHSA's staff member newsletter, to inform them of the reaccreditation timeline and related expectations. She reviewed all evidence submitted for completeness and to ensure all components and sub-components of the applicable standards were met. The JPHSA Public Information Director also assisted with evidence preparation and review. All evidence was approved by the Executive Director. All evidence for the first component of the reaccreditation, called the "self-study" was uploaded to the portal prior to the deadline of December 2, 2019.

Following the completion of the self-study, COA conducted an on-site review. Three COA reviewers, two with program expertise and one with administrative/fiscal expertise, evaluated and interviewed key JPHSA staff members as well as randomly selected staff. The on-site review materials were due by January 31, 2020, and the COA reviewers were on JPHSA premises February 2-5, 2020.

Due to JPHSA's exemplary performance across all areas, the evaluation period following the on-site review was expedited. JPHSA received preliminary notice of the reaccreditation award within three business days after the on-site reviewers left the

premises.

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

Yes, it contributes to the first and third goals of the strategic plan for the reasons discussed in Section C above. The reaccreditation process and resulting award helps to ensure JPHSA's long-term sustainability. It also guarantees ongoing Performance and Quality Improvement activities across all of JPHSA's business and service delivery areas, including those that impact staff member satisfaction and retention.

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

It is JPHSA's belief that all Local Governing Entities should be accredited with an appropriate accrediting body. JPHSA recommends the Council on Accreditation to any provider offering behavioral health, primary care, intellectual/developmental disability, and/or integrated services.

Accomplishment #2: Development of Centralized Care Coordination Program

A. What was achieved?

In Fiscal Year 2019-2020, JPHSA made significant progress in developing the Centralized Care Coordination Program both as an internal support to service delivery and "customer" service and as an evidence-based practice.

To provide some background, JPHSA originally developed its Centralized Care Coordination (CCC) Program in 2015 with the support of a grant from Baptist Community Ministries. The initial CCC Program developed by JPHSA was intended as a problem-solving tool to address responsiveness and coordination between various internal providers, as well as between internal and external providers and referral sources. The role of the care coordinators was broadly defined to ensure timely referrals, service delivery, and follow-up as well as completion of necessary documentation.

A hallmark of the CCC program is the "no wrong door" approach. This means any individual or referral source seeking services can reach out to any care coordinator working in any division and connect with a full range of integrated services in all JPHSA service area divisions. Regardless of the need and whether there are single or multiple needs, any care coordinator can assist with coordination of services.

In November 2018, the CCC program was transitioned from the service delivery areas to the Compliance & Performance Support (CPS) Division, which is service-neutral, to further the planned changes to the program in furtherance of the "no wrong door"

philosophy. Since then, the Quality Improvement Specialist serving as the CCC Program Manager has been engaged with a national-level consultant, Dr. Stephen Phillippi, to develop the CCC program into an evidence-based practice.

In Fiscal Year 2019-2020, the Quality Improvement Specialist and the CCC Supervisor developed a transition plan with the assistance of Dr. Phillippi and the three Division Directors of JPHSA's service delivery areas. This plan expanded program expectations which included changes to initial contact timeframe, follow-up requirements, and staffing and discharge of Care Coordinator caseloads. Additionally, it required that all Care Coordinators be transitioned out of the JeffCare Health Centers, where their offices had been previously stationed, and begin rotating among all JPHSA facilities and service areas. The intent behind this rotating schedule was to ensure all Care Coordinators achieved true integration and learned all JPHSA services and supports in-depth through working in person with staff members within all service areas. In September 2019, the Care Coordinators spent two weeks in an intensive orientation to the new model. During the orientation, Care Coordinators assisted in identifying workflow issues, barriers to care, additional training needs, and suggestions for caseload management. Feedback and data collected during the two-week period was used to improve the CCC transition plan.

The Quality Improvement Specialist worked intensely with the Electronic Health System (EHS) Transition Oversight Committee throughout the EHS conversion. During the second quarter of Fiscal Year 2019-2020, the new EHS was configured, data was validated, workflows were developed, and staff training was completed. CCC was set up as its own program within the EHS. Cases were uploaded to the new EHS from the legacy system, and the CCC staff began receiving and processing referrals electronically using the new workflow. During the third quarter, the EHS configurations completed in the second quarter were monitored and revised as needed to ensure data collection of internal and external referrals. All external referrals were input manually into the EHS by the Quality Improvement Specialist and CCC Supervisor and processed within the EHS. The Quality Improvement Specialist confirmed internal referrals were successfully being entered into the EHS by staff within the service delivery areas, which streamlined the internal referral process and related data reporting greatly.

The data gathered from the new program metrics in Fiscal Year 2019-2020 will be used as a baseline for development of the evidence-based practice going forward.

B. Why is this success significant?

The new processes put into place allow JPHSA to ensure the CCC program truly meets its goals of improving access to all services as well as communication with referral sources. As discussed above, the "no wrong door" approach allows someone seeking services from one service delivery area within JPHSA to also be assessed for and connected with other potential services; and the improved monitoring ensures individuals are linked to services and followed until they are actively engaged. It also

enables JPHSA to better track referrals and communicate with referral sources.

C. Who benefits and how?

The changes to the CCC program directly benefit service recipients, i.e. Jefferson Parish residents, by ensuring a holistic approach to service delivery and increased assistance with making and keeping appointments. JPHSA believes this increased assistance and monitoring will lead to higher engagement in services, and ultimately, better outcomes. The changes in the program also benefit referral sources, i.e. community partners, by providing streamlined access to information and a coordinated approach to care.

Additionally, based on data from pre- and post-transition surveys given to the Centralized Care Coordination staff, staff member job satisfaction increased within the program as a result of the changes implemented.

D. How was the accomplishment achieved?

Please see Section A above. The Quality Improvement Specialist worked closely with a national level consultant, Dr. Stephen Phillippi, as well as other key JPHSA staff members and the Electronic Health System Transition Oversight Committee to develop and implement the changes to the program.

E. 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 CCC Program supports JPHSA in the provision of fully integrated services in a streamlined fashion, thereby helping to improve personal outcomes for service recipients and their families in support of JPHSA's Mission.

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

The goal of creating an evidence-based practice is to allow other agencies to recreate the program practices and methodologies JPHSA has put into place. JPHSA is currently in the data-collection phase of development.

<u>Accomplishment #3: Transition to New Electronic Health System Platform</u>

G. **What was achieved?**

JPHSA's Electronic Health System is a web-based platform which helps the agency maintain service records, conduct clinical practice management and billing activities,

and collect and report service delivery data both internally and externally. The service records maintained within the EHS include clinical data relevant to an individual's care under a particular provider, including demographics, progress notes, diagnoses, medications, vital signs, past medical/behavioral health treatment history, immunizations, laboratory data and radiology reports.

In Fiscal Year 2019-2020, JPHSA fully transitioned from its legacy Electronic Health System provider, Greenway Health, to a new platform, Netsmart's myAvatar.

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

The myAvatar platform offers streamlined and more robust EHS functionalities, which improve staff productivity. This ties back to JPHSA's first goal of the Strategic Plan, which is to ensure long-term sustainability through the availability of adequate resources to meet Mission while adhering to Board Priorities for the provision of services and supports. Thus, the implementation of this new system is a very important accomplishment for JPHSA.

I. **Who benefits and how?**

The myAvatar platform benefits staff by providing more efficient work flows. It also benefits JPHSA as it supports maximization of revenue. Finally, it benefits Jefferson Parish residents by improving ease of access to services through the utilization of a new patient portal.

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

In mid-Fiscal Year 2018-2019, JPHSA received notice from its Electronic Health System (EHS) vendor, Greenway Health, that it would be sun-setting the Success EHS platform in late 2020. The Executive Director and Compliance & Performance Support Division Director worked quickly to create a charter for an EHS Transition Oversight Committee, chaired by the EHS Manager, to begin the process of identifying needs for a new platform and to develop a Request for Proposal (RFP). In addition to the EHS Manager, membership on the EHS Transition Oversight Committee included the Information Technology (IT) Director, Behavioral Health Community Services (BHCS) Division Director, Revenue Cycle Manager, Quality Improvement Specialist, and a JeffCare Site Manager. JPHSA formed a new staff member committee, the Electronic Health System (EHS) Oversight Committee, to assist with developing a RFP to procure a new system and to oversee the transition process. In May 2019, JPHSA again received notice from Greenway Health saying it had decided to move up the Success EHS sunset date to December 31, 2019.

In Fiscal Year 2019-2020, the EHS Transition Oversight Committee finalized and published the RFP. JPHSA utilized stringent evaluation tools, including demonstrations from several vendors, input from staff member reviewers who actually work hands-on with the system, and a detailed and comprehensive scoring mechanism developed by

the EHS Transition Oversight Committee, to select Netsmart's myAvatar platform as its top choice in late July 2019. The Compliance & Performance Support Division Director/General Counsel led negotiations with Netsmart, which ultimately led to a formalized contract with Netsmart in August 2019. As of the date of contract execution, JPHSA and Netsmart immediately began the implementation process with a scheduled Go-Live date of December 2019. This was considered by Netsmart to be an extremely compressed implementation timeline by industry standards. During the months of September, October, and November, the members of the EHS Transition Oversight Committee worked extensively to ensure all core modules and features of the system would be functional as of the Go-Live Date. This included building all related workflows, reports, and widgets, assigning user roles, testing functionality, identifying and mitigating issues, and developing and planning training and monitoring activities.

JPHSA's implementation officially began December 9, 2019. During the week of December 9, intensive staff member user role training was delivered and Netsmart representatives were on-site to assist with ensuring help was available for issues that arose. As stated above, the initial implementation timeline was focused on the "core" modules necessary for JPHSA to ensure continued, uninterrupted business interruptions. Thus, following the implementation date, there remained many optimizations and additional features which had to be developed and implemented. The EHS Transition Oversight Committee was renamed the EHS Oversight Committee in January 2020. This new Committee, Chaired by the JPHSA EHS Manager, lead the optimization efforts and ensured complete implementation was finalized in the third quarter of Fiscal Year 2019-2020.

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

Yes. See section B above.

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

JPHSA's believes all Local Governing Entities should utilize an integrated electronic health system platform as part of their business model.

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

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

- **Please provide a brief analysis of the overall status of your strategic progress.** What is your general assessment of overall timeliness and progress toward accomplishment of results targeted in your goals and objectives? What is your general

assessment of the effectiveness of your strategies? Are anticipated returns on investment are being realized?

Throughout Fiscal Year 2019-2020, 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. An updated Strategic Plan was developed for implementation on July 1, 2020.

- **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 2019-2020. As discussed at length above, JPHSA achieved full four-year reaccreditation, which helps ensure long-term sustainability. Similarly, as discussed above, JPHSA invested in a new and improved electronic health system.

In general, JPHSA maintained its resources in a manner that allowed for the preservation of services even in the wake of the COVID-19 pandemic. This included working with the Division of Administration and Louisiana Department of Health to maximize use of CARES Act funding in a mandated means of finance swap.

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

This goal was achieved over the course of the three Fiscal Years. It was included in the Strategic Plan, including in Fiscal Year 2019-2020. Thus, it was removed from the revised Strategic Plan going into effect July 1, 2020. As discussed at length above, during the Fiscal Year JPHSA further developed and refined its Centralized Care Coordination Program in furtherance of its "no wrong door" approach.

JPHSA attributes this success to the following:

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

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

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

JPHSA made progress toward reaching this goal in Fiscal Year 2019-2020. 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 2019-2020, JPHSA used brand management as a recruitment tool.
- Throughout Fiscal Year 2019-2020, JPHSA expanded its 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 2019-2020, 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 2019-2020, JPHSA continued to utilize an intensive first thirty-day orientation for new staff members as a tool to ensure up-front investment and engagement with JPHSA practices and policies.

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

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

  None.

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

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

  JPHSA revised it Strategic Plan during Fiscal Year 2019-2020 to better play on strengths and address areas in need of more focus. The revised version will be effective July 1, 2020.

- **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, COVID-19 spurred operational adjustments during the fourth quarter of Fiscal Year 2019-2020, 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

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

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

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

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

4. Do corrective actions carry a cost?

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

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

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

◆ A. Check all that apply and 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 2019-2020 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 Fiscal Year 2019-2020 audit was delayed due to COVID-19. It is currently underway (virtually) as of the time of this writing. The OBH review occurred in October 2019. JPHSA was assigned corrective action as a result of this review, which was completed by the stated deadline. The peer review was done with Florida Parishes Human Services Authority and produced no findings or recommendations.

☒ **Policy, research, planning, and/or quality assurance functions in-house**
JPHSA's 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 2019-2020, JPHSA had **no** contracts for policy, research, planning, and/or quality assurance functions.

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

☐ **Program evaluation by contract**
In Fiscal Year 2019-2020, 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 (as discussed at length above); 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**

During the first half of Fiscal Year 2019-2020, JPHSA utilized Greenway's Success EHS as its sole electronic health record for behavioral health, developmental disabilities, and primary care services, as well as i2i to enhance data collection and analysis. As discussed in detail above, a transition to Netsmart's myAvatar platform occurred in December 2019. 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 2019-2020, with Florida Parishes Human Services Authority, focused on administrative functions. The Office of Behavioral Health and Office for Citizens with Developmental Disabilities also conduct annual on-site reviews with peers from other Local Governing Entities as participants.

☒ **Accreditation review**
Please see the first accomplishment for the Fiscal Year, discussed in detail on pages 1-4 of this document.

☒ **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, provide:

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

JPHSA monitors and evaluates its operations and programs on an ongoing basis, as described throughout this report. JPHSA has a highly developed decision-support function in place. Data is analyzed and discussions routinely occur in meetings of the Executive Management Team, Performance and Quality Improvement Committee, Safety Committee, and at the individual division 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: Elizabeth Riehl
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Annual Management and Program Analysis Report
Fiscal Year 2019-2020

Department:	**Louisiana Department of Health (LDH)** 09-301 Florida Parish Human Services Authority
Department Head:	**Dr. 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: Introduction of Primary Care Services

A. **What was achieved?**

Primary Care services were introduced at the Hammond Clinic.

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

This is significant because many of our clients do not have primary care providers but have chronic health conditions. Individuals with mental illness die, on average, 25 years earlier than the general population. Integrating primary care with behavioral health is a best practice.

C. **Who benefits and how?**

The clients we serve benefit by getting their medical problems addressed early before they become worse. Since many of our clients are Medicaid recipients the state benefits by preventing illnesses from progressing unnoticed and become more serious and more costly to treat.

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

This was achieved as a result of funds being identified to hire a new nurse practitioner and two exam rooms were created out of vacant offices.

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, integration of primary care and behavioral health is a best practice supported by many studies.

Accomplishment #2: Addition of Functional Family Therapy Team

A. **What was achieved?**

FPHSA added a functional family therapy team program to the Tangipahoa and Livingston area. Family Functional Therapy (FFT) is an evidence based program that provides therapy in the community to adolescents at risk for out of home placement and their families. FFT has been proven to help reduce out of home placements and keep families together.

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

Livingston parish, in particular, has had one of the highest rates in the state for removal of children from their families. This program is effective in helping families stay together with the right supports which dramatically impacts the long term outcomes for the youths involved.

C. **Who benefits and how?**

The families who stay together and the children who do not end up in a Department of Children and Family Services (DCFS) placement or institutional setting. Their outcomes for future success are proven to be much better if the family can remain intact under healthy conditions. The state benefits by not having to manage custody of children removed from the family in an already overextended foster care system.

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

FPHSA partnered with the national organization that manages FFT to have staff trained and certified to provide this service.

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, FFT is an evidence based practice whose results are considered a best practice for serving this population.

Accomplishment #3: FPHSA entered into an agreement with DCFS to partner in serving families at risk of separation

A. **What was achieved?**

Florida Parish Human Services Authority (FPHSA) and DCFS partnered to provide behavioral health screening and treatment to families in the DFCS system.

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

The area was experiencing the highest rates of removal of children from families in the state, much of that was due to substance use. Because DCFS are not expert in the substance use issues they weren't always best positioned to determine when a substance use issue was treatable or when it was unsafe for the child to remain in the home. The partnership with licensed behavioral health staff helps provide more expert information and access to treatment so that families can remain intact when it appropriate to do so.

C. **Who benefits and how?**

The families who stay together and the children who do not end up in a DCFS placement or institutional setting. Their outcomes for future success are proven to be much better if the family can remain intact under healthy conditions. The state benefits by not having to manage custody of children removed from the family in an already overextended foster care system.

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

Through a contract with DCFS.

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, providing behavioral health services to these families improves the outcomes for the parents and the children involved.

Accomplishment #4: FPHSA provided a multi session seminar on individuals with developmental disabilities and intimate relationships

A. **What was achieved?**
A series of classes were held to discuss the issue of intimacy and relationships among individuals with disabilities.

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

This is an issue that people tend to not want to talk about but there was a request from the community to address this issue. People with Developmental Disabilities (DD) are typically not thought of as having intimate relationships, but it can be part of a healthy life under appropriate conditions. Additionally, individuals with disabilities are disproportionately affected by sexual abuse and more knowledge about appropriate interactions can help protect them from being taken advantage of.

C. **Who benefits and how?**

Individuals with DD in our community who gain a better understanding about a part of their life that is often not spoken about. This can lead to them being abused or acting out inappropriately because the issues have never been discussed with them.

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

By collaborating with a local group who have national certification to teach this population about this issue.

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

Goal 1 of the strategic plan speaks to improving the quality of life and community participation for those that we serve.

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

Possibly… in that its goal is to allow individuals affected by DD to live safer lives in the community with all of the rights and opportunities of those not affected by developmental disabilities.

Accomplishment #5: Title of significant accomplishment: Carried out several Zero Suicide related initiatives.

A. What was achieved?

(1) Fifty FPHSA and community staff were trained in Cognitive Behavioral Therapy for Depression and Suicide;

(2) Three ASIST trainings were conducted in the community;

(3) A thorough review of FPHSA policies and procedures was completed by a qualified suicidologist to provide training and recommendations;

(4) A marketing campaign was conducted to raise awareness for suicide treatment;

(5) Ongoing training and consultation with cognitive behavioral therapy for suicide and depression experts was provided to FPHSA staff to aid in implementation of the principles used to reduce suicides.

B. Why is this success significant?

The FPHSA catchment area has historically had the highest rates of suicide across the state. These steps, along with our zero suicide campaign steps, are meant to improve upon this as we work towards eliminating suicides among the population we serve.

C. Who benefits and how?

Individuals and their families across the FPHSA catchment area who may be at risk for being impacted by suicide.

D. How was the accomplishment achieved?

Through the application of a grant from Baptist Community Ministries which funded all of these initiatives.

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

Yes, goal 1 of the strategic plan speaks to improving the quality of life of those the agency serves who have behavioral health conditions and goal 2 speaks to improving the effectiveness of behavioral health care services. This effort improves our ability to accomplish both.

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

Yes, the principles of Zero Suicide are internationally recognized as best practice for reducing suicides.

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?

     Florida Parishes Human Services Authority expects this to continue to the extent that funding remains stable. The pandemic has negatively impacted finances, pandemic related budget reductions have done the same and threaten to be worse the longer that the impacts continue. 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 is 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 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?

  A resolution is not imminent, as we have hoped for some improvements, but have exhausted all avenues and will be changing records soon.

- **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.

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?

This problem has been going on for many years and continues. This isn't a problem limited to FPHSA's area but is a concern statewide.

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 ultimately fulfill its mission and complete the strategic plan goals. Management is encouraged, though, by the recent compensation changes approved by the Department of Civil Service and hope to see a positive impact in the coming months. Additionally, the agreement by the legislature to stabilize the budget for the near future should positively impact recruiting and retention.

B. Corrective Actions

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

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

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

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

4. Do corrective actions carry a cost?

☐ No. If not, please explain.

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

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

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.

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.

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 replacement of the electronic health record with a new one that meets our needs.

3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? *No*
4. Are corrective actions underway? *Yes*
    a. If so:
        - What is the expected time frame for corrective actions to be implemented and improvements to occur? *6-9 months for procurement, customization, and implementation*
        - How much progress has been made and how much additional progress is needed? *Several records were evaluated and one was recently chosen. The procurement, customization, and implementation remain.*
    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.*

    The specific costs are still unknown but the costs are estimated to be similar to what we currently pay for our record

    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?

As of now, we expect that we will be able to cover this as it is expected to be similar to existing costs which it will replace.

c. Will additional personnel or funds be required to implement the recommended actions? If so:
Unknown at this time but hopefully not
   - 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.

☒ **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 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:**
   Independent Peer Review

2. **Date completed:**
   6/10/2020

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 into 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 Instrument is used 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:**

Jefferson Parish Human Services Authority was FPHSA's peer reviewer. There were no findings or recommendations.

7. **Major Recommendations:**
   None.

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:**
   Human Services Accountability Plan Annual Monitoring Report (DDS)

2. **Date completed:**
   March 12, 2020

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

4. **Methodology used for analysis or evaluation:**
   The monitoring goal is verification of Performance Measures and Quality Management Initiatives for Developmental Disabilities Services through records reviews. Monitoring occurs on an annual basis for performance indicators shown in the outcome measures in Section II: D of the Human Services Accountability Plan (AP) as agreed by the Office for Citizens with Developmental Disabilities (OCDD) and the Human Service Interagency Council (HSIC). Records are also reviewed for your Flexible Family Fund (FFF) Program, Preadmission Screening and Resident Review (PASRR) Program, New Opportunities Waiver (NOW), Children's Choice (CC) Waiver, Supports Waiver (SW) and Residential Options Waiver (ROW) to determine compliance with program policies and guidelines. Each LGE is expected to review its performance indicator data results, develop, and implement a Corrective Action Plan (CAP) when a performance standard is not met. OCDD Central Office is responsible for reviewing CAP(s) and providing

technical assistance based on the best and promising practices and services provided that are consistent with statewide strategies and evidence-based principles.

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

6. **Major Findings and Conclusions:**
   PI# 9 during all 4 quarters, percentage of persons served employed in community fell short of the goal. PI# 11 Compliance with POC meeting needs of person served was met at 100%. PI#'s 4, 14, 17, 18, 22 had mixed results throughout the 4 quarters.

7. **Major Recommendations:**
   Q1 – Continue with corrective action plan for PI #9. Continue holding employment fairs. Support coordination agencies have a corrective action plan in place for PI #11.
   Q2 – Continue with corrective action plan for PI #9. Discontinue corrective action plan for PI #11. The performance indicator was met for two consecutive quarters. Performance indicators # 14, 17, 18 and 22 require a corrective action plan.
   Q3 – Continue with corrective action plans for PI #14, 17, 18 and 22. Performance Indicator #3 requires a corrective action plan. OCDD no longer requires data for PI #9 due to the COVID-19 pandemic.
   Q4 – Continue with corrective action plans for PI #3 and 22. Discontinue corrective action plans for PI #14, 17 and 18. The performance indicators were met for two consecutive quarters.

8. **Action taken in response to the report or evaluation**:
   Caps and continued focus to come into compliance:
   Q1 – Update and continue with corrective action plan for PI #9. This is a statewide corrective action plan. Continue holding employment fairs. Requested a corrective action plan for PI #11 from support coordination agencies.
   Q2 – Update and continue with corrective action plan for PI #9. Discontinue corrective action plan for PI #11. The performance indicator was met for two consecutive quarters. Corrective action plans were implemented for Performance Indicators # 14, 17, 18 and 22.
   Q3 – Update and continue with corrective action plans for PI #14, 17, 18 and 22. Implement a corrective action plan for Performance Indicator #3. OCDD no longer requires data for PI #9 due to the COVID-19 pandemic.
   Q4 – Update and continue with corrective action plans for PI #3 and 22. Discontinue corrective action plans for PI #14, 17 and 18. The performance indicators were met for two consecutive quarters.

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

10. **Contact person for more information:**
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    Title: Executive Director

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

2. **Date completed:**
   Q1 - 10/21/19, Q2 – 1/28/20, Q3 – 4/20/20, Q4 – 8/6/20

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
   Developmental Disabilities Services (DDS) will provide services that emphasize person-centered individual and family supports to people with developmental disabilities. Delivery of services will result in an increased percentage of people within the FPHSA catchment area that remain in the community rather than being institutionalized.
4. **Methodology used for analysis of evaluation:**
   LaPAS calculation methodology

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

6. **Major Findings and Conclusions:**
   Q1 – The FFF Q4 target is lower than the FY20 performance standard due to 100% of FFF slots not being filled.
   Q2 – There was an increase in the number of individuals receiving IFS services. This is reflected in the increased numbers for the IFS services performance indicator and IFS crisis services performance indicator. The total number of FFF slots was anticipated to increase to 208. There was a lack of response from caregivers and fewer children on the waiting list meeting FFF eligibility criteria. The total number of FFF needs to be lowered.
   Q3 – With the onset of the COVID-19 pandemic, the opportunity to reach new recipients in the community lessened. People previously receiving IFS and/or IFS crisis services requested one-time expenses through the IFS budget. Resulting in fewer new individuals receiving services. This is evidenced by the decrease in IFS services and IFS crisis services. OAAS referred more PASRR requests than anticipated. Waiver discharges to an institution were fewer than anticipated. This is a positive outcome.
   Q4 – More IFS Crisis services than anticipated were funded due to the COVID-19 pandemic. OAAS referred more PASRR requests than anticipated. Eighteen (18) individuals were referred more than once. The goal is for Waiver participants to remain in the community. Four (4) out of 1,784 individuals were discharged to an institution. Since the indicator is cumulative, the percentage reported decreases when there are few institutionalizations and an increase in waiver admissions. This is a positive outcome.

7. **Major Recommendations:**
   Q1 – Change the FFF Quarter 4 target.
   Q2 – Change the IFS and IFS crisis and FFF targets.
   Q3 – Change the IFS and IFS crisis targets. A portion of the IFS services funding will be moved from IFS services to the IFS Crisis budget.
   Q4 – N/A

8. **Action taken in response to the report or evaluation:**
   Q1 – FFF targets were decreased.
   Q2 – Targets were adjusted for Q3 and Q4.
   Q3 – A portion of funding was moved from IFS to the IFS Crisis budget. The Q4 target was changed to reflect the decrease in IFS funding and increase to IFS Crisis funding.
   Q4 – N/A

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

10. **Contact person for more information:**
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    E-mail: Richard.Kramer@fphsa.org

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

2. **Date completed:** 3.5.20

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 97.72% in compliance. There were a few physical plant issues sited that could potentially be risk hazards. These included relocating a fire extinguisher, adding a surge protector, covering extension cords in order to eliminate potential for tripping. The only

major finding with inspection reports was that may a report was either not done or logged, and this may have been the result of a transition of duties between staff.

7. **Major Recommendations:** Mitigation of potential hazards identified.

8. **Action taken in response to the report or evaluation:**
   All identified potential hazards were corrected and the CAP submitted to ORM. All hazards have been addressed and mitigated.

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

10. **Contact person for more information:**
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1. **Title of Report or Program Evaluation:**
   Accountability Plan (AP) Behavioral Health
2. **Date completed:** 12/12/19 (reviews conducted 11/14/19 through 12/4.19.

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**): Not calculated.

6. **Major Findings and Conclusions:**
   There were findings related to documentation.
   All service sites exceeded standards, and the opportunities were addressed.

7. **Major Recommendations:** None noted.

8. **Action taken in response to the report or evaluation:**
   FPHSA reviewed the reports with leadership and staff and each service site executed the improvement plan that was submitted to OBH as FPHSA's corrective action plan.

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

10. **Contact person for more information:**
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1. **Title of Report or Program Evaluation:**
   CARF Survey
2. Date completed: December 16, 17, 18 2019

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
   To independently and objectively evaluate the continuation of FPHSA's quality improvement activities and provide feedback for any areas of performance that may have undesired effects on staff, persons served and the broader community. The process also provides FPHSA validation of its strengths and accomplishments that help the organization to meet its goals and embody its values and missions. CARF accreditation also serves as a seal of approval that FPHSA performs at standards that are aligned with behavioral healthcare best practices.

4. **Methodology used for analysis or evaluation:**
   Onsite records reviews, P&P reviews, interviews with staff, person served and community stakeholders.

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

6. **Major Findings and Conclusions:**
   Three-year accreditation extended through January 31, 2023:
   Intensive Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
   Outpatient Treatment: Alcohol and Other Drugs/Addictions (Adults)
   Outpatient Treatment: Mental Health (Adults)
   Outpatient Treatment: Mental Health (Children and Adolescents)
   Residential Treatment: Alcohol and Other Drugs/Addictions (Adults)

7. **Major Recommendations:**
   Leadership Recommendations:
   The expansion of the cultural competency and diversity plan.
   The revision of the strategic plan to place more emphasis on sustainability and uses input from persons served.
   The re-examination of the risk management plan and its annual review and update as necessary in response to review findings.
   The re-examination of the technology plan so that it aligns with the strategic plan Revisions recommended above.

The revision of the accessibility plan to place timelines on all barriers.

Practice Recommendations:

Maintain a current waiting list.

Revise assessment tool to emphasize the interpretive summary.

Review treatment plans to be sure that goals are expressed in the person served own words, uses strengths and abilities noted in the assessment and is given to the person served once developed.

Continual update and revision of the transitional plan so that discharge is seamless and aligned with identified needs. The plan is given to the person served during transition.

Records Management:

Document that a complete orientation was done at admission and that the transition/discharge plan was given to the person served.

8. **Action taken in response to the report or evaluation:**
   All recommendations were addressed in CAPs and submitted to CARF. They were all accepted.

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

10. **Contact person for more information:**
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1. **Title of Report or Program Evaluation:**
   FPHSA Monitoring Summary Report

2. **Date completed:** 7/16/2019

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
   FPHSA PSH program participated in a file review of assessments, plans, progress notes and infrastructure (change in address since last review.)

4. **Methodology used for analysis or evaluation:**
   Records review of 7 persons served charts.

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

6. **Major Findings and Conclusions:**
   The major finding was related to treatment plans that lacked evidence of annual updates, as required by the program.

7. **Major Recommendations:** Terms were met and finding needed a QI plan.

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

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

10. **Contact person for more information:**
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1. T**itle of Report or Program Evaluation:**
   AETNA QI Record Review (LDH/OBH)

2. **Date completed:** 7/15/2019

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
   Onsite (Mandeville Behavioral Health Clinic) records review.

4. **Methodology used for analysis or evaluation:** Random sample of records were reviewed.

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

6. **Major Findings and Conclusions:** Final score: 84% (met the required benchmark score.)

7. **Major Recommendations:**
   Opportunities for improvement include were noted in the following areas: cultural competency; medication management and progress note documentation.

8. **Action taken in response to the report or evaluation:**
   CAPs were developed and are on-going as part of the QI program.

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

10. **Contact person for more information:**
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1. **Title of Report or Program Evaluation:**
   AETNA QI Record Review (LDH/OBH)

2. **Date completed**: 9/12/2019

3. S**ubject or purpose and reason for initiation of the analysis or evaluation:**
   Desktop treatment record review at Slidell Behavioral Health Center.

4. **Methodology used for analysis or evaluation:**
   Random sample of records from the rating period.

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

6. **Major Findings and Conclusions:**
   Final score: 91% (exceeded the benchmark of 80%). Opportunities for improvement were noted in the following areas: Persons served Bill of Rights and Individualized Treatment Planning.

7. **Major Recommendations:**
   Use of the APA and LAMEDICAID websites for guidance related to opportunities for improvement with treatment record-keeping.

8. **Action taken in response to the report or evaluation:**
   Although no Cap was required, FPHSA conducts internal audits to monitor areas with opportunities for improvement.

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

10. **Contact person for more information:**
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    Telephone: (985) 543-4333
    E-mail: Richard.Kramer@fphsa.org

1. **Title of Report or Program Evaluation:**
   Office of the Legislative Auditor

2. **Date completed:**
   6/10/2020

3. **Subject or purpose and reason for initiation of the analysis or evaluation:**
   Financial Procedural Audit

4. **Methodology used for analysis or evaluation:**
   To evaluate certain controls FPHSA uses to ensure accurate financial reporting, compliance with applicable laws and regulations, and to provide accountability over public

funds. In addition, we determined whether management has taken action to correct the finding reported in the prior report.

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

6. **Major Findings and Conclusions:**
   Finding 1: Weaknesses in Controls over Payroll; Finding 2: Weaknesses in Controls over Accounts Receivable

7. **Major Recommendations:** N/A

8. **Action taken in response to the report or evaluation:**
   FPHSA updated payroll procedures to better manage the approval processes. Accounts Receivable procedures were also updated to address uncollectible balances.

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

10. **Contact person for more information:**
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Annual Management and Program Analysis Report
Fiscal Year 2019-2020

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

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

Undersecretary: **Ruth Johnson**

Interim Executive Director: **Jan Laughinghouse, Ph.D., LCSW- BACS**

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: Launch of the CAHSD Opioid Outreach Mobile Unit (2/3/2020):

A. **What was achieved?**

Capital Area Human Services District (CAHSD) unveiled a repurposed ambulance that was mobilized to high impact areas where opioid use and overdose are known to be high.

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

The opioid outreach team will provide recovery coaching, HIV and Hepatitis C testing,

linkages to other services, and Naloxone (Narcan). Narcan is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist—meaning that it binds to opioid receptors and can reverse and block the effects of other opioids. It can very quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of overdosing with heroin or prescription opioid pain medications.

C. **Who benefits and how?**

Those with or a risk of opioid use disorders benefit from increased access to treatment and the EBR community at-large benefits from having a public health issue addressed.

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

This accomplishment was achieved through the use of LaSOR (Louisiana State Opioid Response) funding to contract with Capital Area Reentry to provide the 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: 20th Crisis Intervention Training (CIT) 10/12-16/2019:

A. **What was achieved?**

CAHSD completed Crisis Intervention Training (CIT) with 29 law enforcement officers from Baker Police Department, Baton Rouge Police Department, East Baton Rouge Sheriff Office, and Gonzales Police Department

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

Since 2008, CAHSD has trained 567 officers in 20 of the 40-hour CIT classes. We've trained 146 cadets in 6 CIT classes during BRPD Basic Training Academies. We usually accept law enforcement officers from any of the law enforcement agencies within our area. During FY20, we only completed one of our CIT classes and we canceled our Spring class, due to COVID-19. CAHSD also presented 1-day classes on behavioral health and de-escalation to an additional 843 law enforcement officers and dispatchers.

C. **Who benefits and how?**

Law enforcement officers benefit from having training to do their jobs more effectively

and safely with citizens who have behavioral health issues, and the citizens with behavioral health issues benefit from being routed to treatment as opposed to the judicial system. The judicial system benefits from not having the system overburdened with citizens who would best be served with community-based treatment rather than incarcerated where they pose a danger to themselves and staff at these institutions.

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

CAHS provides this training, as a public service, at no cost to the community or participating law enforcement agencies. Our employee, John Nosacka, LCSW-BACS, facilitates the training and enlists community volunteers to present on topics such as addiction, mental illness, etc.

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: *Recovery Starts Here* Campaign with Channel 33/Fox 44 (BR Proud):

A. **What was achieved?**

In April 2020, CAHSD began a behavioral health awareness and educational media campaign, with an emphasis on opioid use and misuse.

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

We anticipated that behavioral health needs would increase markedly during the pandemic, and we wanted the community to know that CAHSD is and ready to serve them when the services were needed most. The ads run on television and the internet.

C. **Who benefits and how?**

The citizens within our 7-parish catchment area (Ascension, East Baton Rouge, East Feliciana, Iberville, Point Coupee, West Baton Rouge, and West Feliciana) are provided with educational information about behavioral health issues and how to access help at CAHSD.

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

By working with Channel 33/Fox and contract media consultants to develop educational spots for NBC, FOX, KZUP, & CW21 and digital banners.

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

Yes

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

Yes

Accomplishment #4: Behavioral Health Collaborative Meeting highlighting the Bridge Center for Hope and Mobile Outreach (1/9/2020):

A. **What was achieved?**

In January 2020, CAHSD hosted a behavioral collaborative meeting that provided community stakeholders with an update on the Bridge Center for Hope and introduced the *Crisis Now* model. Information on mobile mental health services and opioid outreach was also provided by representatives from CAHSD, Capital Area Reentry Program, and Merakey.

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

This is significant because voters approved a funding referendum for the Bridge Center for Hope in 2019, and have a vested interest in the progress of the organization as it moves toward opening in Fall 2020. CAHSD provided an open forum for the organization's Executive Director, Charlotte Claiborne, and RI International (the contractor who was awarded the contract) to speak to the community about how the crisis stabilization services will be provided.

C. **Who benefits and how?**

Charlotte Claiborne and the Amy Pugsley (RI International) explained that the citizens of EBR parish will benefit through a reduction in the cost of care, decreased hospital emergency room visits, and police overuse.

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

By coordinating with representatives from the Bridge Center for Hope, RI International, Merakey, Capital Area Reentry Program, and CAHSD employees to make

presentations.

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: Alternative to Opioid Pain Management workshop:

A. **What was achieved?**

CAHSD sponsored a free community workshop on managing pain with alternatives to opioids (e.g. restorative movement, mindfulness-based stress management, and meditation).

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

This success was significant because this workshop fulfilled one of the community recommendations listed in CAHSD regional response to the opioid epidemic.

C. **Who benefits and how?**

Beneficiaries included community stakeholders such as citizens with chronic pain, health professionals, prescribers, practitioners of holistic medicine, and therapists who work with individuals with chronic pain.

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

We achieved this success by coordinating with local practitioners and the EBR Parish main library.

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

Yes

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

Yes

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

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

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

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

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 strategic plan has been updated to build on the successes experienced with value based purchasing (expansion into shared savings programs with two additional third-party payors) and integrated health care (expansion of existing services with BR Clinic and OHCC).

  CAHSD's plan addresses the shortfall of technology for use in clinic operations and data reporting by outlining the process for selecting a new electronic health record.

- **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?
   The 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?
   This problem affects entire district

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 the World Health Organization, the Center for Disease Control, Louisiana Department of Health, Governor's Office of Homeland Security and Emergency Preparedness, Mayor's Office of Homeland Security and Emergency Preparedness, 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

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

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

1. What corrective actions do you recommend to alleviate or resolve the problem or issue?
   Implementation of district-wide COVID-19 Mitigation Strategies

2. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   No

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

Yes, mitigation strategies were implemented in March 2020. The strategies were developed based on recommendations from the CDC and the CAHSD Medical Staff Organization, headed by the Medical Director, Dr. Aniedi

Udofa. The strategies have been refined and adjusted based on the phases announced by the governor. The timeframe will be determined by the duration of the declared pandemic. Improvements have already occurred in safety of operations for the staff and clients.

4. Do corrective actions carry a cost?

☐ No. If not, please explain.

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

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

The costs for personal protective equipment and other COVID-19 supplies and services vary.

b. How much has been expended so far?

CAHSD has expended $54,427.30 in FY 20; and $24,254.25 in FY 21.

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?

In FY2021, $8,512,784 in IAT Funding has been allocated to the CAHSD from the Governor's Office of Homeland Security & Emergency Preparedness (GOHSEP) through the Coronavirus Aid, Relief and Economic Security (CARES) Act. Additionally, $56,000 in Emergency COVID-19-Federal funding for the purchase of PPEs and other supplies and $771,683 in COVID-19 Crisis Counseling Regular Services Program Federal funding has been provided.

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 (See C. above)

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.

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

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

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

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

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

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

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

variances occur, or if modifications and additions are needed.

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

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

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

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

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

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

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

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

2. Date completed
Quarterly from July 1, 2019 through June 30, 2020.

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:
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Title: Interim Executive Director
Agency & Program: Capital Area Human Services District
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E-mail: Janzlean.Laughinghouse@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2019-2020

Department:	**Louisiana Department of Health (LDH)** 09-303 Developmental Disabilities Council
Department Head:	**Dr. Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Executive Director:	**Sandee Winchell (7/1/2019 – 1/1/2020)** **Shawn Fleming (1/2/2020 – 6/30/2020)**

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:

1. Providing input to LDH on the implementation of the Tax Equity and Fiscal Responsibility Act (TEFRA)-like program offering a Children's Medicaid Option;
2. Recommendations of changes to the final rule of Individual and Family Supports and Consumer Care Resource programs were published in the March 2020 edition of the LA Register.

B. Why is this success significant?
TEFRA will ensure families of children with developmental disabilities and complex medical needs will have a safety net of Medicaid to cover necessary medical procedures. Families across the state will have more equity in access to state funded services outside of the waiver system.

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

D. How was the accomplishment achieved?
This legislative accomplishment was 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. This accomplishment directly contribute to the success of the Council's five-year goals and annual objectives/activities.

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

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

A. What was achieved?
The Council provided support to multiple capacity building initiatives. A series of activities, including multi-day, intensive training sessions coupled with on-going technical assistance in the area of customized employment has improved the awareness and skill sets of employment support providers in effective approaches, strategies and techniques to develop customized employment opportunities for individuals with the

most significant support needs. This activity has been conducted over multiple years in the Council's Five-Year plan and has resulted in professionals becoming certified and qualified to provide this employment service through Louisiana Rehabilitation Services.

In collaboration with Early Steps and LSU-Human Development Center (HDC), intensive training was provided to childcare center personnel and Early Interventionists in three regions of the state on effective strategies to include young children with developmental disabilities. Unfortunately, the one-on-one coaching sessions to follow-along with this training could not be conducted due to the onset of COVID-19 and closures of child-care centers.

Due to the widely received success from the previous year, ten 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. The workshops held in April, May, and June were conducted virtually to accommodate for the safety and health of individuals and prevent the risk of exposure to the Coronavirus.

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 higher education institutions located in north Louisiana 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. Unfortunately, due to COVID-19, this year's class was cancelled after the March 2020 session.

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 are being 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 finalized the last remaining year of action planning for its five-year plan (2017 - 2021). Each activity is reviewed for performance outcomes and adjustments are made in response to feedback and outcome data.

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

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

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

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

("Problems or issues" may include internal concerns, such as organizational structure, resource allocation, operations, procedures, rules and regulations, or deficiencies in

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

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

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

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

B. Corrective Actions
   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:

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

This report is based on the federal fiscal year – October 1 to September 30, and therefore covered the first quarter of state fiscal year 2018-2019. A report

covering the remainder of the 2019 state fiscal year (October 1 to June 30) is scheduled to be submitted to the federal government in December 2020.

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

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

For more information contact:

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Interim Executive Director
Developmental Disabilities Council
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(225) 342-1970 (fax)
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Annual Management and Program Analysis Report
Fiscal Year 2019-2020

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

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

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

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

Accomplishment #1: Title of significant accomplishment: (Adult Behavioral Health Services) Access to Care: Open Access Model, Centralized Scheduling and Telemedicine

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

clearly a measure of access to care.

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

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

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

B. Why is this success significant?
These initiatives reduce the barriers that may hinder persons from being seen by clinicians. Increasing access to care goes to the heart of MHSD's mission of ensuring person-centered support and services are available and provided to eligible individuals in the tri-parish area. Combined with telemedicine, centralized scheduling can literally increase service capacity by matching a person in need of services to an available MHSD clinician housed at any MHSD clinic. That is, if a clinician is available to provide care in one clinic location, through telemedicine technology, that clinician is able to render services even if the person served presents at a different clinic location.

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

D. How was the accomplishment achieved?
By planning and coordination of efforts with clinic management and staff, the MHSD Care/Call Center, the Mental Health and Addictive Disorders programs and the Executive Leadership Team.

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

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

Accomplishment #2: (Care Management/Administration) MHSD Dashboard:

A. What was achieved?

The continued development of the MHSD monthly data dashboard and the expansion of dashboards for provider groups and Telehealth monitoring. MHSD strives to create and maintain a data driven environment. The dashboard is comprised of data tables and charts related to person served demographics, service utilization, access to services, service outcomes and persons served satisfaction. Due to best practices precautions and protocols related to COVID 19, MHSD shifted a large portion of its service provision to telebehavioral health services in the latter part of FY20. Tracking and monitoring the administrative and clinical response to Telehealth service provision was added to the monthly dashboard. The expansion of dashboards specific to provider groups (e.g., prescribers, nursing, mental health clinicians and addiction clinicians gives an even more differentiated, "drill down" picture of performance within the organization.

B. Why is this success significant?

The dashboard serves as tool to provide manageable and timely information to MHSD's Leadership, Board, staff, persons served and the public relative to MHSD's performance in key areas. This, in turn, promotes the transparency promised by the organization in terms of tracking and measuring performance.

C. Who benefits and how?

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

D. How was the accomplishment achieved?

The utilization of electronic data sources, as well as, information sharing with MHSD Mental Health, Addiction and Intellectual/Developmental Disabilities Divisions, allows the MHSD Division of Quality and Data Management to produce the monthly dashboard. 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: (Care Management/Administration) ROSC

A. What was achieved?
In FY20, MHSD continued to advance efforts towards the establishment of a ROSC (Recovery-Oriented Systems of Care) in Orleans, Plaquemines and St. Bernard Parishes. Simply stated, a ROSC is a network of clinical and nonclinical services and supports that sustain long-term, community-based recovery. Implementation of a successful, sustainable ROSC, however, is complex.

As part of its initial implementation, MHSD secured technical assistance from SAMHSA to conduct two environmental scans to assess MHSD's readiness for change and to outline the systems assets, capacities, gaps, and challenges pertaining to ROSC development. With completion of the two scans MHSD moved into the next phase of implementing a ROSC by applying for and obtaining grants to fund critical next steps in ROSC development. One of those steps was to hold a ROSC Recovery Walk to educate the larger public about those in recovery and the need of a support system to aid their recovery. In FY20 progression of ROSC development led to MHSD hosting the 1st ROSC Symposium, with over 200 participants in attendance. As a result of this gathering, several agencies decided to become "ROSC Champions"— agencies interested in learning more about how to incorporate ROSC practices in their service delivery. Also as part of the ROSC progression in FY20 MHSD implemented "Project Reach", a grant funded program designed to support and collaborate with local barber and beauty shops by educating owners on treatment options to best serve patrons with behavioral health (mental health/substance use) challenges.

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

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

D. How was the accomplishment achieved?
MHSD Executive Management provided administrative and staffing resources to support the implementation of the ROSC. This includes, but is not limited to, SAMHSA Technical Support, resources and activities that led to grant funding, a dedicated team of Peer Support Specialist, and leadership from the MHSD Advocacy Division.

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

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

Accomplishment #4: (Care Management/Administration) MHSD Grant Activity

A. What was achieved?

MHSD continued its robust grant activity (i.e., identification, application and awards) in FY20. 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.

- 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.

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

- 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 ~~is~~ 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: (Care Management/Administration) MHSD Professional Development Opportunities

A. What was achieved?

Throughout FY20 MHSD staff participated in ongoing workforce development and management that is in line with State, Civil Service and national accreditation standards (e.g., CARF). Examples of these mandatory trainings included, but are not limited to, State Employee Ethical Standards, Cultural Competence, HIPAA and Behavioral Health, Best Practices Delivering Telehealth, Understanding and Accepting our Differences - Implicit Bias, and Hand Hygiene. In addition to the above trainings, MHSD Executive Leadership made available two mandatory special topic trainings/workshops:

1. Service Provision to Special Populations: LGBTQ Community
2. Cyber Security: Protecting MHSD Against Cybercrime
3. Outreach and Prevention: Implementation of the Virtual Health and Wellness Outreach
4. Telehealth Training and Certification

B. Why is this success significant?
Effective workforce development and management promote engagement and organizational sustainability and foster 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.

D. How was the accomplishment achieved?
MHSD Executive Leadership tasked the Human Resource Department to notify MHSD staff of the various training offerings and to monitor staff's successful completion of the trainings.

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

YES

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

YES

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?

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 Telebehavioral 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. Due to COVID-19 social distances guidelines, outreach events and one-on-one prevention activities with at-risk substance use populations were severely curtailed in the 3rd and 4th quarters of FY20. Innovative and alternative methods to connect with the community have been and are being developed.

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 FY21.

- **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

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

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

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

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

4. Do corrective actions carry a cost?

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

regarding types and amounts of costs.

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

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

- A. Check all that apply and add comments to explain each methodology utilized.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Other (please specify):

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

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

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

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

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

1. Title of Report: **AP/Accountability Plan**
2. Date Complete: 8/12/2020
3. Subject/Purpose: To guide the delivery of addictive disorders (AD), Developmental Disabilities (DD), and Mental Health (MH) services funded by appropriations from the state.
4. Methodology: Site monitoring consisted of a joint OBH and OCDD Review team to include data reviews, chart audits, and interviews with staff.
5. Cost: Allocation of committed staff time to the process for the day.
6. Major Findings: none
7. Major Recommendations: none
8. Action taken: MHSD responded as needed in writing with a Plan of Correction (POC) to any major findings.
9. Availability: AP is available in hardcopy and electronic file; report file will be available in same format.
10. Contact person for more information, including
    Name: Rochelle Head-Dunham, M.D.
    Title: Executive Director/Medical Director
    Agency & Program: 09-304 Metropolitan Human Services District (MHSD)
    Telephone: 504-535-2909
    E-mail: Rochelle.Dunham@mhsdla.org

1. Title of Report: **Independent Financial Audit**
2. Date Completed: August 31, 2020
3. Subject/Purpose: Full independent audit of MHSD as an independent fiscal entity
4. Methodology: External audit firm selected by LLA and used standard audit approach including A-133 single audit
5. Cost: None
6. Major Findings: No findings – unqualified audit
7. Major Recommendations: No recommendations for MHSD
8. Action: MHSD has shared report with its Board and Leadership staff.

9. Availability: hardcopy and electronic format
10. Contact person for more information:

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

1. Title of Report or Program Evaluation: **MHSD Operations Risk Management Audit**
2. Date completed: March 19, 2020
3. Subject or purpose and reason for initiation of the analysis or evaluation Annual Audit/compliance review
4. Methodology used for analysis or evaluation Full site visits with auditor, sit down meeting with auditor to review required records.
5. Cost (allocation of in-house resources or purchase price) N/A
6. Major Findings and Conclusions scored: Pass 80.98%, status: compliant
7. Major Recommendations:
    - **Inspections:** Include bodily injury and/or property concerns in Investigative Procedures.
    - **Return to Work**: Conduct and document employee awareness/training within 90 days of hire with all new employees. Conduct and document employee awareness/training once every 5 years after initial employee awareness/training. Complete the DA WC4000 form each month and maintain a copy for the audit.
    - **Blood Borne Pathogens**: Conduct documented employee awareness training on bloodborne pathogens for all low risk employees at least once every 5 years after initial orientation training.
    - **Hazardous Materials**: Conduct and document an inspection/assessment of all buildings, grounds, vehicles and any other area of your site to determine if there are any hazardous materials present.
    - **Records and Forms**: Ensure DA 2054 forms that have been signed and dated annually are available on all authorized drivers. DA 2054 must be signed by ED within 45 days. Ensure ODR's reviewed annually are available on all authorized drivers. Complete a DA 2041 for each vehicle accident and maintain a copy for the audit.
    - **Equipment Management Program**: Develop a current, specific inventory of all applicable program equipment (mechanical and electrical) that includes the name of the equipment, location, model number and serial number. Maintain and have available preventive

maintenance documentation for mechanical equipment. Develop a written Lockout/Tagout Program.

- **Elevators and Fire Service Key/Equipment Room**: Write procedures outlining availability of the fire service key including a listing of personnel assigned the responsibility of the fire service key and the procedures to ensure the fire service key is provided to the local fire department or that the key is readily accessible upon their arrival. Provide documentation that the fire service key is provided to the designated employee.
- **Bonds, Crime and Property**: Develop written procedures to address reporting losses/damages to the correct Claims unit within a timely manner.

8. Action taken in response to the report or evaluation:
    - **Inspections**: Change verbiage in Risk/Safety Plan to include procedures for bodily injury and/or property concerns.
    - **Return to Work**: During orientation, new hires are informed of the TRW Policy. System set up for reminder of 5 year training for all employees. Completion of DA WC4000 form put into action monthly.
    - **Blood borne Pathogens**: low Risk employees to receive copy of policy that they will sign off on receiving every 5 years.
    - **Hazardous Materials**: MHSD has no Hazardous Materials, so we are allowed to put on MHSD letterhead a statement saying "A site assessment found no hazardous materials at the facility" Must be placed in binder for ORM to see when they visit.
    - **Records and Forms**: Have authorized signatures, and appropriate date annually on DA 2054 forms. Run ODR's same time every year.
    - **Equipment Management Program**: Facilities Department to update ALL equipment and inventory. Have information on each piece of equipment and where it's housed. Since MHSD does not do LO/TO (our contractors do) Facilities Department is to obtain LO/TO procedures for each contractor that services MHSD. Must have statement in binder on letterhead saying that we don't do LO/TO with contractor LO/TO procedures attached.
    - **Elevators and Fire Service Key/Equipment Room**: Facilities knows where the fire key is for CP, we've never had a fire key for CC. Statement in binder on letterhead should say such, and document who knows where the key is at CP.
    - **Bonds, Crime and Property**: Include a statement in policy that speaks to specific property and negotiable items.
9. Availability (hard copy, electronic file, website): Hard copy, and electronic file.
10. Contact person for more information:

    Name: Rochelle Head-Dunham, M.D.
    Title: Executive Director/Medical Director

Agency & Program: 09-304 Metropolitan Human Services District (MHSD)
Telephone: 504-535-2909
E-mail: Rochelle.Dunham@mhsdla.org

Annual Management and Program Analysis Report
Fiscal Year 2019-2020

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**
Assistant Secretary:	**Tara LeBlanc** Interim Medicaid Director

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

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

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

Accomplishment #1: Operationalized the use of federal tax information (FTI) in post-eligibility determinations

A. What was achieved?
Louisiana Medicaid started using the Internal Revenue Service (IRS) interface available through the Centers for Medicare and Medicaid Services (CMS) to conduct post-eligibility determinations for a portion of the Medicaid population. The process compares self-attested income data reported on Medicaid applications to Federal Tax Information

(FTI) reporting on annual tax filings.

B. Why is this success significant?
This accomplishment aligns with the agency's Medicaid Eligibility Determination and Enrollment strategic plan to maximize the use of data and technology to produce efficiencies that facilitate the (re)enrollment of eligible individuals and ensure program integrity. This implementation also mitigates Louisiana Legislative Auditor (LLA) findings related to eligibility controls and establishes compliance with House Bill No. 1 for Fiscal Year 2018-2019.

C. Who benefits and how?
The State of Louisiana, including its taxpayers and CMS benefit from this implementation because it helps ensure individuals receiving Medicaid coverage are eligible for the program, which is funded by State and Federal budget.

D. How was the accomplishment achieved?
This accomplishment was achieved by implementing technical systems and infrastructure needed to exchange and utilize the IRS data for Medicaid eligibility determinations. The resulting information is sent to a specialized operations team that has been trained and background checked to IRS specifications to handle and review the data. This required a new work site to be established along with operational processes and procedures.

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

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

Accomplishment #2: Third party liability recoveries total $12.4 million for Louisiana's Medicaid fee-for-service and managed care populations

A. What was achieved?
Third party liability (TPL) recoveries represent dollars collected by Louisiana Medicaid through its contractor, HMS Holdings Corporation, from private insurance companies or from providers for services originally paid for by fee-for-service (FFS) Medicaid. These recoveries occur when HMS determines the member had private insurance at the time of the service after Medicaid paid for their service. Traditional recoveries combined with disallowances and credit balance audits totaled $2.5M in recovered dollars for FFS Medicaid for SFY 20. Additionally, beginning in SFY 20, recoveries include dollars recouped from private insurance companies or from providers for services originally paid for by a Medicaid member's managed care organization (MCO) when the MCO discovered the member had private insurance. MCOs have one year from the service date of the claim to recoup any payments made for that member the private insurance should

have covered. After the one-year period, Medicaid, through its contractor HMS, can pursue the recovery. The MCO Come Behind process totaled $9.9M in recoveries for SFY20.

B. Why is this success significant?
The implementation of the MCO Come Behind ensures that Louisiana Medicaid is pursing all recoveries for all members. Its implementation in SFY 20 drastically increased the states' recoveries for TPL.

C. Who benefits and how?
Louisiana Medicaid benefits from a robust TPL recovery program as it ensures Medicaid remains the payor of last resort when other insurance is responsible for payment of a claim. The state and taxpayers benefit from this accomplishment as it demonstrates Louisiana Medicaid is being a good steward of public dollars.

D. How was the accomplishment achieved?
As detailed in A, this accomplishment was achieved via the TPL recovery process for FFS Medicaid and the implementation of the MCO Come Behind Process in SFY 20.

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

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

Accomplishment #3: New Fiscal/Employer Agent contractor for the Self-Direction program

A. What was achieved?
Self-direction provides waiver participants the ability to serve as their own employer and to choose the people they want to provide supports for them. Medicaid's contracted Fiscal/Employer Agent (FEA) serves as the intermediary between self-direction families and Medicaid and manages employee enrollment, payroll, and filing of Medicaid claims on behalf of the employer/family. Previously under the self-direction option, Medicaid contracted with a single FEA. Medicaid released a Request for Proposals (RFP) for its FEA services on April 2, 2019. After an intensive evaluation and scoring process of the proposals, Medicaid awarded contracts to two FEAs: Acumen Fiscal Agent and Morning Sun Financial Management.

B. Why is this success significant?
Awarding two FEA contracts offers each Medicaid self-direction participant/family the right to choose the FEA that is most qualified to meet their needs. Choice of providers also encourages competition among the FEAs, which helps to ensure a higher level of

customer service and quality for participants.

C. Who benefits and how?
Medicaid waiver participants benefit from utilizing the self-direction service delivery option because it allows participants to become the employers of the people they choose to hire to provide supports for them. This is important because some of the state's most vulnerable individuals (e.g., children with developmental disabilities and the elderly) participate in this program and, through this participation, they are able to select and maintain workers that are best suited to meet their personalized care needs. There are currently over 2,600 waiver participants that take advantage of this option to self-direct their services.

D. How was the accomplishment achieved?
Previously, Medicaid contracted with a single FEA to oversee the fiscal and employer functions of the self-direction program. When it was time to release a new RFP, Medicaid reached out to other states with similar self-direction programs to examine best practices. There was a decision rendered to allow Medicaid the option of contracting with multiple FEAs should the outcome of the RFP evaluation warrant awards to multiple vendors. Following announcement of the awards, Medicaid convened a multi-agency workgroup and embarked upon a six-month work plan to ensure a smooth transition with the new FEA contractor.

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

F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes, whenever possible allowing for choice encourages contractors and providers to compete for their clients, which lends to a higher level of customer service and overall quality of service.

Accomplishment #4: Quick Expansion of Medicaid telehealth services during COVID-19 public health emergency

A. What was achieved?
Louisiana Medicaid responded quickly to the COVID-19 public health emergency by rapidly expanding coverage and utilization of telehealth services. Once the Office for Civil Rights at the United States Department of Health and Human Services (HHS) announced flexibilities related to telehealth remote communications during COVID-19, Medicaid quickly expanded its existing telehealth coverage policy to include additional modalities and services, including:

- Allowance for telehealth via an audio-only system
- Allowance of telehealth using everyday technology (i.e., disseminating information about the federal waiver of HIPAA)

- Expansion of telehealth coverage for physical therapy, occupational therapy, and speech/language therapy
- Expansion of telehealth coverage for applied behavioral analysis
- Expansion of telehealth coverage for well-child visits
- Expansion of telehealth for triaging dental issues to determine whether in-person emergency dental attention is required

B. Why is this success significant?
Louisiana was one of the earliest states severely affected by COVID-19 and, at one point, had the fastest growing outbreak than any other region in the world.

C. Who benefits and how?
All Medicaid beneficiaries who accessed these expanded telehealth benefits benefitted because they received critical healthcare services during the public health emergency. Medicaid providers also benefitted from the promotion and expansion of telehealth as it provided them with an ability to maintain a relationship with their patients while at the same time providing a revenue stream for their practice at time where face-to-face interactions were limited. This revenue stream was critical to some providers' ability to maintain their practice and ensure a provider network available for beneficiaries post-pandemic.

D. How was the accomplishment achieved?
Fast and collaborative work by Medicaid clinical leadership and the Medicaid benefits, provider relations, and policy teams accomplished this achievement.

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

Accomplishment #5: Medicaid Recipient Fraud Investigative Unit (MRFIU) referrals and cost savings

A. What was achieved?
The Medicaid Program Integrity MRFIU submitted 1695 referrals to local law enforcement (the Attorney General's [AG] Office) to further investigate Medicaid recipients who were determined to have received Medicaid eligibility falsely. The MRFIU also identified $3,778,167 of cost savings per member per month (PMPM) capitation payments paid to the Medicaid MCOs. This cost savings represents the amount of PMPM from payments to the MCOs from the time the MRFIU determined a recipient was ineligible to the recipient's next renewal date.

B. Why is this success significant?
This accomplishment is significant because identifying recipients receiving Medicaid benefits falsely saves Medicaid and the state taxpayer dollars.

C. Who benefits and how?
Medicaid benefits by maximizing services for those who are eligible and truly in need. It also benefits the taxpayers of Louisiana from having to pay more to provide services to those that are not eligible.

D. How was the accomplishment achieved?
The Unit established in 2018 focuses on fraudulent recipient eligibility. The MRFIU works closely with Medicaid eligibility and the AG to identify cases to refer to the AG.

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

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

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

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

<u>Accomplishment #1: Operationalized the use of federal tax information (FTI) in post-eligibility determinations</u>

Implementing the use of FTI as an additional data source for use in the eligibility determination process does achieve progress towards the compliance, goals, and strategies for Program A: Medical Vendor Administration however, the unique restrictions surrounding the use of FTI create operational constraints that are difficult to navigate. More time is necessary to understand the effectiveness and return on investment this implementation yields.

<u>Accomplishment #2: Third party liability recoveries total $12.4 million for Louisiana's Medicaid fee-for-service and managed care populations</u>

Third party liability recoveries, including the implementation of the MCO Come Behind in SFY 20, continuously ensure that Louisiana Medicaid remains the payor of last resort. This accomplishment ties directly to Activity 3 - Financial Management of the Strategic Plan.

Accomplishment #3: New Fiscal/Employer Agent contractor for the Self-Direction program

The contract for the second FEA agency began January 1, 2020 and will run concurrently with the other FEA contract for three years. Providing a choice of FEAs for the self-direction program is promoting a best practice model when providing services to the Medicaid population. By allowing choice, Medicaid is increasing the likelihood of greater participant satisfaction.

Accomplishment #4: Quick Expansion of Medicaid telehealth services during COVID-19 public health emergency

Louisiana Medicaid's rapid response to the COVID-19 public health event by expanding coverage and utilization of telehealth contributed to the success of the following section of the department's strategic plan: 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.

Accomplishment #5: Medicaid Recipient Fraud Investigative Unit (MRFIU) referrals and cost savings

The MRFIU is on target related to their goals and objectives as stated in Activity 4-Program Integrity, Objective IV: Through the Program Integrity Activity, identify and review recipient eligibility.

- **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 #2: Third party liability recoveries total $12.4 million for Louisiana's Medicaid fee-for-service and managed care populations

The implementation of the MCO Come Behind marks significant progress in Louisiana Medicaid's pursuit to identify and recover all dollars expended for Medicaid members who had other primary health insurance. Now that it is in place, Medicaid will continue to identify and collect recoveries from this process. The current success has been a collaborative effort between Medicaid Enterprise Systems (MES) and contractor HMS.

Accomplishment #3: New Fiscal/Employer Agent contractor for the Self-Direction program

The self-direction program continues to grow; providing a choice of FEA agencies enhances this option. Significant progress occurred by providing a choice of FEA contractors that enables participants to select the provider that best meets their needs. The new FEA contractor for the self-direction program is performing better than expected by exceeding its goals and objectives. Much of the success is attributed to a clean transition facilitated by Medicaid, ensuring program deliverables and expectations were clear. Medicaid has noted increased enrollment month-to-month for the new contractor, which suggests their entry into Louisiana's self-direction program was successful.

Accomplishment #4: Quick Expansion of Medicaid telehealth services during COVID-19 public health emergency

Medicaid is making significant progress expanding telehealth coverage in response to COVID-19. Although the most significant progress occurred in a relatively short period, the agency expects to continue to revise policies to ensure that more telehealth options continue to be available throughout the public health emergency and beyond. The current success has been a collaborative effort between Medicaid program operations and compliance and policy teams and CMS.

Accomplishment #5: Medicaid Recipient Fraud Investigative Unit (MRFIU) referrals and cost savings

The MRFIU is new; this was its first full fiscal year of operation. The MRFIU was able to achieve these results through excellent organizational and planning by management. The MRFIU had a large inventory of cases to review with the MRFIU being in place prior to FY 20. The results of the referrals may be higher than usual; however, it is the expectation that the cost savings will be as high or possibly higher in future years as the MRFIU prioritizes resources and cases.

- **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: Operationalized the use of federal tax information (FTI) in post-eligibility determinations

There are several factors contributing to a lack of progress including potentially better operational options for data sources, competing priorities, budget constraints, and the current hiring freeze. Louisiana Medicaid uses several other data sources to verify information outside of FTI so prioritizing the use of FTI above other priority items to pursue agency goals and objectives may not result in the highest return on investment.

Strategic planning for staffing and workspace are needed to handle current workload given current COVID-19 public health emergency, as well as support future system enhancements to increase logic that is expected to increase workload. Technical support is needed to operationalize work from home options which can help mitigate staffing and workload constraints due to current in-office requirements (Bienville building only) to access the data. A recent IRS audit also resulted in several critical technical findings that require resolution from the Office of Technology Services, which is experiencing staffing constraints to handle the multiple findings across several agencies, in addition to Medicaid.

- **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: Operationalized the use of federal tax information (FTI) in post-eligibility determinations

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

The Strategic Plan for Medicaid Eligibility Determination and Enrollment continues to be necessary in many other efforts outside of operationalizing the use of FTI and therefore does not require a revision to the Strategic Plan.

Accomplishment #2: Third party liability recoveries total $12.4 million for Louisiana's Medicaid fee-for-service and managed care populations

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

The Strategic Plan states that the purpose of establishing and maintaining an effective collections/recovery and cost avoidance program is to reduce Medicaid expenditures and improve program integrity. Monitoring of third party liability (TPL) claims processing enables the Department to enforce that Medicaid is the payer of last resort. Maximizing recoveries result in the most efficient use of Medicaid funds. This accomplishment ties directly to this purpose and does not require revision to the Strategic Plan.

Accomplishment #3: New Fiscal/Employer Agent contractor for the Self-Direction program

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

No strategic plan revision is necessary for this accomplishment.

Accomplishment #4: Quick Expansion of Medicaid telehealth services during COVID-19 public health emergency

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

No strategic plan revision is necessary for this accomplishment.

Accomplishment #5: Medicaid Recipient Fraud Investigative Unit (MRFIU) referrals and cost savings

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

No strategic plan revision is necessary for this accomplishment.

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

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

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

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

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

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

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

1. What is the nature of the problem or issue?
   The nature of the problem or issue is under-resourcing due to budget/staffing constraints that continue to grow year over year, and even more so during the current COVID-19 public health emergency.

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

3. What organizational unit in the department is experiencing the problem or issue?
   The agency is limited to a certain number of staff that remains stagnant, unable to expand resources to support program growth due to state budget constraints, and often unable to recruit viable candidates because salaries are not competitive with the commercial and private sectors. All of this leads to a lean workforce and shallow resource pool.

   Further, we are now reducing contract budgets to address state budget shortfalls, many of which are staff augmentation contracts that Medicaid relies on to help fill the resource gaps due to internal/civil service limitations.

   Lastly, Civil Service constraints on Medicaid result from restricting hiring to the program manager series. Medicaid is in itself a singular program. It is the largest state budget and has evolved beyond the program manager series due to its complexity and expansive federal regulations. To assume that all staff will manage individual programs within the Medicaid framework is not practical. Rather, they manage complex facets of the overall program. For example, we require the skillset of data analysts/scientists to comply with federal and state reporting requirements and to identify areas to advance the program along with national initiatives and other states (e.g., health outcomes, utilization trends, expenditure forecasting, etc.); however, it is a challenge to recruit data scientists/required skill sets because we must fit them into the salary and job constraints of the program manager series. These types of specialized skillset require their own job series. Medicaid continues to work with Civil Service to address these challenges.

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

Providers and Medicaid recipients are affected by our inability to recruit key vacancies. For example, this has led to deficits in provider network management and provider relations staff along with encounter/claims oversight, creating additional burden on providers seeking redress of payment issues. Another example is the ongoing LaMEDS implementation. With high turnover and many vacancies, Medicaid technology resources are limited and cannot always keep up with the pace of implementation and maintenance that is required to bring the new system into contract compliance.

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

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

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   LDH is unable to adequately support program growth and meet federal compliance requirements, and this increases provider and Medicaid member abrasion.

B. Corrective Actions

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

   ☒ No. If not, skip questions 2-5 below.
   ☐ 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 and add comments to explain each methodology utilized.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Title of Report or Program Evaluation
2. Date completed
3. Subject or purpose and reason for initiation of the analysis or evaluation
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions
7. Major Recommendations
8. Action taken in response to the report or evaluation
9. Availability (hard copy, electronic file, website)
10. Contact person for more information, 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 2020
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 2017 who were born premature at less than 37 weeks gestational age and are in their first six months of life is 4.85 percent. The calendar year 2016 re-hospitalization rate was 4.79 percent. This indicates that the re-hospitalization rate in this group of newborns has remained fairly stable over the past two reporting years.
7. Major Recommendations: (Not Applicable)
8. Action taken in response to the report or evaluation: (Not Applicable)
9. Availability (hard copy, electronic file, website): https://ldh.la.gov/index.cfm/newsroom/detail/2928
10. Contact person for more information, including:
    Name: Jen Katzman
    Title: Senior Staff Advisor to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-5166
    Email: Jennifer.Katzman@LA.GOV

Report # 2

1. Title of Report or Program Evaluation: **Louisiana Medicaid Diabetes and Obesity Report**
2. Date completed: June 2020
3. Subject or purpose and reason for initiation of the analysis or evaluation: Per Louisiana Revised Statute (RS) 46:2616 and RS 46:2617, the Louisiana Department of Health (LDH) is required to submit an annual diabetes and obesity action plan to the Senate and House Committees on Health and Welfare after consulting with, and receiving comments from, the medical directors of each of its contracted Medicaid partners.
4. Methodology used for analysis or evaluation: Each Medicaid managed care plan is required to complete a template that requests data designed to meet requirements of RS 46:2617. The template consists of 12 reports that gather diabetes and obesity prevalence and utilization within each plan to address diabetes and obesity items in RS 46:2617. The resulting 60 reports 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. Seek legislative appropriation of funds for a new Medicaid covered service to allow Medicaid recipients to receive nutritional consultations and services provided by registered dietitians.
    b. Encourage the use of outpatient nutritional services provided by registered dietitians for all patients and all diagnoses, not just those diagnosed with diabetes and obesity.
    c. Promote the use of diabetes self-management education (DSME) programs or incorporate elements of these programs into case management activities for patients diagnosed with diabetes. DSME programs have been associated with improved health outcomes for patients diagnosed with diabetes.
    d. Implement reforms in the education system aimed at improving diabetes and obesity outcomes in Louisiana.
8. Action taken in response to the report or evaluation: (Not Applicable)
9. Availability (hard copy, electronic file, website): https://ldh.la.gov/index.cfm/page/2115
10. Contact person for more information, including:
    Name: Jen Katzman
    Title: Senior Staff Advisor to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-5166
    Email: Jennifer.Katzman@LA.GOV

Report # 3

1. Title of Report or Program Evaluation: **Medicaid Managed Care Quarterly Transparency Reports SFY 2020**
2. Date completed: March 2020, May 2020, July 2020
3. Subject or purpose and reason for initiation of the analysis or evaluation: In response to ACT 482 of the 2018 Regular Legislative Session, the Louisiana Department of Health (LDH) is required to submit the Medicaid Managed Care Quarterly Transparency report.
4. Methodology used for analysis or evaluation: Compilation of specified monthly and quarterly data on Medicaid Expansion Program and Medicaid Managed Care Pharmacy Benefits Manager revenues.
5. Cost (allocation of in-house resources or purchase price): Compiled by internal staff.
6. Major Findings and Conclusions: (Not Applicable)

7. Major Recommendations: (Not Applicable)
8. Action taken in response to the report or evaluation: (Not Applicable)
9. Availability (hard copy, electronic file, website):
   https://ldh.la.gov/index.cfm/newsroom/detail/5061
10. Contact person for more information, including:
    Name: Jen Katzman
    Title: Senior Staff Advisor to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
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Report # 4

1. Title of Report or Program Evaluation: **Medicaid Managed Care Transparency Report**
2. Date completed: June 2020
3. Subject or purpose and reason for initiation of the analysis or evaluation: This report is the seventh in a series produced by the Louisiana Department of Health (LDH) to satisfy statutory reporting requirements intended to ensure certain outcomes achieved by Medicaid Managed Care Programs as per La Revised Statute 40:1253.2.
4. Methodology used for analysis or evaluation: To the greatest extent possible, the data are extracted from state systems that routinely collect and maintain operational data on the Medicaid Managed Care Program, the Medicaid Management Information System (MMIS), Management Administrative Reporting Subsystem (MARS Data Warehouse or MDW), or ISIS the state administrative system. When unavailable from state sources, data were collected from the managed care entities or sourced from either routine reporting deliverables or ad hoc reports requested specifically for this purpose.
5. Cost (allocation of in-house resources or purchase price): Compiled by internal staff
6. Major Findings and Conclusions: (Not Applicable)
7. Major Recommendations: Not Applicable
8. Action taken in response to the report or evaluation: (Not Applicable)
9. Availability (hard copy, electronic file, website):
   https://ldh.la.gov/index.cfm/newsroom/detail/5716
10. Contact person for more information:
    Name: Jen Katzman
    Title: Senior Staff Advisor to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
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    Email: Jennifer.Katzman@LA.GOV

Report # 5

1. Title of Report or Program Evaluation: **Healthy Louisiana Claims Report**
2. Date completed: October 2020, February 2020, June 2020
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: Not Applicable
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 2018 forward.
9. Availability (hard copy, electronic file, website): https://ldh.la.gov/index.cfm/newsroom/detail/4894
10. Contact person for more information:
    Name: Jen Katzman
    Title: Senior Staff Advisor to the Medicaid Director
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Report # 6

1. Title of Report or Program Evaluation: **LaCHIP Annual Report**
2. Date completed: June 2020
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: 189,761 children and pregnant women have acquired access to critical healthcare coverage in SFY 2020.
7. Major Recommendations: (Not Applicable)
8. Action taken in response to the report or evaluation: (Not Applicable)
9. Availability (hard copy, electronic file, website): https://ldh.la.gov/index.cfm/newsroom/detail/2238
10. Contact person for more information:
    Name: Jen Katzman
    Title: Senior Staff Advisor to the Medicaid Director
    Agency & Program: Bureau of Health Services Financing (Medicaid)
    Telephone: 225-342-5166
    Email: Jennifer.Katzman@LA.GOV

Report # 7

1. Title of Report or Program Evaluation: **Evaluating the potential delivery of** Medicaid- funded non-emergency transportation services by transportation network companies.
2. Date completed: March 2020
3. Subject or purpose and reason for initiation of the analysis or evaluation: As directed by HCR 89 of the 2019 Regular session, the Louisiana department of Health (LDH) examined the impact of transportation network company (TNC)
4. Methodology used for analysis or evaluation: Not Applicable.
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:
    a. Identify and define a plan to resolve major safety and compliance issues prior to the implementation of TNC services.
    b. Determine the Medicaid population for TNCs to serve, any limitations to the type and volume of services, and the projected fiscal impact.
    c. Evaluate the corresponding effect on the traditional network of NEMT providers in the state.

d. Consider implementing a TNC pilot program for a subset of the Louisiana Medicaid population prior to a full-scale rollout.

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/HCR89322020.pdf
10. Contact person for more information:
    Name: Jen Katzman
    Title: Senior Staff Advisor to the Medicaid Director
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Report # 8

1. Title of Report or Program Evaluation: **Medicaid Pharmacy Comprehensive Plan**
2. Date completed: March 2020
3. Subject or purpose and reason for initiation of the analysis or evaluation: In accordance with Act 263 of 2019 Regular Session, the Louisiana Department of Health (LDH) developed a comprehensive plan to administer the Medicaid prescription drug program.
4. Methodology used for analysis or evaluation: LDH engaged Mercer Government Human Services Consulting (Mercer) to develop the plan.
5. Cost (allocation of in-house resources or purchase price): Compiled by Mercer staff; falls within scope of work of contract.
6. Major Findings and Conclusions: The LDH Pharmacy program continues to administer the Medicaid prescription drug program in the most clinically effective and cost efficient manner possible.
7. Major Recommendations: (Not Applicable)
8. Action taken in response to the report or evaluation: LDH will utilize the information presented to move forward with administering the Medicaid Pharmacy program and will continue implementation of a Single preferred drug list (PDL).
9. Availability (hard copy, electronic file, website): https://ldh.la.gov/assets/docs/LegisReports/ACT263RS2019C392020.pdf
10. Contact person for more information:
    Name: Jen Katzman
    Title: Senior Staff Advisor to the Medicaid Director
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Report #9

1. Title of Report or Program Evaluation: **Medicaid Forecast Report SFY 19/20**
2. Date completed: May 20, 2020
3. Subject or purpose and reason for initiation of the analysis or evaluation: Provide a comprehensive overview of Medicaid spending, including projections for future revenues and expenditures for the state fiscal year.
4. Methodology used for analysis or evaluation: Program staff develops budget projections based on utilization trends, enrollment trends, and other known factors affecting the management of the Medicaid program. Actual year-to-date expenditures come from the Medicaid Data Warehouse and ISIS.
5. Cost (allocation of in-house resources or purchase price): Compiled by in-house staff
6. Major Findings and Conclusions: (Not Applicable)
7. Major Recommendations: (Not Applicable)
8. Action taken in response to the report or evaluation: (Not Applicable)
9. Availability (hard copy, electronic file, website): https://ldh.la.gov/index.cfm/newsroom/detail/5359
10. Contact person for more information:
    Name: Jen Katzman
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Report #10

1. Title of Report or Program Evaluation: **Medicaid Year-End Financial Report**
2. Date completed: December 2019
3. Subject or purpose and reason for initiation of the analysis or evaluation: Provide a comprehensive overview of Medicaid spending.
4. Methodology used for analysis or evaluation: Expenditure data comes from the Medicaid Data Warehouse and ISIS.
5. Cost (allocation of in-house resources or purchase price): Compiled by in-house staff
6. Major Findings and Conclusions: (Not Applicable)
7. Major Recommendations: (Not Applicable)
8. Action taken in response to the report or evaluation: (Not Applicable)
9. Availability (hard copy, electronic file, website): https://ldh.la.gov/index.cfm/newsroom/detail/5377
10. Contact person for more information:
    Name: Jen Katzman
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Annual Management and Program Analysis Report
Fiscal Year 2019-2020

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

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

Undersecretary: **Ruth Johnson**

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

Accomplishment #1: Successful Completion of CMS & State Performance Standards:

A. What was achieved?

The Health Standards Section (HSS) achieved 100% successful completion of State Performance Standards and the Centers for Medicare and Medicaid Services (CMS) Performance Standards. The State Performance Report that is reported to CMS every year indicates a full explanation of the criteria by which each state is to follow in order to achieve compliance with the varied levels of priorities. This is completed by CMS at the end of each federal fiscal year. CMS obtains a complete workload report of all activities completed during each year and evaluates those accomplishments based upon the criteria established in the Mission Priority Document (MPD). The MPD sets forth the percentage of work that must be completed for each tier priority and the workload reports verify that such was completed. CMS also pulls samples of the documentation presented in conjunction with onsite reviews to determine that the documents fully comply with the established principles of documentation. The state of Louisiana was the only state in Region 6 to fulfill this requirement. In addition, there were no recommendations for improvement.

B. Why is this success significant?

This achievement is significant because it exemplifies the high standards and qualifications of field staff to ensure safe delivery of care provided by healthcare facilities and other providers licensed/certified by LDH's Health Standards Section.

C. Who benefits and how?

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

D. How was the accomplishment achieved?

We attribute our success and progress to the concerted and ongoing efforts provided by the HSS staff, who continuously work to implement and establish standardize processes across all programs. HSS has been re-focused to utilize all available electronic processes to improve efficiencies. This forward thinking progress and utilization of available technology has contributed to increased accountability, enhanced training and communication and has created an open dialogue to problem solve and identify concerns and resolutions thus contributing to the consistency in the survey process. HSS will avail the use of When Actually Employed (WAE) workers who are previous survey staff, retired, and now seeking to work on an as needed, no benefits basis. Currently, this section has and continues to seek out all access to affordable technology that will improve access for the public and providers. The established efficiencies from the electronic processes has increased the ability to identify opportunity for improvements, submit reports timely, and increase attention to problem solve more efficiently and timely.

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

Yes. It is critical to update training protocols on a continuous basis, as laws and regulations both on the State and Federal levels continue to evolve and require training for each provider type surveyed by the HSS staff.

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

No. However, HSS strives to be on the forefront of best practices. As an active partner with sister agencies (the Office for Citizens with Developmental Disabilities, the Office for Aging and Adult Services, and the Office of Behavioral Health), HSS is dedicated to finding the most effective and practical solutions for optimal use of resources afforded by the Department.

Accomplishment #2: Successful Online Physical Activity and Nutrition Challenges:

A. What was achieved?

The Bureau of Minority Health Access and the Louisiana Governor's Council on Physical Fitness and Sports hosted three online wellness challenges:

1. Conquering Covid-19 Steps Challenge (statewide)

2. National Senior Games Association Wellness Challenge (nationwide)
3. Louisiana Highway Safety Commission Challenge (nationwide)

B. Why is this success significant?

During the COVID-19 pandemic, medical experts confirmed the best ways to fight the coronavirus are to be physically active, eat healthy and avoid too much stress. These challenges address all three.

C. Who benefits and how?

Adults benefited the most because athletic gyms closed and participants were encouraged to exercise in their neighborhoods or at home per federal and state quarantine guidelines. In addition, these challenges allowed members to develop pen pals online and encourage one another across the country.

D. How was the accomplishment achieved?

Participants could sign up online at oyohla.com to enter their steps, log their fruit and vegetable intake, and access online coaches and nutritionists.

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

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

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

Yes, this accomplishment represents a Best Management Practice as it demonstrates successful collaboration with community partners. Many state agencies across the state participate in or create their own wellness challenges utilizing the Own Your Own Health platform free of charge.

Accomplishment #3: Initial Implementation of the LDH's First Health Equity Strategic Plan:

A. What was achieved?

We achieved the development and initial implementation of the Louisiana Department of Health's first health equity strategic plan - *LDH Phase I Health Equity Plan* via the Office of Community Partnerships & Health Equity (OCPHE).

B. Why is this success significant?

Health disparities and inequities are commonplace in Louisiana. From COVID-19, COPD, cancers, HIV/STIs, HPB, obesity, heart disease and other morbidities, many or

most of Louisiana's differences in health outcomes happen because of social determinants of health (SDoH). SDoH are social or economic factors that contribute to people, populations, and communities' health outcomes (e.g., where people live, work, and play). Health equity principles, best practices, and overall quality assurance standards support improved health outcomes by aiding entities and organizations in better understanding and thus responding to the needs of the people, populations, and communities LDH serves. The LDH Phase I Healthy Equity Plan operationalizes agency-wide protocols and practices that support and ensure (in each program office) that the 10 Essential Public Health Services are executed: https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html. The LDH Phase I Healthy Equity Plan requires uniform health equity practices and protocols from each program. The plan can be seen here: https://ldh.la.gov/assets/cphe/Equity_Framework.pdf .

C. Who benefits and how?

LDH customers (i.e., Louisiana citizens utilizing LDH program and services) and staff benefit from the LDH Phase I Healthy Equity Plan. The plan provides guidance and support that builds LDH staff's capacity to achieve the 10 Essential Public Health Services. There are seven key action steps within the plan that speak to *how* the plan benefits staff and customers. Three key *hows* are highlighted below:

- OCPHE develops and recommends training and workshops to develop staff's understanding and application of health equity, cultural competency, and barriers to health. SDoH approaches best practices within their respective work (in all six program offices):
  - LDH State Facilities
  - Office of Public Health
  - Office of Behavior Health
  - Office of Aging and Adult Services
  - Medicaid
  - Office for Citizens with Developmental Disabilities

- All six program offices are required to and have created health equity action teams (HEAT). Meeting on a monthly bases, each HEAT will examine data and information related to health disparities, health inequities of their target people, populations, and communities (PPC), while also reviewing their target PPC's SDoH. Each HEAT will use its information to a) make real-time policy, program, or service recommendations to the HEAT's respective office leadership and b) develop an aligning 12-month work-plan to guide their process of meeting their self-identified health equity deliverable.

- All program offices adhere to the LDH Phase I Healthy Equity Plan's Community Engagement Framework (CEF; pages 15 – 30 of the plan). Effective community engagement is a crucial component of improving health outcomes and supports reductions in health disparities. Thus, the CEF provides community engagement standards for LDH. Further, it also includes 21 action-steps, of which the program offices must select 11 to execute over 12 months. The CEF focuses on building

(agency-wide) LDH staff's capacity to engage people, populations, and communities by establishing equitable community engagement practices that support LDH in promoting health - access to medical, preventive, and rehabilitative services.

D. How was the accomplishment achieved?

In January 2019, OCPHE staff led the execution of several interagency assessment-activities. Also, a planning body of 34 LDH staff persons (i.e., the LDH HEAT Executive Committee) was developed and utilized to inform the planning, processes, strategies, action steps of the planning process, as well as the contents of the plan. Assessment-activities included surveying LDH staff via a cultural assessment tool (via a consultant), key informant interviews, and pseudo focus group activities with LDH staff. These initial assessments are centered around surveying and identifying LDH's operations, programming, and services, specific to culture and diversity. Later, health equity and social determinants of health assessments were executed. These assessments helped determine the degree of a) health equity awareness among LDH staff and b) the operationalization of health equity best practices agency-wide. After these assessments were completed, OCPHE staff compiled assessment findings into a report - *2019 Office of Community Partnerships & Health Equity Health Equity Assessment*: https://drive.google.com/file/d/124a3ZoGGEc_Sy2geNtaQS4ZwnUbiMymP/view?usp=sharing. The report informed the development of LDH's first health equity plan - *LDH Phase I Healthy Equity Plan*: https://ldh.la.gov/assets/cphe/Equity_Framework.pdf . The plan was finalized in December 2019 and approved in January 2020.

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

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

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

Yes, this accomplishment represents a Best Management Practice as it demonstrates successful collaboration with community partners.

Accomplishment #4: Minority Health Month Activities:

A. What was achieved?

During National Minority Health Month in April, the Louisiana Department of Health's Bureau of Minority Health Access and Promotions (BMHA) joined Louisiana Primary Care Association in raising public awareness about health and health care disparities that continue to affect racial and ethnic minorities and efforts to advance health equity. Minority Health activities are coordinated through federally qualified health centers across the state.

B. Why is this success significant?

The Minority Health Month Campaign advances health equity and reduces health disparities. The Campaign raised awareness about life- threatening illnesses and educated community members on how to access affordable, culturally competent health services, the first step to eliminate health disparities. During the 30-day campaign, Federally Qualified Health Centers partnered with community groups, faith-based organizations, regional and local health departments and other public and private entities to conduct events (i.e. health screenings, educational events, health fairs, etc.

C. Who benefits and how?

1. Racial and Ethnic groups, such as African Americans, Native Americans, Hispanic/Latino Americans, Asian Pacific Islanders and Disadvantage Whites.
2. Promote healthy lifestyles in their communities;
3. Provide crucial information to allow individuals to practice disease prevention;
4. Showcase the resources for and providers of grass roots health care and information;
5. Highlight the resolution of the disparate health conditions between Louisiana's minority and non-minority populations; and
6. Gain additional support for the ongoing efforts to improve minority health year round.

D. How was the accomplishment achieved?

Collaborated with Louisiana Primary Care Association and all Federally Qualified Health Centers (FQHCs) state wide.

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

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

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

Yes. State agencies across the state are involved in the initial planning for this campaign.

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. 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 can be used to assess its performance, the Department would be limited in its ability to make significant progress.

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

- **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:

  The Health Standards Section (HSS) achieved 100% successful completion of State Performance Standards and the Centers for Medicare and Medicaid Services (CMS) Performance Standards. This success is attributed to the concerted efforts provided by the HSS staff, who continuously work to establish standardized processes across all programs.

- **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?

Revisions were made to the strategic plan in FY19, and the plan is good through 2025. 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 Louisiana Department of Health Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for programs within the Office of the Secretary, other LDH agencies, and for some Local Governing Entities (LGEs). Each agency/LGE, with input from Executive Management, develops its own Operational Plan and Strategic Plan. Plans are then submitted to the Office of the Secretary for review and feedback. Recommendations are made directly to the Assistant Secretaries or the Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies review and evaluate performance during that fiscal year in order to determine if the information gained from this review should be used to improve strategic and operational planning, or program management operations.

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

("Problems or issues" may include internal concerns, such as organizational structure,

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

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

No department management or operational problems exist.

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

B. Corrective Actions
   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:

1. Title of Report or Program Evaluation:
   2019 Office of Community Partnerships & Health Equity Health Equity Assessment:
   https://drive.google.com/file/d/124a3ZoGGEc_Sy2geNtaQS4ZwnUbiMymP/view?usp=sharing

2. Date completed:
   August 2019

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   The report helped determine the degree of a) health equity awareness among LDH staff, b) the operationalization of health equity best practices agency-wide, and c) thus inform the content – strategies and action steps, within the *LDH Phase I Healthy Equity Plan*:
   https://ldh.la.gov/assets/cphe/Equity_Framework.pdf .

4. Methodology used for analysis or evaluation:
   - Surveys – health equity/SDoH and Intercultural Development Inventory (IDI),
   - key informant interviews,
   - pseudo staff focus groups,
   - Reports
     - Consultant IDI reports, findings
     - 2019 Office of Community Partnerships & Health Equity Health Equity Assessment – Summary Report

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

6. Major Findings and Conclusions:
   2019 Office of Community Partnerships & Health Equity Health Equity Assessment – Summary Report [key finding]:
   - Familiarity with the term "health equity": only 22% indicated a solid understanding
   - Familiarity with the term "social determinants of health:" only 39% indicated a solid understanding
   - How Offices' (i.e., offices, bureaus, divisions) work are advancing health equity: 50% tackling health equity (via voluntary training); 23% using resilience tactics & interventions; 46% enhancing capacity; 15% executing all tactics, interventions that address inequalities
   - Data collection: six agencies did not indicate racial demographic data were a priority or that it was collected or assessed
   - Community Outreach and follow-up: 20% indicated they either: never or rarely conduct follow up with community after services/resources are delivered
   - 47% of the Offices did not provide a clear indication of how they used demographic data to inform their work

7. Major Recommendation:
   Proceed with the implementation of the health strategic plan – its strategies and action steps

8. Action taken in response to the report or evaluation:
   Development and implementation of the LDH Phase I Healthy Equity Plan

9. Availability (hard copy, electronic file, website):
   - OCPHE website: https://ldh.la.gov/index.cfm/subhome/63
   - 2019 Office of Community Partnerships & Health Equity Health Equity Assessment: https://drive.google.com/file/d/124a3ZoGGEc_Sy2geNtaQS4ZwnUbiMymP/view?usp=sharing
   - LDH Phase I Healthy Equity Plan: https://ldh.la.gov/assets/cphe/Equity_Framework.pdf

10. Contact person for more information:
    Name: Dr. Earl N. Benjamin-Robinson, DrHSc
    Title: Deputy Director
    Agency & Program: Office of Community Partnerships & Health Equity
    Telephone: (225) 342-8490
    E-mail: Earl.Benjamin@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2019-2020

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

Department Head: **Dr. 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: Addition of Nutritional Services to Integrated Care Program:

A. What was achieved?

The South Central Louisiana Human Services Authority (SCLHSA) successfully integrated Nutritional Services as part of its Integrated Care (Behavioral Health and Primary Care) Program in FY20. The goal for adding this service was to improve and promote overall health within the general population. SCLHSA recognized the need for

patients to take care of both their physical and behavioral health needs. The mind and the body cannot be separated; symptoms and illness in one impacts the health of the other. Both physical health and behavioral health benefit from prevention efforts, screening tests, routine check-ups, nutritional review and treatment. Our philosophy of holistic care recognizes and respects the role of individuals and their families in the health care experience and we strive to provide our patients with person centered treatment that reflects their total mind and body needs. SCLHSA took this approach one step further in our CARF accredited Health Home by focusing on patients dietary habits, food/drug interaction and physical activity levels to help our patients in their pursuit of wellness and resilience.

B. Why is this success significant?

The Affordable Care Act of 2010, Section 2703 (1945 of the Social Security Act), created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for individuals with Medicaid who have chronic conditions. CMS expects state health home providers to operate under a "whole-person" philosophy. Health Homes providers are charged with integrating and coordinating all primary, acute, behavioral health, and long-term services and supports to treat the whole person. Adding nutritional services to this care model completes the picture and helps the patients to focus on the whole person.

C. Who benefits and how?

The patient is the beneficiary of an integrated approach to care. A Health Home (person-centered medical home or patient-centered medical home (PCMH)) is a care model that involves the coordinated care of individual's overall health care needs and where individuals are active in their own care. The SCLHSA Health Home offers coordinated care to individuals with multiple chronic health conditions, including mental health, substance use disorders, all internal medicine and disease management initiatives to include obesity, asthma, diabetes, etc. The Health Home is a team-based clinical approach that includes the patient, his or her providers, and family members, when appropriate. The Health Home builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses. Dietary Services help the patient focus on appropriate nutritional choices, food/drug interactions and physical activity to help round out the holistic spectrum.

D. How was the accomplishment achieved?

SCLHSA implemented Primary Care Services in 2014 as a way to service all of our patient needs in a “one-stop shop”. SCLHSA’s treatment philosophy is based on the recovery process. The goal of the Health Home process is to guide clients in understanding their potential to heal themselves by collaborating with the client, family members and other individuals. SCLHSA’s Health Home is responsible for

providing primary care and comprehensively addressing multiple areas of need including psychological, physical, vocational, social, financial, dietary and spiritual needs. The team consists of a primary care nurse practitioner, medical assistant, case manager and dietician along with the capability to consult with a psychiatrist (child or adult), registered nurse, psychologist, etc. at each site. This collaboration forms a supportive network enabling clients to make positive changes and manage their behavior in order to achieve their highest possible quality of life. Adding the dietician to the care team has allowed SCLHSA to work with both primary care and behavioral health patients in understanding their medication and food connections, develop healthy eating plans that have contributed to weight loss and the addition of physical exercise tips has also improved strength and energy in those patients in the program. Nutritional Services has seen approximately 2, 938 unique individuals and provided 6,166 services in this past year. Some of the results have been extraordinary with patients losing up to 70 pounds and being taken off some of the multiple medications they were on prior to treatment. Consults have been received from both of the primary care and behavioral health care providers in our agency. Adding this service to our care spectrum had added another layer in the continuum to recovery and resiliency for our patients.

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

The addition of Nutritional Services as part of our Health Home Model treatment protocol serves to emphasize the agency mission statement "To promote overall health within the general population by increasing public awareness and access for individuals with behavioral health and developmental disabilities to integrated primary care and community based services while promoting wellness, recovery and independence through education and the choice of a broad range of programmatic and community resources." Specifically, the Health Home Program coincides with the following objective of the SCLHSA Strategic Plan:

- To provide comprehensive services and supports which improve the quality of life and community participation for persons in crisis and/or with serious and persistent mental illness, emotional and behavioral disorders, addictive disorders, and/or developmental disabilities, while providing appropriate and best practices to individuals with less severe needs.

SCLHSA's Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that a patient's needs are addressed in a comprehensive manner. This is done primarily through a care manager who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual Health Home.

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

Patients can achieve both improved physical and behavioral health by concurrently addressing their expressed needs. For years, physical and mental health treatment has been provided in separate locations and systems. SCLHSA's Health Home is an evidence-based model that uses a person-centered approach developed from research supporting the integration of health care. Benefits include: Care Coordination; Health Promotion; Individual and Family Support; Referral to Community and Social Support Resources (if needed); Transitional care and Follow-up services from In-patient to other settings; Connection to Doctors and Counselors; Help understanding routine labs, testing and medication and Nutritional Services that address nutritional education, food/drug interaction and physical activity when considering the whole person. This total care concept will lead to a reduction in emergency room visits and hospitalizations costs of care by improving patient outcomes through treating patient's total health care needs.

Accomplishment #2: Implementation of OBOT/MAT Program:

A. What was achieved?

The South Central Louisiana Human Services Authority (SCLHSA) in collaboration with Louisiana State University Health Sciences Center- New Orleans (LSUHSC-NO) and the Louisiana Department of Health (LDH) Louisiana State Opioid Response (LaSOR) implemented an Office Based Opioid Treatment (OBOT) Program for qualifying individuals with an Opioid Use Disorder (OUD). This new Specialty Program for addictions patients in our seven parish catchment area gives them more options to choose from as part of their person centered treatment regimen. The program is evidenced based and gives SCLHSA an opportunity to diversify treatment from the normal abstinence taught in most addictions treatment formats. The main reason behind adding this new program was to increase affordable care options for our patient population. The underlying goal for the SCLHSA service expansion was access, affordability, and addressing the needs of our patients and filling gaps in key program areas in our agency and in the community. This program complements our existing treatment service array and gives an individual another option to choose to make their personal care plan more relevant and meaningful.

B. Why is this success significant?

The addition of a service to the SCLHSA program structure enhances the agency's work product and the quality service delivery provided to our clients on a daily basis. Service additions are also important because they are developed from input with other community providers in our catchment area that identified needs and approached our agency about ways to help fill identified service voids. Because of this program addition, SCLHSA will

also be able to better maximize reimbursement from payer sources such as the Statewide Management Organization (SMO, and other community partners such as the Sheriff's Office, Public School Systems, District Attorney's Office, and the Court system. Additionally, any new program affords SCLHSA the opportunity to initiate some fee for service codes for private pay that meet community needs in the school system and with the judicial system and address one of our Strategic Goals to increase the fiscal integrity of our agency.

C. Who benefits and how?

The SCLHSA clients benefit by receiving outpatient services that are evidenced-based and represent best practices for treatment/services delivery, client satisfaction, and performance improvement. Medication Assisted Treatment (MAT) is the use of medication in combination with counseling and behavioral therapies to provide a 'whole-patient' approach to the treatment of substance use disorders. MAT is not substituting one drug for another. Instead, medications relieve withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT provides a safe and controlled level of medication to overcome the use and abuse of opioids and alcohol. The MAT Program includes: · A comprehensive assessment · Medication Management for Opioid Dependence and/or Alcohol Use Dependence · Individual and/or group counseling for at least 3 months · Recovery support services · Random urine drug screens · Laboratory testing · Case Management Services · Peer Support Services · Mental Health Services, when applicable · Medical or Medically Supported Detox referral, when applicable · Inpatient and/or Residential Treatment referral, when Applicable and Intensive Outpatient Treatment, when applicable.

The particular service addition SCLHSA selected allows our agency to improve communication with persons served; create person-focused standards that emphasize an integrated and individualized approach to services and outcomes; provide accountability to funding sources, referral agencies, and the community; instill management techniques that are efficient, cost-effective, and based on outcomes and consumer satisfaction; supply evidence to federal, state, provincial, and local governments of commitment to quality programs and services that receive government funding; and guidance for responsible management and allow for professional growth of personnel.

D. How was the accomplishment achieved?

The SCLHSA Board of Directors and staff committed to hold the agency to the performance improvement standards included in the Strategic Goals and Objectives focusing on the unique needs of each person the agency serves, and monitoring of the results of services we provide. The addition of the MAT Program (OBOT) SCLHSA selected, allows our agency to improve communication with persons served; create person-focused standards that emphasize an integrated and individualized approach to services and outcomes; provide accountability to funding sources, referral agencies, and the community; instill management techniques that are efficient, cost-effective, and based on outcomes and consumer satisfaction; supply evidence to federal, state, provincial, and

local governments of commitment to quality programs and services that receive government funding; and guidance for responsible management and allow for professional growth of personnel. Linking with LDH and LSU also gives us credibility for service structure and community buy in of the product.

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

As a service provider, SCLHSA has the advantage of utilizing clearly defined and nationally accepted standards to ensure that our services maintain excellence. Through our CARF accreditation, we are compelled to focus our agency on best business practices to include: business improvement, service excellence, competitive differentiation, risk management, funding access, positive visibility, accountability and peer networking. All of these factors contribute to our strategic plan by assisting us in the development of policies, procedures and the initiation of services that are aligned nationally with best practices in the fields of behavioral health and developmental disabilities. The most important factor in this model is ensuring customer satisfaction. Customer service is not just about what you do today. It is a way to leverage your business to generate future prospects as well. Deepening strong relationships through community partnerships has helped to yield more opportunities to market our services and expertise. Pleased clients make referrals to other individuals that can lead to more business opportunities for our agency. SCLHSA has benefitted tremendously from focusing our staff on the short- and long-term benefits of the very best customer service which yields dividends by means of patient retention, wellness, recovery and community support.

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

SCLHSA offers Medication Assisted Treatment (MAT) in combination with cognitive behavioral therapy. An integrated care team approach consisting of a Physician, Nurse, Counselor, Case Manager and Peer Support Specialist provides a person-centered, whole patient approach to treatment for Alcohol and Opioid Use Disorders. Clients may self-refer or can be referred by a counselor, physician/prescriber, hospital, community agency, etc. The intent of the Medication Management Best Practice Model is to: Reduce and relieve cravings, Reduce and relieve withdrawal symptoms, Increase treatment retention and Reduce the risk of relapse. There is no minimum or maximum recommended length for MAT. Success is based on patient willingness to fully participate in treatment. Our Prescribers and Clinicians work together with clients to determine an individual treatment plan. The implementation of this program is evidence that SCLHSA makes a continual effort to improve efficiency, fiscal health, and service delivery -- creating a foundation for patient satisfaction and the agency impetus to formulate new goals and objectives that push the organization to the next level of performance and compliance.

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

To answer this question, you must determine whether your anticipated

outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

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

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

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

  The South Central Louisiana Human Services Authority will continue to utilize all Strategic Plan strategies with a concentrated focus on utilization management, monitoring and related follow-up activities, client engagement, and positive outcomes to achieve the Authority's goals and objectives. The South Central Louisiana Human Services Authority strives for continued progress toward achieving Strategic Goals and Objectives in support of its Mission: To increase public awareness of and to provide access for individuals with behavioral health

and developmental disabilities to integrated community based services while promoting wellness, recovery and independence through education and the choice of a broad range of programmatic and community resources.

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

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

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

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

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

  1. To what do you attribute this lack of progress? For example: **NONE Noted**
     - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
     - Is the lack of progress due to budget or other constraint?
     - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
     - Other? Please specify.
  2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution? **NONE Noted**

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

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

  South Central Louisiana Human Services Authority's implemented additional strategies specific to: expansion of eligibility criteria, strengthened collaboration with community partners/stakeholders; intensified focus on evidence-based and best practices for treatment/services delivery; increased access to social support systems; increased monitoring; increased technical assistance to contractors; and,

pervasive performance and quality improvement activities. All strategies were geared to assure sustainability, increase capacity, and continue the delivery of high quality effective services and supports. The Authority also honed performance indicators, retaining some trending data with the bulk of the attention focused on the development of true and meaningful outcome measures.

☐ No. If not, why not?

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

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

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

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

A. Problem/Issue Description

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

   During FY 2019-2020, South Central Louisiana Human Services Authority again experienced a reduced level in State General Funds (SGF). Additionally, the Expenditure Freeze Executive Order contributed to a reduction in the amount of funds that could be expended on supplies/items for every day work purposes. This action does hamper the ability to provide supplies to staff and impedes work capability by restricting purchasing and distribution as well as limiting some services to patients in the community setting.

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

   Yes, the South Central Louisiana Human Services Authority continues to adapt its goals and strategies to remain within funding levels and sustain viability in the

provision of services to the behavioral health and developmental disabilities communities.

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

   Every activity of the South Central Louisiana Human Services Authority to include Behavioral Health Services (mental health and addictive disorders), Developmental Disabilities Services, and the Administration component (which includes utilization management, monitoring, human resources, information technology and fiscal functions, etc.) is experiencing the effect of these budget shifts.

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

   - Individuals Served
   - Residents of South Central Louisiana Human Services Authority catchment area to include Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary and Terrebonne parishes.
   - Every employee (all areas and at all levels)
   - Contractors and their employees
   - Community Partners such as the seven Parish Presidents and Council/Jurors, Sheriff's Office, Coroner's Office, Public School Systems, District Attorney's Office, Juvenile Judges, and local not-for-profit community hospitals and social service organizations, etc.

5. How long has the problem or issue existed?

   The negative effect of reduced funding was noted beginning in FY 2010-2011, as we were a new local governing entity at that time and has continued through the FY 2019-2020 Fiscal Year.

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

   South Central Louisiana Human Services Authority receives the bulk of its funding from the State of Louisiana. The State Legislature has battled large budget deficits over the last couple of years which have been addressed through utilizing "rainy day or one time funds. Multiple reasons exist for this situation to include budget decisions made by the previous administration, oil prices continuing to drop, healthcare costs sky rocketing or as in this year a pandemic that has almost completely shut down all business and government funding sources, etc. The estimated budget gaps then trickle down to all state agencies through reduction of the amount of state general fund that each agency receives. These funds represent the bulk of personnel, operating, supply and travel costs which are seldom replaced once taken. It is then incumbent upon the agency to find ways to minimize cuts without affecting patient care – a very difficult and sometimes impossible feat to accomplish.

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

   South Central Louisiana Human Services Authority will address all impacts and potential impacts of decreased funding with urgency and will utilize effective and flexible strategies/tactics to continuously improve performance, service quality and to identify and capture alternative revenue streams while still providing core services to our patient population.

B. Corrective Actions

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

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

1. What corrective actions do you recommend to alleviate or resolve the problem or issue?
   - Continue execution of the agency Performance Improvement Plan to assure best use of limited resources, streamlined operations and service delivery, high levels of productivity, open capacity, and high quality outcomes for individuals receiving services and supports.
   - Work with LDH and the Healthy Louisiana Plans to ensure Medicaid reimbursement is optimized for evidence-based practices offered by SCLHSA in the home and in the community.
   - Continue implementation of the South Central Louisiana Human Services Authority Compliance and Risk Management Plan.
   - Research grant funding opportunities for expansion of new programs and/or to sustain existing programs.
   - Explore opportunities to partner with pharmaceutical programs for research studies related to behavioral health and developmental disabilities.
   - Continue to explore and seek relationships with private payors to open new streams of revenue.
   - Link with as many insurance vendors as possible to secure reimbursement for services provided to insured patients outside of the state vendor system.

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

   This is the tenth year that SCLHSA participates in the budget and AMPAR process as a local governing entity and the sixth time that these recommendations have been addressed as part of our mitigation plan for sustainability.

3. Are corrective actions underway?

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

   All corrective actions identified above are ongoing and will continue to be monitored for completion with no end date established at the present time. Progress has been made in all areas; however, progress must be accelerated to position the South Central Louisiana Human Services Authority for continued success relevant to the dramatic changes with the addition of the Healthy Louisiana Programs, the ongoing implementation of National Healthcare Reform and recovery from the national COVID-19 pandemic.

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

4. Do corrective actions carry a cost?

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

Correction Actions for the South Central Louisiana Human Services Authority are viewed as business and service delivery processes woven into the fabric of SCLHSA's daily operations. Primary responsibility for setting expectations and monitoring progress rests with the Board of Directors and the Executive Director;

primary responsibility for execution of corrective actions rests with members of the Executive Management Team, Senior Management and all SCLHSA Staff. Resources needed to successfully carry out these processes are through the Human Resources component; related duties and responsibilities are included in each Executive Management Team member's position description and in employees performance planning and rating documents. The Executive Management Team staff are to assure processes are ongoing and expectations are met or exceeded.

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

- A. Check all that apply and add comments to explain each methodology utilized.

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

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

South Central Louisiana Human Services Authority's Administrative Services Division provides ongoing monitoring of clinical and administrative functions. Audit tools, with identified criteria and targets are utilized; results are reported; and, appropriate process improvement and/or corrective actions are executed. Further, South Central Louisiana Human Services Authority developed process improvement and fiscal functions to audit Authority performance using benchmarks set forth in the Council on Accreditation of Rehabilitation Facilities (CARF) standards and to implement process improvement and/or corrective action as needed. A member of the Executive Management Team oversees each of these areas to assure there is no duplication of effort.

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

and the Louisiana Legislative Auditor (LLA) staff. The LLA conducts performance audits, program evaluations, and other studies as needed to enable the legislature and its committees to evaluate the efficiency, effectiveness, and operation of state programs and activities. The Centers for Medicare & Medicaid (CMS) also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

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

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

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

☒ **Program evaluation by in-house staff**
Performance is monitored on an ongoing basis utilizing the South Central Louisiana Human Services Authority's Strategic Plan, Operational Plan, Performance Improvement Plan, Risk Management Plan, and position-specific performance expectations. All have clearly stated expectations and performance targets. The Executive Director, Executive Management Team, Managers and Supervisory Staff share responsibility for oversight of these functions. Outcomes are reviewed and reported to the Board, staff and stakeholders on a quarterly basis.

☒ **Program evaluation by contract**
The South Central Louisiana Human Services Authority Contract Committee meets on a quarterly basis for review of contract objectives, service data information and financial projections for the fiscal year. The Contract Monitors have the opportunity to share any issues with service provision

or funding at that time. Additionally, each contractor is given the results of the quarterly meetings should there be any identified needs for improvement. SCLHSA also requires that its contractors fill out a survey on the previous service year and offer comments on ways to improve the contractual relationship. Suggestions are reviewed and changes may be implemented to the contract process for performance improvement purposes.

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

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

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

☒ **Performance-based contracting (including contract monitoring)**
LDH contracts are required to contain a description of the work to be performed including goals and objectives, deliverables, performance measures and a monitoring plan. SCLHSA initiates a Statement of Work (SOW) for every contract entered into by the agency. The SOW clearly defines the work product, accountability for services, goals and objectives to be met by both the contract agency and SCLHSA. Additional paperwork required includes the Code of

Conduct Form, Disclosure of Outside, Employment/Contract Form and the Permission for Public Information on Social Media Form

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

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

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

☐ Other (please specify):

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

☐ Yes. Proceed to Section C below.

☒ No Skip Section C below.

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

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

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

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

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

Annual Management and Program Analysis Report
Fiscal Year 2019-2020

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 A. Sizer**

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

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

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

Through implementation of the agency's Five-Year Strategic Plan and in alignment with the overarching vision, mission, and tenets, Northeast Delta Human Services Authority experienced continual growth and realized numerous outstanding accomplishments during FY20. 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?

Northeast Delta Human Services Authority (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. Development and maintenance of a successful integrated service network is vital to the operation and administration of the integrated approach. Ongoing relationship-building efforts and communication through regular meetings, community involvement and education, and outreach continue to be the driving forces underlying the agency's success and improved outcomes of the individual served. Some of these initiatives included:

Louisiana Opioid Summit

During FY20, NEDHSA hosted its second Opioid Summit: Reducing the Pain. The purpose of the conference was to inform the people of our region about prescription drug and opioid misuse and abuse and how this national and state crisis affects millions of people across America and thousands of Louisianans every day. With over 250 individuals in attendance, it offered an opportunity for behavioral health professionals, healthcare workers, law enforcement, federal, state, and local officials, clergy, and advocates to come together and collaborate on how to meet this complex societal issue with action. The Summit included four breakout sessions focused on two tracks: clinical and community. This well-attended summit brought much awareness and information to the attendees.

NEDHSA's Opioid Prevention Program, funded by the Louisiana State Opioid Response grant, provided 100 bags to Madison Parish Hospital and Rural Health Clinic. The bags contained Deterra®, a prescription drug disposal bag, agency-related information brochures, opioid-related statistics, and Narcan, an opioid overdose reversal agent and prescription aid. Further, in continuing the agency's efforts in providing ongoing education about Louisiana's opioid crisis, NEDHSA's Prevention and Wellness services for FY20 focused on educating community leaders, school-aged children, and the general community.

Faith-Based Outreach

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

In FY20, NEDHSA continued its Faith Partnership Clergy Training aimed at helping faith communities address addiction in their congregations and memberships. This fiscal year's event was a two-day training focused on equipping clergy with knowledge and skills to initiate and support prevention and addiction recovery ministry efforts in faith congregations and communities. Also, in supporting NEDHSA's Faith Partnership Initiative, focus group meetings were held quarterly to engage, problem-solve, inform, equip, and encourage faith leaders during the development of their congregation's efforts to address alcohol, drug, and addiction issues.

NEDHSA partnered with New Living Word Ministries in Lincoln Parish for the Ruston Listening Session in FY20. During this session, community and faith leaders congregated to discuss their concerns of local social issues and to gain insight on concrete, actionable steps to address these issues in their community. NEDHSA also attended a Community Prayer Rally in Ouachita Parish, joining local pastors, law enforcement officers, and community members, in raising mental health awareness and speaking to attendees about the stigma around mental illness and the need to address mental health issues in families and communities.

NEDHSA launched the new Transformations Blog in FY20. The Transformations Blog explores NEDHSA's role in addressing substance abuse, addiction, and developmental disabilities locally and nationally. This platform was designed to deliver impactful content that inspires, motivates, and encourages readers to think and act differently as the agency works together with citizens and government to help transform broken people, families, communicates, and social systems. The Transformations Blog is updated on the NEDHSA website the first Monday of each month and is available online as well as through the agency's mobile app.

Signs of Suicide Training

In FY20, NEDHSA hosted Signs of Suicide Training, curriculum of the nonprofit initiative, Signs of Suicide, which provides suicide prevention, education, and screening throughout the country. Nearly 60 mental health professionals, counselors, and school staff from the region received training on how to safely address and prevent bullying, self-injury, and contagion at the training.

Louisiana Reentry Program

A pilot program created by NEDHSA in FY19 in partnership with Goodwill Industries of Northeast Louisiana, the Louisiana Reentry Program, LA-Re, is an ex-offender re-entry program that seeks to address the socioeconomic issues that increase recidivism among the formerly incarcerated. The goal of LA-Re is to give nonviolent, mentally ill and addicted ex-offenders an opportunity to receive the help they need post-incarceration so that they can build and maintain a positive social role within the community thereby avoiding the high individual, family, community and societal costs of recidivism. Following the direction of the state, NEDHSA drafted a template based on the need of the communities served as these services are considered vital to this area. Participants are matched with case managers who will work with incarcerating

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

Since its inception in September 2018, 57 clients have been referred to the La-Re community re-entry program, with 91.2% of referrals enrolled. Of the 52 clients admitted into the program, 46.15% participants have been closed and 53.85% are ongoing at the time of this report. The closed participants include successful program completions (54.17%); transfers to prisons outside of program service area (8.33%); re-arrest (4.17%); early release from prison (20.83%); and participant request to be discharged from the program (12.5%). Around 98% of participants completed a Pre-Needs Assessment upon entry into the program, and one (1.92%) did not. Pre-Needs Assessments were completed on average within 5.24 days from program entry, and 69.23% (n = 36) of these were completed on the same day the participant was admitted to the program. Every enrolled LA-Re participant (100%) completed both a Tobacco Use Screening Assessment and a Gambling Addiction Screening Assessment upon enrollment, as required. Since the first participant was enrolled into the LA-Re Pilot Program in FY19, 89 outgoing referrals have been made to secure services and programs identified through completion of individual participant Needs Assessments, averaging about 1.7 referrals per participant. At the time of admittance to the LA-Re Pilot Program, participants completed a Pre-Life Skills Assessment. This 20-item assessment evaluates the participants' current level of knowledge in several areas, including goal-setting, stressors to reintegration, state requirements for obtaining legal employment, workplace and salary familiarity, behavior self-regulation, transferable skills, responsibility, and respect for others. At baseline the average Life Skills Assessment score was 88.1 (score range of 60 to 100). Post-Life Skills Assessments have been completed for the 24 participants completing the program. For this subgroup of participants, pre-score average was 85.6 (score range of 60 to 95) and post-score average was 96.5 (score range of 85 to 100), and average increase of 12.73%. To date, only one LA-Re Program participant has returned to prison prior to the last follow-up at 90 days.

Expungement Initiative

During FY20 NEDHSA launched a new initiative providing agency clients residing in Lincoln Parish the opportunity to pursue expungement with the aid of a professional attorney. NEDHSA clients who were currently receiving services, or who had completed the screening process to be seen at a NEDHSA outpatient clinic, and had a criminal conviction or arrest for a misdemeanor or felony in Lincoln Parish were eligible to participate in this initiative. The program was designed to provide an additional way for the agency to reach those clients who were actively seeking treatment and recovery and offer them a second chance to be reintegrated back into society. NEDHSA also provided participants with information about the agency's services, including behavioral and primary health care clinics and screening services, transitional housing, workforce training, and support services. The expungement event was a key component of NEDHSA's overarching workforce initiative, which is designed to help citizens gain self-sufficiency by providing them with the tools and skills necessary to re-enter the workforce and become a contributing member of society.

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, 229 clients have been referred to SOWS, with 110 clients being admitted to the workforce program. Of these, 27.3% maintained employment for at least 30 days; 25.5% maintained employment for at least 60 days; and 22.7% maintained employment for at least 90 days.

Operation Golden Years

In FY20, NEDHSA partnered with the University of Louisiana at Monroe's College of Business and Social Sciences, signing a memorandum of understanding (MOU). This MOU will serve as a catalyst in the expansion of the Operation Golden Years initiative that was launched during FY19. 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, 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, which allows seniors to safely dispose of unused prescription medications. This

program continued throughout FY20, and an additional Take Back box was unveiled on the campus of University of Louisiana – Monroe (ULM), providing another location for safe disposal of unused prescription medication.

As a part of FY20 Operation Golden Years outreach and education, NEDHSA's Executive Director spoke at the University of Louisiana Monroe's Addiction and the Elderly Symposium II, discussing challenges faced by Louisiana's senior citizens. Outreach activities also included NEDHSA representation at the area's 6th Annual Old Fashioned Christmas Party where staff provided and distributed Deterra® bags and other giveaways while speaking with attendees about the significant issues many seniors are facing throughout the region, as well as a similar event at a local senior development community in Ouachita Parish. Additionally, as part of the Operation Golden Years Initiative, NEDHSA Executive Director and representative staff visited the Franklin Parish Council on Aging for senior engagement and outreach.

Economic Impact Study

During FY20, a study evaluating the economic impact of Northeast Delta Human Services Authority (NEDHSA) on Northeast Louisiana was conducted by ULM Economic Professors in Monroe, Louisiana. The economic impact study, which was designed to measure the contributions of NEDHSA's operations, analyzed agency contributions to local, regional, and statewide economies through its expenditures on personnel wages, network of partnerships, sponsored programs and services, and clinical operations, all of which benefit the state of Louisiana through direct, indirect, and induced impacts. The study revealed a highly significant reduction in the level of economic activity in Northeast Louisiana in the absence of NEDHSA. This impact was estimated in three ways: (1) the impact on household income (NEDHSA wages and resulting rents, interests, profits); (2) the regional value-added (additional economic value resulting from NEDHSA partnerships and sponsorships); and (3) the total impact (increased monetary value of regional transactions due to the existence of NEDHSA). Jobs alone created by NEDHSA, both directly and indirectly, result in local and state single-year sales tax and state income tax revenues totaling $869,452 and over $5.5 million 10-year present value. Overall, the study revealed an economic contribution of NEDHSA totaling over $21.2 million for single-year and over $191.9 million for 10-year present value. Without the presence of NEDHSA, there would not only be a decrease in treatment, service, and program options for the citizens of Region 8, but also a direct negative economic impact on the region as well as the state of Louisiana.

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?

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 behavioral health needs of the citizens of northeast Louisiana, and actively puts programs and services in place that meet citizens' needs and to fill healthcare gaps.

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

YES (See Section II below.)

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

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

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.

In FY20, PIPBHC Grant programmatic services were expanded beyond our Bastrop Mental Health Clinic to include clients seen for mental health and/or addiction disorders at our Monroe Behavioral Health Clinic. Following initial assessment of 172 potential new enrollees, an additional 152 clients were enrolled into the PIPBHC Grant program in FY20, increasing our total enrollment to 223 by the end of the fiscal year. Six-month reassessments were completed on 159 clients, and 12 clients completed 12-month reassessment. Additional agency staff, which included a dedicated Advanced Practice Registered Nurse (APRN), an RN Integrated Care Manager, and a Wellness and Health Educator, was added to the Integrated Healthcare Team to provide our clients with on-site primary health screenings and assessments, as well as

individualized health and wellness assessments and plans. A renovation and expansion project was completed at our Bastrop Mental Health Clinic in FY20, and the clinic was rededicated as a fully-integrated behavioral and primary health center in order to address the complex needs of those with mental illness and substance use disorders. The Bastrop Outpatient Clinic now provides dedicated space for primary healthcare services, including a separate waiting area and clinic examination room, and a large classroom was added to be used for health and wellness education for clinic clients, as well as PIPBHC grant clients.

B. Why is this success significant?

Behavioral Health and Primary Care Integration is one of the three interdependent frameworks representing NEDHSA's logical framework of program and service delivery. Agency programs and services are built on the foundation of healthcare integration and specifically developed to address the ongoing needs of the clients served. Since its establishment in 2013, NEDHSA has worked to provide integrated health services by not only offering clients access to outpatient and inpatient services for behavioral health and substance abuse and addiction disorders, but also providing clients with access to prevention and wellness programs and other services aimed at treating the whole person. Integrated care further addresses the clients' social and socioeconomic needs, including housing, transportation, and employment, as well as primary healthcare needs. Serving as a grant awardee for this important federal initiative allowed NEDHSA to expand existing primary health services by providing funding for additional services and programs related to primary healthcare, significantly expanding our primary healthcare team, and reaching more clients in need of primary healthcare. 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 expansion of our existing integrated care model. NEDHSA clients in need of one or more services are eligible to enroll into the grant where they are followed at 6-month intervals and assessed for primary healthcare needs as well as ongoing service and program needs. Grant participants are screened for diabetes, high cholesterol, obesity, and other primary health concerns and undergo lab work and a basic physical examination. Minor health concerns are treated by the NEDHSA primary health team and more complex health issues are referred out.

D. How was the accomplishment achieved?

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

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

Yes, one of the primary strategic initiatives outlined in NEDHSA's Strategic Plan for FY 2015-2020 is Integrated Behavioral and Primary Healthcare, specifically acknowledging SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) Program and its goals of improving the physical health status of people with mental illness and addictions.

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

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

Accomplishment #3: Developmental Disabilities Services:

A. What was achieved?

The Northeast Delta Human Services Authority Developmental Disability Services Department (NEDHSA DD) continues to take an active part in the systems transformation initiative for developmental disability service delivery. During FY20, the NEDHSA DD department served over 2,000 individuals. As the single point of entry for the NEDHSA service area, the NEDHSA DD department provided 576

individuals with developmental disabilities $878,513 in stipends, services, supplies, and home and vehicle modifications that allowed those individuals to remain living in their homes and communities. The NEDHSA DD Medicaid Waiver program unit provided programmatic oversight including certification and accountability of over 1,300 Medicaid Waiver participants.

In FY20, the NEDHSA DD department resumed work through the Partners in Employment (PIE) initiative with a new contractor in November of 2019. The purpose of PIE is to promote, educate, and place people with developmental disabilities in the workforce. PIE activities have continued to grow through NEDHSA's partnering with agencies and businesses in the community who are willing to learn, hire, and support employment of individuals with developmental disabilities. NEHDSA continues to focus on the development of meaningful, community-based competitive employment opportunities for our clients with developmental disabilities. PIE improves employment outcomes for interested adults with developmental disabilities using a rapid job search philosophy which is person-centered and includes assessment, placement with a job coach, and 90 days of follow along assistance. Initiated in December 2017, the PIE program has reached 122 staff with local developmental disability support coordinating agencies and provider agencies through five in-person meetings during January, February, and March of 2020 and provided virtual training and education to 10 agencies contracted with NEDHSA outside of the DD service delivery system. Additionally, PIE provided education and in-service to all NEDHSA staff in the Developmental Disabilities Department, as well as the Prevention and Wellness Team, through both in-person and virtual meetings. Staff associated with PIE completed 40 hours of CORE employment training and the PIE program received 19 referrals for program intake between February 1, 2020 and June 30, 2020.

Additionally, the NEDHSA Developmental Disabilities team hosted its regional quarterly provider meeting in Ouachita Parish. Over 60 Developmental Disabilities service providers from across the agency's 12-parish region gathered to share and receive information related to the Developmental Disabilities service system, including changes in policies and processes, essential dates and deadlines, and upcoming training opportunities. NEDHSA DD staff also shared information regarding the referral process to various programs, initiatives, and services that are part of NEDHSA's primary and behavioral health integrated care model.

B. Why is this success significant?

All of the work performed by the NEDHSA DD department is critical to the ongoing service delivery system for people within the NEDHSA area. Delivery of need services to people who have no other resource to obtain these services is vital for people to remain in their homes and communities. Management of these services and funds must be in place to assure quality and compliance to maintain funding, cost efficiency, and sustainability. The PIE initiative, in particular, is significant to NEDHSA's efforts to take a lead role in making systematic changes that will lead to improving the success for people with developmental disabilities that want to go to

work. Statistically, people with disabilities are significantly unemployed or underemployed, and NEDHSA has determined that something must be done to change this outcome.

C. Who benefits and how?

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

D. How was the accomplishment achieved?

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

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

YES (See Section II below.)

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

Yes, this level of support, both financially and philosophically should be shared with other executive branch departments and agencies.

Accomplishment #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. In FY20, NEDHSA celebrated the opening of its new Prevention and Wellness Center with community

leaders and stakeholders. 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 FY20:

Prevention and Wellness Webinars

In FY20, NEDHSA's Prevention and Wellness Department presented a series of free training webinars aimed at building stronger communities one person at a time. The free webinars were live, utilized the Zoom internet platform, and were available to professionals, first responders, and the general public. The webinars' topics included opioid prevention, coalition building, bullying, grief management, COVID-19 resiliency, and adverse childhood experiences. As the COVID-19 pandemic increased the level of anxiety and trauma in our region, especially for those who were already dealing with mental illness and other challenges, NEDHSA provided these sessions in an effort to help the people of northeast Louisiana remain hopeful and informed. The webinars were well-attended and included the following:

- How to Save a Life: Opioid Overdose Prevention and Narcan Rescue
- The Power of Prevention & Coalitions: A Discussion on Bullying & Beyond
- Transforming Grief Talk: The Role of Grief and Loss in Addiction Recovery
- How to Adapt, Cope, and Respond to COVID-19
- Understanding Adverse Childhood Experiences

Generation XR

The Generation XR education program increases public awareness of prescription drug abuse and provides prevention services and information to healthcare and community leaders, parents and their children, and others in order to prevent abuse of prescribed medication. During FY20, the program was presented to 113 seniors, aged 65 and up, throughout five parishes.

LaSOR NARCAN Training and Kit Distribution

NEDHSA hosted 28 NARCAN Training and Kit Distribution events during FY20. The events were held across three different parishes in the service area, and 190 kits were distributed during these events. NEDHSA's NARCAN training is free and provides information to attendees to help (1) learn how to determine if a person may be overdosing from opioid use and how to respond to an opioid overdose; (2) learn how to properly administer Narcan (naloxone), a medication used to block the effects of opioids, to an individual experiencing an opioid overdose: and (3) learn about ways to reduce opioid overdose deaths and ways individuals can help stay safe.

SYNAR Checks

The SYNAR Program, overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA), requires states to establish and enforce laws to prohibit the distribution and sale of tobacco products to minors. Regular SYNAR checks are performed to ensure compliance with these laws. NEDHSA completed 394 SYNAR checks in FY20 with an 88% compliance rate.

School-Based Opioid Education
During FY20, NEDHSA provided opioid education to over 1,500 students in 3rd to 11th grade.

Prevention and Wellness Community Events
In FY20, NEDHSA hosted several community events through the Prevention and Wellness Department to spread awareness of NEDHSA's new health initiative. The agency hosted its first Transformations 5K/1K Walk and Run in the community where several participants joined agency staff in the event emphasizing wellness, which plays an important role in behavioral health in maintaining recovery and stabilization. NEDHSA hosted a series of activities during national Red Ribbon Week for students, teachers, and faculty in Ouachita Parish aimed at promoting a drug and alcohol-free lifestyle. Also hosted was a sober tailgating alcohol-free zone at ULM as a promotion of alcohol awareness among college students in our region. Additionally, hundreds of people attended NEDHSA's first JiggAerobics event, included in the agency's new fitness initiative #getfitHSA that is part of the integrated care model. The event was among the first in an expansion of community fitness offerings across the region aimed at increasing access to healthy activities and inform communities about the importance of staying fit and active.

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 to fill healthcare gaps.

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

YES (See Section II below.)

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

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

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. 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 added 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.

NEDHSA COVID-19 Social Health Impact Assessment
In FY20, the agency developed the NEDHSA COVID-19 Social Health Impact Assessment, designed to collect data related to the COVID-19 pandemic and its effects on the social health of our agency clients, as well as citizens residing in our 12-parish service area and beyond. Areas of assessment included: demographics; personal relationships and living situation; employment; resource concerns, including household finances, food security, healthcare, and social and relationships; personal well-being; mental and behavioral health status; and general media access and pandemic practices. A total of 467 agency clients completed the assessment, and 139 individuals from the region, state, and beyond completed the assessment, which was available online for the public. Agency clients were contacted by agency clinical staff to complete the

assessment and to discuss their feelings and concerns about the pandemic.

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 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 FY20, telehealth visits were implemented 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 the 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 were 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?

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 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 on time and on target for accomplishment?

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

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

NEDHSA strategic plan goals were implemented as outlined in the FY2015-2020 Strategic Plan. Continued progress is being tracked, documented, and reported. Performance improvement processes were implemented in FY19 and continued in FY20 to monitor the number of referrals to NEDHSA partner agencies. Increases in the number of persons receiving individual and family support services are noted for FY20, as well as an increase in number of persons receiving Flexible Family Fund services and number of persons receiving developmental disabilities services. Achievement in meeting performance standards is further evidenced by the agency's expansion of services and quality of care.

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

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

Our agency is tracking above average on many indicators, but not significantly higher than anticipated. We consider this a measure of stability in our ability to project with increased accuracy and managing the expectations of meeting our goals.

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

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

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

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

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

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

None.

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

None.

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

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

As the completion of the 5-year strategic plan for FY2015-2020 approached and the end-of- fiscal-year reports were being completed, NEDHSA revisited its strategic plan to make sure it properly reflects the goals and the objectives of the agency and also captures areas for improvement for the upcoming years. NEDHSA's FY2021-2025 Strategic Plan was developed with an outcomes-based approach where evaluation, planning, and development of services and programs will be data-driven. While current objectives will be maintained, new strategies will be added to existing ones in order to achieve agency goals. This will allow us to build upon our current successes and further grow in areas where we are continually evolving.

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

Our strategic plan is centrally located on the agency's intranet for all employees to view. A large percentage of the performance indicators are also reported in LaPAS and through AIP reviews. Our agency has quarterly performance improvement committee meetings to discuss the performance indicators and strategies to enhance our delivery of services. As leadership makes data-driven decisions about management and funding, we consider the performance indicators to help us determine how to streamline our funds and processes for improved outcomes.

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

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

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

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

There are no management or operational issues.

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

B. Corrective Actions

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

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

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

- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

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

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

- A. Check all that apply and 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 2019-2020

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

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

Undersecretary: **Ruth Johnson**

Assistant Secretary: **Fernando Lopez-Evangelio, MHSA, Ph.D.**

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

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

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

Accomplishment #1: The Implementation of the ACL Recommended Guidelines for State Adult Protective Services Programs:

A. What was achieved?

The Office of Aging and Adult Services (OAAS) participated in the Administration for Community Living (ACL), Office of Elder Justice and Adult Protective Services (OEJAPS), technical assistance project to use the National Voluntary Consensus Guidelines to enhance the Louisiana Adult Protective Services (APS) program.

B. Why is this success significant?

Louisiana was chosen as one of four states to participate in the ACL Guidelines Technical Assistance Pilot Project to implement the Voluntary Consensus Guidelines for State APS Systems. APS leadership worked in conjunction with ACL, the National Adult Protective Services Association, and New Editions to determine short, intermediate, and long-term goals for implementation of the National Voluntary Consensus Guidelines.

C. Who benefits and how?

Implementation of the ACL National Voluntary Consensus Guidelines for State Adult Protective Services (APS) Systems (Guidelines) intends to assist OAAS to develop an efficient, effective APS program and to provide recommendations from the field about quality practice.

D. How was the accomplishment achieved?

ACL, the National Adult Protective Services Association, and New Editions, in collaborative coordination with the leadership of the OAAS Adult Protective Services program, determined short, intermediate, and long-term goals for implementation of the National Voluntary Consensus Guidelines.

OAAS used the guidelines to focus on policies and practices related to one of the Guidelines domains (topics): Domain 1. Program Administration. Within this domain, OAAS focused on incorporating guidance from the following element (subtopic): 1L, responding during community emergencies, in response to programmatic needs resulting from COVID-19 mitigation efforts.

OAAS created content on emergency response (including COVID) for the APS Manual, a tip sheet for APS workers on safety for home visits; a resource sheet for addressing worker stress; and a tip sheet for the public on supporting the well-being of vulnerable adults during the COVID-19 pandemic.

In addition, OAAS established future goals for integrating the guidelines content into APS practice, including conducting a crosswalk between the guidelines and the APS policy and procedure manual to identify gaps and establishing an action plan to address priority areas for updating the manual as needed.

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

Yes, it contributes to “Improving access, quality and outcomes for populations receiving and at risk of needing long-term supports and services.” and

“Ensuring vulnerable adults are protected from abuse and neglect while living in community settings.”

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

Yes, OAAS participation in the project pilot demonstrates the benefits a department or agency can achieve by participating in specialized, expert federal technical assistance initiatives designed to improve program performance and outcomes.

Accomplishment #2: My Place Transition Benchmarks and Continuation of Funding of the Money Follows the Person Program:

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 SFY2010-2011, the Centers for Medicare and Medicaid Services (CMS), approved a supplement to the already approved state budget, providing OAAS the opportunity to operate the My Place Louisiana 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. As recent as March 27, 2020, MFP was granted yet another short-term funding extension under the COVID-19 Relief Package. 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.

This year, OAAS achieved the CMS proposed calendar year transition benchmark of 240; moving exactly 240 Nursing Facility residents back into their desired communities with Medicaid long term care community based services.

B. Why is this success significant?

Continuing to meet or exceed proposed transition benchmarks, allows OAAS and Medicaid to draw down administrative funds at 100% to cover the cost of program staff and transitional supports required by participants to transition. These funds also allow OAAS to continue their efforts towards developing infrastructure that promotes the rebalancing of Medicaid long term care funding from institutional based care setting to home and community based care (HCBS) settings.

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. The low turnover of staff in this program allows OAAS and the Louisiana Department of Health to reach its CMS proposed benchmarks allowing for the continued funding of the demonstration. Continued funding allows OAAS the ability to create infrastructure to support successful transitions presently and in the future. The department benefits in that, for every person that signs up to transition under the demonstration, the department receives an increased Federal Medial Assistance Percentage (FMAP) up at as

much as 90% for HCBS services that are provided for the first 365 days post transition. 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 above what is currently offered in OAAS waivers. Participants also receive additional monitoring by a transition coordinator and can access post transitional maintenance funding to help sustain the transition for the first 365 days post transition into the community. The program continues to maintain, on average, a re-institutional rate of less than 4% for participants in their 365 days of post transition.

D. How was the accomplishment achieved?

This accomplishment was achieved by the OAAS My Place staff. Staff worked in conjunction with OAAS regional office staff, contract HCBS support coordination agencies, Nursing Facility discharge staff, as well as the Louisiana Permanent Supportive housing program and local housing resources to coordinate and facilitate the timely and successful transition of participants from institutional care to home and community based care in the community.

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

Yes, it contributes to "Achieving and maintaining a legally compliant and appropriately balanced Long Term Services & Supports (LTSS) system, which assures choice within a sustainable, cost-effective continuum of community-based services and facility-based services.", "Improving access, quality and outcomes for populations receiving and at risk of needing long-term supports and services." And "Administering and operating OAAS programs in a cost-effective manner while achieving high quality outcomes."

The continued success of the My Place program allows the Office of Aging and Adult Services to continue its work on the rebalancing of long term care from institutional based care to home and community based options. The rebalancing is realized in the savings to Medicaid which averages $25,000 per person, per year for each person transitioning from Medicaid institutional based care to home and community based care (HCBS). This is coupled with the enhanced FMAP that is given for the first 365 days of a person's community-based services post-transition.

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

Yes, lessons learned from 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, has been asked several times by CMS to provide guidance and support to other MFP states that are struggling to achieve transition benchmarks.

Accomplishment #3: Permanent Supportive Housing (PSH) Expansion:

A. What was achieved?

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

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

B. Why is this success significant?

All of these efforts constitute an expansion of PSH and have increased the program's capacity to serve people transitioning from high-cost institutional care. This is important to assuring the state's compliance with the Americans with Disabilities Act and the U.S. Supreme Court *Olmstead* decision. It is also essential to the state's agreement with the U.S. Department of Justice (DOJ) to create 1,000 additional housing units and/or subsidies to transition and divert persons with Serious Mental Illness from nursing homes by 2023.

C. Who benefits and how?

Low income individuals with disabilities and their household members benefit from having access to high quality, community-integrated, affordable housing with tenancy supports to help them to be successful tenants and maintain housing stability. PSH has a 94% program retention rate and 59% of households see an increase in income after they are housed by the program. PSH reduces inpatient hospital, emergency department, and institutional care which benefits the health outcomes of the population it serves, as well as taxpayers.

D. How was the accomplishment achieved?

One of the new rental assistance programs was the result of a successful application to the U.S. Department of Housing and Urban Development (HUD) for Non-Elderly Disabled Mainstream Housing Choice vouchers. HUD originally awarded the state 50 vouchers and an additional 65 in FY20. The other rental assistance program is a state-funded program created to comply with the state's agreement with DOJ. Program staff at OAAS and LHC worked with court-approved technical assistance providers to create program guidelines and procedures consistent with HUD subsidy guidelines and other rental assistance guidelines used in the PSH program. The existing infrastructure of the PSH program facilitated the timely deployment of these additional resources.

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

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

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

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

The interagency collaboration between OAAS/LDH and the LHC and Louisiana Housing Authority is valuable; but Louisiana PSH is more of a national model than a model applicable to other Louisiana state agencies.

Accomplishment #4: Waitlist Reduction Plan Implementation:

A. What was achieved?

The LDH Office of Aging and Adult Services (OAAS) has made significant progress in reducing the number of applicants waiting for a service on the Community Choices Waiver (CCW) Request for Services registry. The CCW Waitlist Reduction Project began with 26,622 individuals on the registry. LDH has already been successful in eliminating the wait for services for people with developmental disabilities and wanted to extend this success to older adults and those with adult-onset disabilities and their families. As of mid-September 2020, there are 10,675 individuals on the registry, which is a 60% reduction. Currently there are 5,641 individuals waiting for home and community based services (HCBS) of the 10,675 individuals on the registry, which are not receiving any HCBS service at this time.

Additionally, during the 2019 Legislative session, OAAS requested and received an additional 500 CCW slots. During fiscal year 2020, OAAS successfully certified a participant into all 500 slots.

B. Why is this success significant?

Long waiting lists, by themselves, or in conjunction with other factors, place states at risk for lawsuits based upon the Americans with Disabilities Act (ADA) and the ADA-based U.S. Supreme Court *Olmstead* decision. Individuals waiting for services are often at high

risk of nursing facility placement and may end up receiving more expensive forms of care if their support needs are not addressed within reasonable timeframes.

C. Who benefits and how?

The community benefits as individuals request, and then receive, support from the CCW. CCW provides Medicaid in-home and community-based services that are an alternative to nursing home care for older adults and people with adult-onset disabilities, increasing the number of individuals receiving quality support in the setting of their choosing. CCW is also a cost effective alternative to Nursing Facility care, benefitting the State and Department of Health.

D. How was the accomplishment achieved?

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

In June 2019, CMS authorized the state to give priority for waiver offers to individuals not already receiving another form of Medicaid home and community-based service. This allowed LDH and OAAS to prioritize those who truly are waiting for in home care and have no other form of home-based assistance from Medicaid. Historically, about 35% of people on the registry for CCW are already receiving another form of home and community based service.

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

Yes, it contributes to program goals to "Achieve and maintain a legally compliant and appropriately balanced LTSS system, which assures choice within a sustainable, cost-effective continuum of community-based and facility-based services" and to "Improve access, quality, and outcomes for populations receiving and at risk of needing long-term supports and services."

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

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

Accomplishment #5: Serious Mental Illness/ Dept of Justice Update:

A. What was achieved?

Office of Aging and Adult Services made strides in addressing goals as outlined in LDH's Agreement with the U. S. Federal Department of Justice (DOJ). Working in conjunction with the Office of the Secretary and the Office for Behavioral Health, OAAS operationalized a plan to divert individuals from Nursing Facility Placement; developed a data use plan, finalized a methodology for projecting diversions in 2021 and diverted 164 individuals from nursing facility placement. Additionally, OAAS developed and implemented an interim intensive case management strategy, developed transition monitoring tools, developed strategies to enhance in-reach efforts, and most significantly, assisted 47 individuals to transition from nursing facility placement into a community-based setting of their choice. All individuals live with a Serious Mental Illness (SMI) and some type of physical disability that qualifies them for nursing facility level of care. The individuals who transitioned indicated a desire to return to a community of their choice and requested assistance with the supports needed to facilitate such a transition and maintain placement in the community post-transition.

B. Why is this success significant?

Successes, specifically the work to transition individuals to the community, is significant because it helps LDH and OAAS comply with ADA and Olmstead person first principles by fully supporting a person's choice in living and receiving assistance in the most integrated setting possible. The physical and behavioral health supports and services needed to successfully remain in the community are being wrapped around transitioned individuals and monitored by OAAS Transition Coordinators through the interim intensive case management program. All services are provided in a person first manner and strive to assist the person in experiencing better life satisfaction, improved sense of well-being, and better health outcomes. Research supports that better health outcomes are associated with community living with sufficient supports for those living with Serious Mental Illness (SMI).

This work is especially significant given barriers posed by the COVID 19 public health emergency. Barriers during 2020 include, 'stay at home orders', no visitation policies at Nursing Facilities, social distancing and reduced access to community resources normally available to adults in need.

C. Who benefits and how?

The individuals transitioned benefit in terms of better health outcomes and quality of life associated with living in a setting of one's choice. Additionally, the state benefits in terms of costs savings, as supporting individuals in communities is more cost effective than institutional care. Overall, this work is enabling LDH and OAAS to continue to comply with the U. S. Department of Justice Agreement.

D. How was the accomplishment achieved?

Accomplishments were achieved through collaborative efforts within LDH. OAAS works

with the Office of the Secretary and OBH to fulfill the goals of the Agreement. These offices within LDH also work with a subject matter expert to work towards meeting the goals of the Agreement, and to share those results routinely with the U. S. Department of Justice. Accomplishments of transitioning individuals into the community were achieved through OAAS's My Choice Louisiana Transition Coordination team. OAAS Transition Coordinators (TC's) meets with individuals that are identified by the Agreement as meeting a specified target criteria; i.e. living with serious mental illness is one component of the targeted criteria. The TC assesses the individual's support needs and explores the person's desire to live in the community. Once these target population individuals indicate a desire to transition, the TC reviews the identified support needs and sets about incorporating various resources such as, OAAS service options (LT-PCS, waiver, PACE, etc.), Permanent Supportive Housing supports, behavioral health services, etc., to form a supportive network in order to successfully transition the individual into the community and then to maintain that placement once transitioned. The actions of the Transition Team led to 47 transitions during the fiscal year with minimal re-institutionalization rates.

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

Yes, it contributes to "Improving access, quality and outcomes for populations receiving and at risk of needing long-term supports and services."

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

Yes, having individuals achieve successful re-integration into the community that leads to better health outcomes and cost savings for the state is an accomplishment that should be shared with others agencies and replicated where applicable.

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

OAAS continues to make progress in many areas related to its strategic goals and objectives.

- **Please provide a brief analysis of the overall status of your strategic progress.**
  The accomplishments above contribute significantly to the OAAS strategic progress. They correspond to OAAS strategies 1.1, 2.2, 2.3, 2.5, 3.1, 5.1, 5.2, 5.3, 5.5, 5.6, 5.7, 7.2, 7.3, 7.5, 7.6, 7.7 and 7.8 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?**

  Money Follows the Person Transitions and continued funding, Waitlist Reduction, DOJ Transitions and Permanent Support Housing (PSH) Expansion are helping OAAS make progress on maintaining an appropriately balanced LTSS system and will help the office improve on LAPAS measures related to the percentage of LTSS recipients who are served in the community.

- **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, but the accomplishments highlighted were led by OAAS. Waitlist Reduction and the Adult Protective Services ACL Project was undertaken entirely by OAAS.

  - **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?**

  To what do you attribute this lack of progress?
  - 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.

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

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?

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

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

There are no significant department, management or operational problems 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.) Not applicable.
   3. What organizational unit in the department is experiencing the problem or issue? Not applicable.
   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.) Not applicable.
   5. How long has the problem or issue existed? Not applicable
   6. What are the causes of the problem or issue? How do you know? N/A
   7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Not applicable

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

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

   1. What corrective actions do you recommend to alleviate or resolve the problem or issue?
   2. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
   3. Are corrective actions underway?
      a. If so:

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

b. If not:

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

4. Do corrective actions carry a cost?

☐ No. If not, please explain.

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

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

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

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

☒ **Internal audit**

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

Internal Audit also provides management with evaluations of the effectiveness of

internal controls over accounting, operational and administrative functions.

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

CMS also conducts audits and reviews LDH and its agencies for compliance with program standards and accountability for funds received to administer programs.

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

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

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

☒ **Benchmarking for Best Management Practices**
The LDH Division of Planning and Budget reviews, researches and develops

objectives, performance measures and strategies for each LDH agency.

☒ **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 2019-2020

Department: **Louisiana Department of Health (LDH)**
09-324 Louisiana Emergency Response Network

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

Undersecretary: **Ruth Johnson**

Executive Director: **Paige Hargrove**

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

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

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

Accomplishment #1: Lake Charles Memorial Hospital verified as Level III Trauma Center:

A. What was achieved?

Lake Charles Memorial Hospital was verified as a Level III Trauma Center by the American College of Surgeons (ACS) and then designated as such by the Louisiana Health Standards Department.

B. Why is this success significant?

Provides “Golden Hour” access to a Level III trauma center to 251,191 Louisiana

citizens that previously did not have access to a trauma center within a 60-minute drive time – the Golden Hour.

C. Who benefits and how?

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

D. How was the accomplishment achieved?

In 2011, the LERN Board set a goal to establish an ACS verified trauma center in every region of the state. At the time, we only had two trauma centers – one in Shreveport and one in New Orleans. Now we have nine ACS verified trauma centers. We achieved this by hiring a trauma medical director to consult directly with hospitals in building their centers. We also established the "trauma program" process, which allows hospitals seeking trauma center verification to receive trauma patients once they have met certain benchmarks. The hospital CEO signs an attestation and the requirements are verified by the LERN trauma medical director on an ongoing basis. The trauma program process is a stepping-stone to verification. LERN facilitated Lake Charles Memorial Hospital in achieving verification every step of the way – from pushing their administration and board to consider embarking in the process, funding their trauma registry, providing seed funding for trauma medical director and trauma program manager, to Trauma Program Development, to finally achieving verification.

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

Yes – Strategy 1.1 in our 5-year plan is to utilize the expertise of the LERN Trauma Medical Director to facilitate the establishment of a verified trauma center in each of the LDH regions by 2025.

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

Yes, the trauma program and medical director consultation is probably unique to LERN. Developing mechanisms to provide consultation and a road map to achieve a desired goal should be a best practice for all.

Accomplishment #2: St. Tammany Parish Hospital verified as Level III Trauma Center:

A. What was achieved?

St. Tammany Parish Hospital was verified as a Level III Trauma Center by the American College of Surgeons (ACS) and then designated as such by the Louisiana Health Standards Department.

B. Why is this success significant?

This is significant because it adds another trauma center on the North Shore, bringing the total number of state trauma centers to nine.

C. Who benefits and how?

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

D. How was the accomplishment achieved?

In 2011, the LERN Board set a goal to establish an ACS verified trauma center in every region of the state. At the time, we only had two trauma centers – one in Shreveport and one in New Orleans. Now we have nine ACS verified trauma centers. We achieved this by hiring a trauma medical director to consult directly with hospitals in building their centers. LERN facilitated St. Tammany Parish Hospital in achieving verification by sending our trauma medical to consult in their program development. The LERN Regional Commission also coordinates the pre-hospital trauma operations committee with the three trauma centers on the Northshore – a requirement for verification.

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

Yes – Strategy 1.1 in our 5-year plan is to utilize the expertise of the LERN Trauma Medical Director to facilitate the establishment of a verified trauma center in each of the LDH regions by 2025.

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

Yes, 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 #3: Pediatric Trauma Program at Our Lady of the Lake Children's Hospital:

A. What was achieved?

Our Lady of the Lake Children's Hospital committed to the development of a Level II Pediatric Center. They achieved the first step by attesting to meeting the LERN defined requirements and the LERN Executive Committee approved their Program effective October 5, 2019.

B. Why is this success significant?

This is significant because there are zero pediatric trauma centers in Louisiana. The only other Trauma Program is located in North Louisiana at Ochsner LSU Health in Shreveport.

C. Who benefits and how?

Children injured in Louisiana South of Alexandria will benefit from this accomplishment. More children die of injury each year than from all other causes combined. Only 57 percent of the nation's 74 million children live within 30 miles of a pediatric trauma center that can treat pediatric injuries, regardless of severity. Although most traumatic injuries are treated in hospital emergency departments, hospitals may not have the resources needed to treat injured children. For example, they may lack specially sized medical equipment. Pediatric trauma centers, however, are required to have these resources.

D. How was the accomplishment achieved?

The LERN Board directed the LERN Executive Director and the Trauma Medical Director to engage hospitals with pediatric capability and ask them to consider pursuing pediatric trauma center verification. We focused on existing adult trauma centers and other hospitals specializing in pediatric medicine. We made the case for the need and community benefit.

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

Yes – it contributes to strategy 1.1 1.1 Utilize the expertise of the LERN Trauma Medical Director to facilitate the establishment of a verified trauma center in each of the LDH regions by 2025.

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

The trauma program and medical director consultation is probably unique to LERN. Developing mechanisms to provide consultation and a road map to achieve a desired goal should be a best practice for all.

Accomplishment #4: Improved ED to ED transfer efficiency of trauma patients:

A. What was achieved?

We decreased average Emergency Department (ED) to ED transfer time by 21 minutes for time sensitive trauma patients.

B. Why is this success significant?

Every minute matters when a patient is not at the definitive are hospital with the resources to treat the time sensitive illness. When we started working on this process in October 2018, the baseline for ED to ED transfer was 3 hours and 25 minutes. We

have decreased this time by 21 minutes.

C. Who benefits and how?

Trauma patients needing a higher level of care benefit from this accomplishment.

D. How was the accomplishment achieved?

We expanded the called center responsibilities to include facilitating transfers. We marketed this service with hospitals statewide and developed a transfer database and report to track the process measures. We were also able to hire a Data Manager which allows us to build more sophisticated reports and work smarter.

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

Yes – it contributes to ensuring 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?

Yes, you cannot improve what you do not measure.

Accomplishment #5: Hired a STEMI medical director and initiated a STEMI Data Pilot:

A. What was achieved?

Developed a STEMI Data collection process and implemented a STEMI Pilot. STEMI is a common name for ST-elevation myocardial infarction, which is a more precise definition for a type of heart attack. It is caused by a prolonged period of blocked blood supply that affects a large area of the heart. STEMI has a substantial risk of death and disability and calls for a quick response.

B. Why is this success significant?

The primary aim of LERN's STEMI system of care efforts is to develop a comprehensive STEMI system in Louisiana to provide timely access to proven treatments necessary to reduce death. Since inception, participation in statewide data collection was a requirement of all STEMI Receiving Centers, but we had never implemented the required data collection process. The data collected by the STEMI Receiving Centers will provide LERN with valuable information that can provide the opportunity to provide direction for improvement, when the need is identified or when assistance is requested. It will also help to validate the state STEMI system of care. Persons who present with STEMI deserve the opportunity to receive time-sensitive treatment. The data collection requirements focus on the time stamps for evaluation and management of STEMI patients

C. Who benefits and how?

All STEMI patients benefit from this accomplishment.

D. How was the accomplishment achieved?

Clear directives from the LERN Board to get this done was very helpful. Process was modeled after stroke data collection process. The stroke precedent had been set and this was very helpful in soliciting voluntary participation.

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

Yes, Objective III.3: Develop a statewide system of STEMI care to improve outcomes for Louisiana citizens regardless of where they live in the state.

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

Yes.

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

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

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

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

  Goal I: Decrease risk adjusted trauma-related deaths and incidents of morbidity and mortality due to trauma in Louisiana.

  - Six Louisiana Trauma Centers are participating in the Trauma Quality Improvement Program (TQIP). We are in the early stages, but the collaborative allows for us to look at benchmark risk-adjusted outcomes as a state system against all nationally participating TQIP centers, discover areas for system-level trauma center quality improvement and identify and share best practices among collaborative participants.
  - We do not have a comprehensive trauma registry. We now have 11 hospitals submitting data to the state trauma registry. This is up from seven in CY 16. The current 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.

- 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

- We were approved an additional FTE with funding to hire a data manager. This additional staff has helped us better use the data we do have in order to inform decision making and improve systems.

All of these efforts are improving morbidity and mortality, but we need a comprehensive registry 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 is detrimental to patient outcomes. A considerable number of these transferred patients undergo potentially preventable, repeated CT scans adding radiation dose to patients and costs to the healthcare system. Patients directed by the LERN Call Center, for the past 3 years, have a 3% secondary transfer rate. In CY 2018, patients not directed by the LCC had a 24% secondary transfer rate and in CY 2019 this increased to 31%. 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.
- 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 high to level trauma care. Three hospitals have taken advantage of this process and subsequently passed verification by the ACS:
    - Lake Charles Memorial Hospital
    - St. Tammany Parish Hospital
    - Lafayette General Medical Center

  The following two hospitals have been approved as a trauma program:
    - Ochsner LSU Health Shreveport attested to meeting Level II Pediatric Program requirements. Anticipate ACS-COT survey in July 2020. Site survey by ACS 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.
- 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.
- 100% of the population has access to the LERN Call Center for assistance with direction to the most appropriate resourced hospital for trauma, stroke or STEMI.
- LERN established criteria for four levels of stroke hospitals. These levels are used by the public and EMS to access the appropriate hospital for stroke care. Due to new levels of stroke care nationally, the LERN Board recently changed the nomenclature from Level 1-4 to accommodate Thrombectomy Capable Stroke Centers. The new LERN Levels are Comprehensive Stroke Center (CSC= formerly Level I), Thrombectomy Capable Stroke Center (TSC= new), Primary Stroke Center (PSC = formerly Level II), Primary Stroke Center with Endovascular (PSC-E = new), Acute Stroke Ready Hospital (ASRH = formerly Level III), and Stroke Bypass Hospital (formerly Level IV). A level 4 stroke center does NOT have the capability of taking care of stroke patients. LERN

has built a network of stroke centers that provides the public access to either a CSC, TSC, PSC/PSC-e, or an ASRH to 99.3% of the population.

- LERN established criteria for STEMI Receiving centers which require 24/7/365 access to a cardiac catheterization lab. There are 36 STEMI Receiving Centers in the state. These 37 hospitals provide 96.6% of the population with access to a STEMI Receiving Center within a 60-minute drive time.
- LERN also formalized the burn system in Louisiana, helping to provide timely burn care statewide.
- In addition, LERN continued education efforts across the state. For CY 2019, those courses included:
    - Trauma Nurse Core Curriculum (TNCC) = 35 classes, 375 students
    - Emergency Nurse Pediatric Course (ENPC) = 21 classes, 78 students
    - 12 Lead EKG Course = 13 classes, 330 students
    - Rural Trauma Team Development Course = 2 classes, 28 students
    - Hemorrhage Control Training = 1 class, 25 law enforcement agents
    - Stop the Bleed Course = 81 classes, 2313 students
    - AIS Course – 1 class, 21 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 3.1 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 has been included in disaster drills throughout the state
- Will continue to offer the safety class for the Governor's detail focused on: stopping bleeding, choking, CPR and LERN logistics. The first classes were conducted in August 2018.
- Conducted tabletop exercise with the EMS Surge Ambulance contractor to test our processes and procedures.
- Conducted tabletop exercise with Burn leaders to test burn surge capacity in Louisiana.
- Activated TOC for Hurricane Laura

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

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

results have been generated without specific department action?
This past year we made significant progress in the STEMI system. We hired a new STEMI Medical Director and he has done a great job of implementing the start of a data repository for STEMI.
We have been very successful moving systems forward due to leadership from our physician medical directors and due to clear direction provided by the LERN Board. The positive results would not be possible without our physician leaders and our LERN staff implementing the Board's directives. The engagement and participation of our nine LERN Regional Commissions also contribute to our success. Support from LDH is also related to our success.

- Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
  Recent improvements in Quality/Performance Improvement processes are directly related to allocation of an 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.
  - 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.
- 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 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?

The agency believes it will continue to see the benefits of this new position.

- **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?
     We have been very successful moving systems forward due to leadership from our physician medical directors and due to clear direction provided by the LERN Board. The positive results would not be possible without our physician leaders and our LERN staff implementing the Board's directives. The engagement and participation of our nine LERN Regional Commissions also contribute to our success. Support from LDH is also related to our success.
   - Is the lack of progress due to budget or other constraint?
   - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.

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

     Data collection/registry development for Trauma has been difficult, but we are making gains. We now have voluntary participation in the trauma registry from 11 hospitals. Hospitals have a hard time collecting data due to competing priorities. It cost money to hire a data entry person. In addition, we need to switch registries from Image Trend to ESO in order to remedy mapping issues that limit the success of our registry. We have not been able to move forward with this due to funding constraints.
   - 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?

   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 participation is mandated and until we have 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 5-year interval. Each year the LERN Board reviews the strategic priorities and adjusts 12-month goals and the action items to achieve goals. In November 2018, we developed new strategic priorities for 2019-2023.

  ☐ No. If not, why not?

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

  The Executive Director provides a report to the LERN Board of Directors (BOD) at least quarterly. This report includes progress to goals for each strategic priority. The strategic plan is completely re-evaluated annually by the LERN BOD. The LERN Regional Commissions are informed through the Tri-Regional Coordinators and the LERN Administration & Medical Directors. The Tri-Regional Coordinators also submit quarterly Commission Activity Reports (CAR) that provide information on what is being done at the regional level to achieve strategic priorities.

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

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

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

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   The State Trauma Registry has not been able to import data from our 11 trauma centers since CY2017. We do not have data for 2018, 2019 or 2020 to date. This makes it very difficult to target areas of opportunity, injury prevention efforts and to track progress.

2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   Yes. It is very difficult to decrease risk adjusted trauma-related deaths and incidents of morbidity and mortality due to trauma in Louisiana without a functioning trauma registry. We cannot improve what we cannot measure. Fortunately, we participate in the Trauma Quality Improvement Program with the American College of Surgeons and this provides us with some information on performance and opportunities for improvement.

3. What organizational unit in the department is experiencing the problem or issue?
   LERN only has one department – education affects all of our four core components (Trauma, Stroke, STEMI, and Disaster Response).

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
   Our hospital and EMS providers are affected by the problem. We have not issued a trauma registry report since 2017. http://lern.la.gov/wp-content/uploads/2017-State-Trauma-Registry-Report.1.pdf This report provides valuable information to the trauma system on: age distribution of trauma patients, causes of injury that informs injury prevention efforts, causes of mortality, access to a trauma center pre-hospital, payor mix, length of stay for trauma patients, ICU utilization, severity of injury and alcohol/drug screening in injured patients.

5. How long has the problem or issue existed?
   Started having problems in 1st quarter 2018.

6. What are the causes of the problem or issue? How do you know?
   The current software vendor is a stand-alone product that does not directly participate in the Trauma Vendor Alliance. We have been working with them for over a year 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.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
   Lack of visibility on trauma system performance and inability to target injury prevention efforts.

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?

      If Image Trend cannot fix the issue, we need to switch our registry to ESO.

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

      No. We had planned to request funding to switch to ESO, but understanding the budget constraints brought forth by COVID 19, we are trying to work with Image Trend to remedy the problem. Image Trend is increasing its cost by 25% next FY and $9,000 was requested to be included in our budget. Due to the cost of ESO, we are trying to work with Image Trend to provide what we need. If Image Trend cannot deliver, we will request funding with 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?
           Image Trend has communicated that it should be fixed within the month.
         - How much progress has been made and how much additional progress is needed?
           ESO completed the mapping from their end.
      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.

Hosting and maintenance is covered in our existing PO with Image Trend.

☐ 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 and 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:
   LERN Annual Report FY 18-19

2. Date completed:
   March 2019

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Required by LERN Legislation La R.S.40:2845

4. Methodology used for analysis or evaluation:
   Data included in the report is obtained from call center data, from the 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:
   http://lern.la.gov/wp-content/uploads/LERN-Annual-Report-2018-2019.pdf
   Hard copy available upon request.

10. Contact person for more information:
    Name: Paige Hargrove
    Title: Executive Director
    Agency & Program: Louisiana Emergency Response Network
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Annual Management and Program Analysis Report
Fiscal Year 2019-2020

Department: **Louisiana Department of Health (LDH)**
09-325 Acadiana Area Human Services District

Department Head: **Dr. 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 with Lafayette Consolidated Government (LCG) to provide a Christmas Party for people with developmental disabilities and the community:

A. What was achieved?
Acadiana Area Human Services District partnered with the Lafayette Consolidated Government (LCG) to provide a "Christmas Extravaganza" for the community

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

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

D. How was the accomplishment achieved?
Acadiana Area Human Services District (AAHSD) collaborated with LCG. LCG provided the community center and AAHSD staff decorated and created fun and games for the community to enjoy.

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

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

Accomplishment #2: Continued Partnership with OCDD regarding the tiered waiver system:

A. What was achieved?
Acadiana Area Human Services District Partnered with the Office for Citizens with Developmental Disabilities (OCDD) for the continued administering of the tiered waiver system.

B. Why is this success significant?
It changed the way the request for waiver services registry (waiting list) is implemented. It has gone from a first come first serve registry to as needs based screening process.

C. Who benefits and how?
Individuals with developmental disabilities and their families. It will allow quicker access to home and community based services.

D. How was the accomplishment achieved?
OCDD partnered with the district and authorities throughout the state to screen all of the individuals on the registry. Once done, the needs of those individuals were established. Priority was given to those with the highest, most urgent need. 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 training for Child/Adolescent clinical staff in Child/Parent Psychotherapy

A. What was achieved?
Child/Adolescent clinical staff attended in-person training (pre-COVID-19) and continue to participate in virtual training/support calls since onset of COVID-19 restrictions.

B. Why is this success significant?

CPP is an evidence-based practice targeting early-childhood behavioral health issues. Acadiana Area Human Services District (AAHSD) was able to provide this service previously but was required to halt due to staff turnover. As a result of this training opportunity, we will be able to provide the service in more than one clinic location. This also addresses ongoing concerns voiced by stakeholders regarding provision of services to this target population.

C. Who benefits and how?
Early-childhood behavioral health clients age three and up.

D. How was the accomplishment achieved?

This was achieved via training grants offered through the Office of Behavioral Health (OBH).

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

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

Yes.

Accomplishment #4: Initiation of Telehealth Services

A. What was achieved?
Telehealth prescriber services were initiated in January 2020, followed by full provision of clinical services by all staff beginning March 2020 (due to COVID-19 restrictions).

B. Why is this success significant?
The initial prescriber services were implemented to fill service time vacated by contract prescriber moving out of the area. Going to full-delivery of telehealth services was the only way for clients to receive non-emergency services once offices were closed due to COVID-19.

C. Who benefits and how?
All clients benefit from the continuation of routine, non-emergent, services.

D. How was the accomplishment achieved?
The initial prescriber telehealth was provided through contract with Genoa. The remainder of the telehealth deployment involved monitoring changes in telehealth restrictions among the clinical disciplines and providing staff with direction, training, and support in use of tele video platforms for provision of services.

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

Yes

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

Yes

Accomplishment #5: Behavioral Health Coverage for COVID-19 shelter at Chicot State Park

A. What was achieved?
Acadiana Area Human Services District (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 insures that the behavioral health needs of residents were addressed appropriately, which allowed 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 departments Five-Year Strategic Plan/Business Plan on time and on target for accomplishment?

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

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.

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?**

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.

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?

B. Corrective Actions

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

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

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

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

5. Do corrective actions carry a cost?

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

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

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

☐ Internal audit

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

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

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

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

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

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

☒ Peer review
Medical Doctors and OCDD peer review process

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

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

☒ Other (please specify):
Human Services Accountability Plan (AP) monitoring visits by OBH and OCDD

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

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

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

1. Title of Report or Program Evaluation:
   AAHSD Management Report

2. Date completed:
   June 2020

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.
   - 2019/2020 budget submitted and approved. AAHSD maintained operations within budgetary guidelines.
   - AAHSD realized an increase in collections for self-generated revenue. AAHSD has doubled its self-generated collections in the past three years.
   - Professional and service contracts maintained and monitored by AAHSD. Monitoring was increased to at least quarterly for all contracts (some monitored monthly). The monitoring process has received positive comments from two separate regulatory reviews.
   - Employees completed Civil Service PES as required.
   - AAHSD continued its employee training program/schedule and utilized two online training programs – LEO and Relias Learning. Targets and timeframes were met.

- All Senior Managers have maintained a succession plan for their respective areas.
- AAHSD did implement a new pay/performance structure as outlined by State Civil Service.
- AAHSD maintained credentialing by all four MCOs within the State plan.
- AAHSD conducted and/or participated in numerous public events, health fairs, community forums, and other professional forums. This is reflected by the increase in number of stakeholder surveys.
- AAHSD was monitored by: ORM, LDH/OBH and OCDD, LDH/Bureau of Health Standards, State Civil Service, and the Fire Marshal. All reviews were successful.
- AAHSD assumed operation of services, including the provision of crisis services within our designated area.
- Selected staff has completed training in Applied Suicide Intervention Skills Training (ASIST) and have provided training to sixty-three (46) community practitioners.
- AAHSD was trained and participated in OPH/Emergency Preparedness exercises/activities.

7. Major Recommendations:
   None

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

9. Availability (hard copy, electronic file, website):
   Located in the policy and procedure manual and website. This report was made available to the Governing Board, all staff, and copies were available in all service locations for clients/visitors. A copy was sent to senior LDH officials as well as the entire 'Acadiana Delegation'. Additionally, this report is posted on our website for public view.

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

Annual Management and Program Analysis Report
Fiscal Year 2019-2020

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:	**Joseph Kanter, MD, MPH** 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?

1. Office of the Assistant Secretary (OAS)

Accomplishment #1: Continuous Quality Improvement - The Continuous Quality Improvement Program aims to take an innovative approach to complex problems.

A. What was achieved?

The Office of Public Health launched a Continuous Quality Improvement (CQI) Program and as a result, sixteen Lean Six Sigma Green Belts were certified as of June 30, 2020. The CQI program fostered growth in experts throughout the department who now have

the skills to lead process improvement projects in a succinct, goal oriented, data driven, and customer focused manner. The program also resulted in the successful completion of various Lean Six Sigma projects throughout various bureaus within the Louisiana Department of Health. Examples of these projects included:

- Reducing the time to determine Medicaid Long Term Care eligibility
- Improving Waiver Process for the Office of Aging and Adult Services and the Office of Citizens with Developmental Disabilities by reducing the Plan of Care approval time and reducing the time to deliver services
- Reducing the number of defects seen in vendor compliance reviews for Women, Infant and Children (WIC) Nutrition Services
- Completing an improvement project in the Milk and Dairy Unit by Sanitarian Specialty Operations. Quality standardization of inspections and improved mechanical checking of equipment reduced inspection volume and plant check inspection time. Travel time was reduced and workload management is now focused on managing with LEAN principles.

B. Why is this success significant?

Outside of the efficiency gains generated by the projects themselves, employee development was enhanced through the Lean Six Sigma certifications. OPH was able to certify sixteen Lean Six Sigma Green Belts, and forty-six leaders were trained as Yellow Belts. In order to be certified as a Green Belt, trainees were required to define their project, gather data from rudimentary and/or electronic systems, analyze data using statistical software, implement an improvement process (typically a pilot), and establish a control plan to ensure the process changes are sustained.

The Lean Six Sigma training was also important because it developed trainees' skills in rethinking and reorganizing processes and eliminating waste. Ultimately, participants are now able to lead their own projects to find the most efficient and effective solutions to complex problems within the department.

C. Who benefits and how?

The customers of the Louisiana Department of Health and the public at large benefit from the implementation of Lean Six Sigma techniques throughout the department. Lean Six Sigma (LSS) takes a look at existing processes and procedures and strives to eliminate waste and non-value adding activities, which demonstrates to the Louisiana taxpayers and other funders that the Department is a good steward of resources.

D. How was the accomplishment achieved?

This accomplishment was achieved by designating a department Lead of Continuous Quality Improvement (CQI) as part of the greater department strategy to "be good stewards of the state's resources." The Lead is a Master Black Belt, a person certified at

the highest level of the quality improvement methodology of Lean Six Sigma (LSS) who can not only lead projects but to also confer certification on others. The Lead coached, directed, and managed the program with supplemented instruction from a contracted external trainer who specializes in teaching LSS methodology and techniques in healthcare settings. LDH Leadership support and engagement with the LSS methodology was key in the success of this initiative. As a result of this initiative, the department has quality and efficiency embedded throughout the organization.

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

Yes, the successful launch of the CQI program represents a Best Management Practice because it uses a structured program to consistently train leaders for continuous improvement. By teaching staff how to use data to solve challenges, the organization can be more focused on change, reduce waste in processes and improve quality of services. By examining processes in a measured and structured fashion, garnering the ideas and knowledge from the people who do the work to make it better and increase accountability, staff are more engaged in their work and the organization is more effective in their mission.

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 accomplishment of the successful launch of the CQI program represents a Best Management Practice. Lean Six Sigma is an internationally recognized methodology used by Fortune 500 companies to promote continuous quality improvement in a variety of workplace settings. It can be used to improve a cyclical process, a basic procedural process, or even as an individual Lean technique to improve one aspect of a process.

2. Bureau of Nutrition Services (BONS)

Accomplishment #2: Deployment of the Women, Infant and Children New Management Information system and Electronic Benefit Transfer Systems statewide

A. What was achieved?

The Louisiana Special Supplemental Nutrition Program for Women, Infants, and Children (LA WIC) completed its statewide transition from paper vouchers to electronic benefit transfer (EBT) cards in all 105 WIC clinics. This major transformation in services for our WIC participants began as a pilot of the new management information system (LAWIN) and EBT system in Northwest Louisiana (Public Health Region 7) in January 2019. After successfully piloting in this region, Louisiana received approval from USDA Food and Nutrition Service to move from pilot to statewide deployment. The statewide rollout began in clinics and at WIC authorized grocery stores at the beginning of FY20. The clinic transition was completed on October 14, 2019 and the grocery store transition was completed in December 2019.

B. Why is this success significant?

USDA federal regulations required all WIC State Agencies to issue benefits in electronic benefit transfer (EBT) systems by October 1, 2020. This project required five years of coordinating efforts with the WIC funding agency, USDA, and partner states to complete all required federal documents and reports and to receive the approvals needed to move from planning to pilot to statewide implementation. This was a significant undertaking as this project involved a complete change in programmatic operations. LA WIC successfully trained 600+ local WIC staff on a new management information system (LAWIN) and a new process for issuing monthly benefits to approximately 100,000 WIC participants. This success was also significant for WIC-authorized grocery stores. Approximately 475 WIC-authorized grocery stores in the state had to become WIC EBT compliant and learn the new transaction procedures.

C. Who benefits and how?

This transition to EBT and away from paper vouchers benefits WIC participants, staff, authorized grocery stores, and the Office of Public Health. The WIC participants and staff are benefiting from a more up-to-date system and process in clinics. This transformation also provides improved shopping experiences at WIC-authorized grocery stores and better customer service and dignity for the participants the Program serves. LDH's Office of Public Health is benefiting from further improvements in food cost containment and overall program integrity.

D. How was the accomplishment achieved?

Since the project began in 2015, the LAWIN/EBT project has been supported by LDH/OPH leadership, the federal funding agency (USDA Food and Nutrition Service), regional partners (New Mexico and Texas WIC), and internal project team resources. Louisiana was able to secure federal grant funds above the regular WIC base administrative grant to support the transition to these two new systems (LAWIN and EBT).

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

The accomplishment contributes to the overall success of LA WIC, adds to improved program integrity, and supports the objective of providing better access to nutritious supplemental foods to low-income Louisiana women, infants, and children up to age five while serving as an adjunct to health care during critical times of growth and development. Additionally, with these improvements in customer service and benefit redemption processes at the grocery stores, this accomplishment supports the objective of increasing the statewide number of WIC participants served by reaching more potentially eligible women, infants, and children who may have chosen not to enroll under the more cumbersome paper voucher system.

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

Yes. The integration of technology with the goal of improving efficiency is a best management practice and should be a priority for every agency in the state.

Accomplishment #3: Launch of the Louisiana Hepatitis C (HCV) Elimination Plan and progress to date

A. What was achieved?
After many months of planning and consultations with subject matter experts, LDH launched a robust five-year HCV Elimination Plan with the goal of treating 31,000 patients by end of 2024. The 2019-2024 Hepatitis C Elimination Plan is comprised of six interconnected strategies that reflect a collaborative, comprehensive approach to maximizing the potential to identify, link to care and treat persons living with HCV, and prevent new infections. First year progress on each of the strategies is described below:

1. Innovative Payment Model to ensure Access to HCV Cure
   - Entered into a five (5) year partnership with Asegua Therapeutics. As part of Louisiana's plan to eliminate hepatitis C virus (HCV), this partnership allowed for the implementation of a modified subscription arrangement for HCV treatment for persons living with HCV on Medicaid and people living with HCV incarcerated in Department of Corrections (DOC) facilities. This partnership was the first of its kind in the nation and reflects shared commitment to significantly increase access to the cure of HCV in Louisiana.
   - Negotiated and launched a modified payment model resulting in 4,624 people accessing curative treatment and at least 3,827 people completing treatment in the state's combined Medicaid and corrections populations.
2. Educate the Public on Availability of the Cure and Mobilize Priority Populations for Screening
   - Successfully designed and launched a HCV marketing campaign with advertisements garnering over six million impressions via standard display and streaming audio ad buys, and over 9,000 page views to the HCV webpages on the Louisiana Health Hub website (www.LAHHUB.org).
   - Conducted town hall style meetings with internal and external stakeholders in all nine of the state's public health regions.
3. Expand HCV Screening and Linkage to HCV Care
   - Modified SHHP's 14 contracts with community-based organizations to require integrated HIV, syphilis, and HCV testing and added linkage to care for newly diagnosed as the standard of care.
   - Tested 3,779 persons incarcerated in DOC facilities, which resulted in 457 direct-acting antivirals (DAA) prescriptions being written.

- Implemented an HCV linkage to treatment program resulting in just over 200 persons living with HCV being reached by Linkage to Treatment Coordinators (LTCs), verifying 32% were already treated and assisting 12% of those individuals with linkage to treatment.

4. Strengthen Active Surveillance and Scale-up Data to HCV Cure Programs
   - Designed and implemented a modern state-of-the-art viral hepatitis surveillance system, known as HepCat, by the end of the FY 20.
   - Revised the Sanitary Code to include reporting of HCV negative test results
   - Modified the previously developed data system for conducting HIV linkage to care and HCV linkage to cure and trained newly hired HCV Linkage to Treatment Coordinators on its operation.
5. Expand Provider Capacity to Treat HCV
   - Trained 668 providers to treat HCV via detailing, Project ECHO (Extension for Community Healthcare Outcomes), and HCV Champions series resulting in 292 providers having written prescriptions for direct-acting antivirals (DAA) for the first time in Louisiana over the past fiscal year.
6. Implement Harm Reduction and Complementary Treatment Strategies
   - Collaborated with the Office of Behavioral Health's Louisiana State Opioid Response (LaSOR) Program and the Bureau of Community Preparedness' Opioid Program to secure funding for expansion of harm reduction initiatives related to HCV/ opioid use disorder (OUD) treatment and development of syringe service program (SSP) interventions in regions of the state where SSPs can legally operate.

B. Why is this success significant?
With the exception of COVID-19, HCV kills more Americans each year than all other infectious diseases combined. Tens of thousands of people in Louisiana's Medicaid program and correctional facilities are known to have chronic HCV, a disproportionate number of whom are low-income and/or incarcerated. Moreover, the rate of new infections is on the rise as a result of injection drug use associated with the opioid epidemic. Louisiana is now aligned with national treatment guidance from the Centers for Medicare and Medicaid Services (CMS) and two of the leading medical authorities on HCV, the American Association for the Study of Liver Diseases (AASLD) and the Infectious Disease Society of America (IDSA).

C. Who benefits and how?
At the individual level, as more people receive HCV curative treatments and participate in harm reduction syringe services programs (SSP) for HCV prevention, the number of future HCV cases will decrease. With curative treatments near 100 percent efficacy and minimal side effects, people living with HCV now have an unprecedented chance to live virus-free, and avoid liver failure, cancer-causing cirrhosis, liver transplants, and other costly health complications.

At the public health level, the cost savings associated with the modified subscription model for HCV treatment will benefit the agency and the state, allowing it to spend a fixed amount for unlimited access to an otherwise costly cure. Longitudinally, medical costs associated with HCV disease progression will be mitigated.

D. How was the accomplishment achieved?

The implementation of HCV elimination program interventions is carried out by a large cross-unit team within LDH including the OPH Assistant Secretary's Office and the Bureau of Infectious Diseases, including the STD/HIV/Hepatitis Program (SHHP). LDH has also collaborated with many intra-agency and community partners.

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

Yes. This accomplishment is directly related to one of LDH, OPH and SHHP's major priorities: to eliminate hepatitis C. This is also the core outcome of the Department of Health and Human Services (HHS) National Viral Hepatitis Action Plan 2017-2020.

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

Yes. A subscription-based payment arrangement may potentially be applicable to other therapeutic areas and health issues in the state such as diabetes, PrEP, and OUD medications. The Louisiana HCV Elimination Plan is currently being used as a model for other state health departments.

3. Bureau of Regional and Clinical Operations

Accomplishment #4: Community Health Worker (CHW) Pilot:

A. What was achieved?

In May 2019, OPH launched a pilot community health worker (CHW) program, initially branded CareConnect and later named Community HealthWays, in St. Landry Parish. Through this program, Parish Health Unit (PHU) participants are screened for health related social needs (HRSNs), such as education, housing security, and employment. CHWs provide individualized navigation to services to help address these unmet needs. Through January 2020, CHWs screened 1,620 PHU participants and 41% screened positive for unmet social needs. CHWs made 1,239 referrals to programs and resources. Areas of greatest need included food insecurity, employment and utility assistance.

OPH had plans to expand this pilot to six additional parishes in spring 2020, but with the emergence of the COVID-19 pandemic, OPH shifted the program's focus to assist with COVID-19 contact tracing and resource coordination.

B. Why is this success significant?
Community HealthWays seeks to improve the quality of life for Louisiana residents by helping to address individuals' HRSNs and the structural factors that lead to poor health outcomes. Research has shown that similar efforts have yielded decreases in emergency department use and medical costs.

C. Who benefits and how?
Community HealthWays program participants, and the local communities benefit from this program. Individual participants benefit by having their HRSNs met. The communities receive real-time data on individuals' HRSNs and gaps in resources. This data can be used to inform policy and investment.

D. How was the accomplishment achieved?

The St. Landry Community HealthWays pilot was executed by the OPH Region 4 team, including three CHWs, in collaboration with key partners. Key partners in the success of the project include:

- Community Health Worker Workforce Committee, LSUHSC's Community Health Worker Institute, the Louisiana Community Health Outreach Network (LACHON) which provided technical assistance and training
- Medicaid which assisted with the development of a funding/sustainability model for the CHW workforce
- Well-Ahead Louisiana which assisted with the development of a CHW Index to choose expansion parishes

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

The CHW program was identified as the Bureau of Regional and Clinical Operation's "Big Bet" in support of the agency's strategic plan, and is identified and referenced in the plan under the formerly branded name, "CareConnect". The program supports the agency's efforts to integrate Public Health 3.0 strategies promoting population health.

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

Yes. CHW initiatives have been cited as a best practice to address HRSN and advance a population health agenda. The pilot has been shared widely with other branches of state government, namely DCFS.

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?

OPH consistently implements effective strategies to improve the health of Louisianans and contributes a long and impressive list of successes beyond what is mentioned in this report. OPH has played a central role in Louisiana's response to the COVID-19 pandemic. Since COVID-19 emerged in Louisiana, OPH had to adapt and shift priorities while still delivering on 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:

    1. To what do you attribute this success?
    2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

OPH is making significant progress in addressing HCV. Since the launch of the Hepatitis C Elimination Plan, an average of 407 persons have started HCV treatment each month, compared to only 67 persons accessing treatment each month prior to the launch of the plan. As expected, persons who are accessing treatment as a result of the Hepatitis C Elimination Plan are younger. This progress is largely related to the integrated and multi-strategy approach of the Hepatitis C Elimination Plan.

The number of breastfeeding women as a percentage of postpartum women enrolled in Louisiana WIC has gradually improved. In 2018, the average was reported at 22%. Louisiana WIC continues efforts to promote breastfeeding as the optimal method of providing nutrition for infants with the Breastfeeding Peer Counselor Program as well as additional benefits such as increased supplemental foods, a breast pump and support by Certified Lactation Counselors.

The number of monthly callers to the Louisiana Tobacco Quitline has increased significantly. Successful media efforts to promote the Quitline have helped increase call volume to the Quitline.

- **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?

Due to COVID-19 the vast majority of EMS education agencies in the state shut down and postponed courses until adequate safety measures could be put in place, impeding our ability to develop the EMS workforce. In addition, many of the ambulance services and hospital based clinical sites were not available for students to complete training. Normally, the Bureau of EMS licenses in access of 2000 high school students annually. Due to COVID-19, high schools were unable to complete the courses necessary for licensure.

Fewer students are accessing school-based health services due to the closure of schools due to COVID-19 in the fourth quarter of FY2020.

The United States Department of Agriculture's Commodity Supplemental Food Program (CSFP) served 29% fewer individuals than planned in SFY20. This program addresses food insecurity for individuals who meet income and age requirements for participation. Participants who are 60 years of age and older receive food boxes monthly at community distribution sites. CSFP helps vulnerable seniors who may have to choose between food and other daily living needs. In SFY20 Q3 and Q4, participation was impacted by the COVID-19 public health emergency.

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

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

OPH did not revise its 5-year Strategic Plan under Performance-Based Budgeting, as it was revised the previous 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?**

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.

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

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

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

A. Problem/Issue Description

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

An operational concern is network redundancy and security.

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

While we were able to make progress on our strategic plan, time lost this fiscal year in mitigating the attack to our technology infrastructure required a substantial amount of effort that should have been spent advancing the strategic plan even further. This issue is an obstacle to faster and more sustainable progress, as well as protecting valuable information that is not retrievable in some cases. Online portals are only saving resources if our customers and staff can utilize them. Equipment software that is not compatible with our more "locked down" infrastructure has caused further expense to develop workarounds.

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

This is experienced across our agency. Some areas where it has particularly impacted us include the public health laboratory software, procurement (RCAPS) and payment management workflows.

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

This issue affects internal staff and program productivity as well as our external customers and other stakeholders who rely on our services.

5. How long has the problem or issue existed?

This has been a recent issue that occurred in early 2019 and again in late 2019.

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

It is beyond our expertise to fully understand causes of this issue.

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

At the Office of Public Health Laboratory, newborn screening testing, which is time critical, had to be run offline and then results merged to allow reporting. This was only after an expensive technology program was added to one of the instruments. Quite a bit of scientific staff time and OTS time was spent validating the new workarounds and solving for discordant interfaces once security measures were implemented.

In addition, when systems are down, operations are either paused or reverted to paper processes during downtime.

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?

We are experiencing insufficient permanent TO positions to fully execute our mission.

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

While we are able to make progress on our strategic plan, this issue is an obstacle to faster and more sustainable progress.

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

This is experienced across our agency. It has particularly impacted us in implementing programs aimed at social determinants of health, expanding testing in the OPH laboratory, and sewer education and technical assistance provided by Sanitarian Services.

Finally, and importantly, our ability to mobilize staff members to address the COVID-19 pandemic has been hampered due to the fact that many of our employees are contract rather than permanent TO positions. In general, these contract employees can't be activated, so it limits our ability to respond to an emergency. It also results in State employees carrying a heavier load rather than being able to spread to additional employees who work for the 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. It is an obstacle to providing excellent customer service, and internally, existing staff are stretched.

5. How long has the problem or issue existed?

This has been an ongoing issue.

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

The cause of the problem is insufficient permanent TO. When areas of priority require additional TO, then other area vacancies are either not filled, or they are replaced with a temporary employee or contracted employee.

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

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.

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 and 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, reviews 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 (LPAS) 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:

Report # 1

1. Title of Report or Program Evaluation:
   2018 Surveillance Report

2. Date completed:
   September 2020, Data Analysis completed in May 2020.

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   This report includes HIV and STD surveillance data. Information contain herein includes all STD data entered by the SHHP and all HIV data entered as of December 21, 2019.

   Included in the report are traditional analyses to report the morbidity of HIV and STDs by selected demographics and geographic areas. Additional analyses in the report focus on perinatal exposure of HIV and syphilis and highlighted populations of interest such as youth and transgender persons.

   This report provides data on diagnoses of HIV infection, infections classified as stage 3 (AIDS), as well as death and prevalence data.

4. Methodology used for analysis or evaluation:
   Data Analysts use various analytic procedures in SAS to create the varied analyses within the report. The most frequent analyses include frequencies and generating rates using the Census Population Data.

5. Cost (allocation of in-house resources or purchase price):
   The total cost for graphic design production and printing of 1,000 hard copies was

$14,500 in addition to Data Analyst work time and Data Manager work time.

6. Major Findings and Conclusions:

HIV Surveillance

- In the most recent *CDC HIV Surveillance Report (Vol. 31)*, Louisiana ranked 4th in the nation for HIV case rates (20.9 per 100,000 population) and 12th in the number of reported HIV cases. The Baton Rouge MSA ranked 3rd and the New Orleans MSA ranked 7th for HIV case rates (27.3 and 24.2 per 100,000, respectively), among the large metropolitan areas in the nation.

- The New Orleans region had the highest number of new HIV diagnoses and the Baton Rouge region had the highest rate of new HIV diagnoses out of all nine public health regions. The Baton Rouge region had the 2nd highest number and the New Orleans region had the 2nd highest rate of new diagnoses.

- Women accounted for 26% of new HIV diagnoses and the HIV diagnosis rate among men was three times greater than the rate for women in Louisiana.

- Blacks continue to experience severe health inequalities; the HIV diagnosis rate for Blacks was over five times higher than among whites. Although Blacks make up only 32% of the state's population, 70% of newly diagnosed HIV cases and 72% of newly diagnosed AIDS cases were among Blacks.

- Of the 976 persons diagnosed with HIV, 13% had an AIDS diagnosis at the time of their initial HIV diagnosis, an additional 2% had an AIDS diagnosis within three months.

7. Major Recommendations:
Louisiana has some of the highest rates of HIV and STDs in the nation and continued emphasis must be placed on population-level screening, efficient linkage to medical care and treatment.

8. Action taken in response to the report or evaluation:
Analyses within the report are used to educate communities and providers regarding the status of HIV and STDs in Louisiana. In addition, data within the report are used by the public for a multitude of trainings, grant applications, or health notices.

9. Availability (hard copy, electronic file, website):
The report will be available in hard copy, will be distributed as a PDF attachment through email networks, and is available for download from the SHHP website (http://ldh.la.gov/index.cfm/newsroom/detail/1935).

10. Contact person for more information:
    Name: Samuel Burgess, Director, STD/HIV/Hepatitis Program and DeAnn Gruber, Director, Bureau of Infectious Diseases
    Agency & Program: Louisiana Department of Health, Office of Public Health, Bureau of Infectious Diseases, STD/HIV/Hepatitis Program
    Telephone: (504) 568-7474;
    E-mail: samuel.burgess@la.gov and deann.gruber@la.gov

Report # 2

1. Title of Report or Program Evaluation:
   Occupational Health Indicators, Louisiana 2012-2016

2. Date completed:
   January 2020

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   An occupational health indicator is a specific measure of a work-related disease or injury, or a factor associated with occupational health, such as a workplace exposure, hazard, or intervention, in a specified population. Each year, the Section of Environmental Epidemiology and Toxicology's (SEET's) Occupational Health and Injury Surveillance Program collects and submits Louisiana OHI data to the National Institute for Occupational Safety and Health (NIOSH) and the Council of State and Territorial Epidemiologists (CSTE). Indicators allow a state to compare its health or risk status to that of other states, to evaluate trends over time within the state, and to guide priorities for prevention and intervention efforts.

4. Methodology used for analysis or evaluation:
   The CSTE document entitled "Using the CSTE Occupational Health Indicators: A Guide for Tracking Occupational Health Conditions and their Determinants" (2019 OHI Guidance Manual) served as the guideline for data collection. The CSTE guide provides detailed methods for each indicator on how to collect data and calculate frequency measurements that are consistent at a national level. The majority of the data were collected from publicly available, national datasets; however, some data was acquired through sources that are specific to Louisiana, such as emergency department, hospital discharge, and Vital Records databases.

5. Cost (allocation of in-house resources or purchase price):
   Occupational Health Program staff work time.

6. Major Findings and Conclusions:
   There was a significant decrease in the rate of work-related hospitalizations. There was a decrease in the number of work-related amputations with days away from work reported by employers.

7. Major Recommendations:
   N/A

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

9. Availability (hard copy, electronic file, website):
   Website:
   https://ldh.la.gov/assets/oph/Center-EH/envepi/occ_health/Documents/OccupationalHealthHazardIndicatorsinLouisianaReport_1-21-20.pdf

10. Contact person for more information:
    Name: Anna Reilly
    Title: Environmental Health Scientist Supervisor
    Agency & Program: LDH/OPH/SEET/Occupational Health
    Telephone: 504-568-8160
    E-mail: anna.reilly@la.gov

Report # 3

1. Title of Report or Program Evaluation:
   ATSDR's Program to Promote Localized Efforts to Reduce Environmental Exposures (APPLETREE): Annual Performance Report, FFY20

2. Date completed:
   March 19, 2020

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   Annual summary of activities performed through the ATSDR's Program to Promote Localized Efforts to Reduce Environmental Exposures (APPLETREE) grant, as required by APPLETREE guidelines

4. Methodology used for analysis or evaluation:
   Summary of the types and numbers of documents produced, discussion of response actions performed at specific sites, estimates of the number of Louisiana communities who received and comprehended environmental health recommendations and health education materials

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

6. Major Findings and Conclusions:
   - LDH has found it to be challenging to measure the long-term community outcomes at various sites.
   - Although LDH may list a site in a particular FFY work plan, the environmental data collected for that site may not be available during that particular FFY.

7. Major Recommendations:
   Since one of the main challenges is to be certain that community members understand site assessment findings and are receptive to the materials that are provided to them at the meeting, LDH will work closely with ATSDR in community outreach such as the administering of pre- and post- assessment surveys to community members at the various sites throughout Louisiana.

8. Action taken in response to the report or evaluation:
   Continuing training of staff in health education and community outreach

9. Availability (hard copy, electronic file, website):
   Electronic file, originally submitted to ATSDR web submission site

10. Contact person for more information:
    Name: Rosalind Green
    Title: Supervisor
    Agency & Program: LDH/OPH/SEET
    Telephone: (504) 568-8814
    E-mail: Rosalind.Green@la.gov

Report #4

1. Title of Report or Program Evaluation:
   Reducing Drinking Water Exposures in Louisiana

2. Date completed:
   5/22/2019

3. Subject or purpose and reason for initiation of the analysis or evaluation:
   CDC continuation application/project update

4. Methodology used for analysis or evaluation:
   Monitoring and Evaluation approach used to determine if grant objectives/goals were on track for completion

5. Cost (allocation of in-house resources or purchase price):
   N/A

6. Major Findings and Conclusions:
   Project was on track for completion

7. Major Recommendation:
   Continue to work towards unmet goals prior to end of funding period

8. Action taken in response to the report or evaluation:
   Continue to work towards unmet goals prior to end of funding period

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

10. Contact person for more information:
    Name: Darcie Olexia
    Title: Environmental Health Scientist Supervisor
    Agency & Program: OPH/Section of Environmental Epi & Toxicology
    Telephone: 504-568-8146
    E-mail: Darcie.Olexia@la.gov

Report #5

1. Title of Report or Program Evaluation:
   Louisiana Healthy Schools Year 1 Evaluation Report

2. Date completed:
   August 30, 2019

3. Subject or purpose and reason for the initiation of the analysis or evaluation:
   The Center for Disease Control and Prevention (CDC) (grantor) requirement. The evaluation report examined the three Louisiana Healthy School's strategies (infrastructure development, professional development, and technical assistance), per CDC guidelines.

4. Methodology used for analysis or evaluation:
   Data was primarily collected using internal tracking databases created by the evaluator and analyzed using descriptive statistics, quantitative and qualitative analyses. CDC's evaluation framework and reporting guidelines were followed. Evaluation results reported pre-established evaluation questions and corresponding indicators as well as barriers and facilitators.

5. Cost (allocation of in-house resources or purchase price):
   $29,025 Evaluator (.5 FTE Salary + Fringe Benefits)

6. Major Findings and Conclusions:
   Louisiana Healthy Schools provided excellent Professional Development (PD) in year one; however, they struggled to deliver and track Technical Assistance (TA) because there was a lack of protocol and system. They were also not able to develop a coalition and capture School Health Index (SHI) findings. These barriers inhibited the successful implementation of two strategies (infrastructure development and technical assistance).

7. Major Recommendations:
   Recommendations included:
   - Implementing a new protocol to track TA using a TA Request form,
   - Give follow-up resources and surveys after every PD training,
   - Improve coordination with partners in year two,
   - Address the tracking of out-of-school-time and chronic disease management within target school districts and statewide
   - Collect reference numbers for SHI and work with the evaluator to create, and disseminate findings more often.

8. Action taken in response to the report or evaluation:
   The recommendations were implemented from the report in Year 2.

9. Availability (hard copy, electronic file, website):
   Electronic File - T:\Health Promotion\Early Childhood & School Health\2. Operations\1. Grant Management\FY 19\FY 19_CDC 1801 School Health\Reporting and Budget

10. Contact person for more information:
    Name: Hana Sladick
    Title: Healthy Communities Evaluation Coordinator
    Agency & Program: Bureau of Chronic Disease Prevention and Healthcare Access, Healthy Communities
    Telephone: 504-568-2543
    E-mail: hana.sladick@la.gov

Annual Management and Program Analysis Report
Fiscal Year 2019-2020

Department:	**Louisiana Department of Health (LDH)** 09-330 Office of Behavioral Health
Department Head:	**Dr. Courtney N. Phillips** LDH Secretary
Undersecretary:	**Ruth Johnson**
Assistant Secretary:	**Karen Stubbs, J.D.**

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

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: Methadone Coverage Expansion:

A. What was achieved?

Effective January 20, 2020, the Medicaid Program added coverage of Methadone as an authorized medication for Opioid Use Disorder (OUD) treatment provided in Opioid Treatment Programs (OTPs).

B. Why is this success significant?

Prior to Medicaid coverage, the OTPs operated a self-pay cash business (or OBH grant funded).

C. Who benefits and how?

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.

D. How was the accomplishment achieved?

OBH included a budget request in the SFY 2019-2020 LDH budget to include Medicaid coverage of methadone for Medicaid eligible members diagnosed with an OUD. The federal Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act required state Medicaid programs to cover all FDA-approved MAT drugs, including Methadone, by October 1, 2020.

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

Methadone coverage was one of the approaches used to expand evidence-based Medication-Assisted Treatment (MAT), which impacted 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?

OBH engaged staff from its fiscal, policy, and clinical teams, in addition to Medicaid staff, to form a workgroup to develop a work plan and timeline of necessary steps to implement a new Medicaid covered service. Stakeholder involvement, including a series of training calls for the OTPs and the managed care organizations (MCOs), was a key component of the work plan to smooth the transition for these new providers.

Accomplishment #2: 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 2019-2020 was the Center's first full year of operation.

For SFY20, the Center for Evidence to Practice initiated five (5) training cohorts to

train Medicaid-serving behavioral health practitioners in EBPs, with a total of 147 behavioral health practitioners. In addition, 350 behavioral health practitioners were engaged in research-informed practices such as Motivational Interviewing. The Center for Evidence to Practice has also developed and refined their website to provide user-friendly information to consumers and stakeholders on EBPs and how to access them, including an interactive map of LA Medicaid EBP providers across the state.

B. Why is this success significant?

This initiative expands and increases access to evidence-based practices in behavioral health for LA Medicaid youth population. In addition, this also 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 the Louisiana Department of Children and Family Services as well. (Resources are available if needed.)

D. How was the accomplishment achieved?

Medicaid and OBH jointly funded the work of the Center for Evidence to Practice, under the Center for Healthcare Value and Equity (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

Accomplishment #3: 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.

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 #4: Board of Regents (BOR) Narcan Project:

A. What was achieved?

Through research and funds by the OBH, the Louisiana Board of Regents (BOR) passed the Opioid Education, Training and Reporting Policy. Narcan (naloxone) is an opioid antagonist used for the complete or partial reversal of opioid overdose, including

respiratory depression. Narcan is also used for diagnosis of suspected or known acute opioid overdose and also for blood pressure support in septic shock. Narcan has been secured for every public institution of higher education in the state, as well as additional private institutions while educating campus communities on the dangers of opioids misuse and abuse.

B. Why is this success significant?

The policy will go into effect fall 2020 and will require (1) that the entire campus community receive information about the dangers of opioid misuse, (2) that certain campus persons (designated students, staff, and law enforcement) receive naloxone administration training, and (3) mandates the reporting of any naloxone administrations on campus. This accomplishment makes Louisiana one of a handful of states to implement policy in this area as we tackle this national crisis on all fronts, utilizing every tool at our collective disposal.

C. Who benefits and how?

This benefits current and future generations of Louisiana's college students who will be able to safely matriculate throughout their college experience free from the negative consequences of opioid misuse and abuse, while learning skills to keep themselves, their families and their communities safe as well. This was accomplished through the teaching of safe medication practices and Narcan administration training in the event of a suspected opioid overdose, while helping to erase the stigma of those who are in recovery and highlight available resources for those who may be battling addiction.

D. How was the accomplishment achieved?

This all-hands-on-deck process entailed the BOR convening a workgroup of representatives from all four public higher education systems and a representative from the association of private colleges to create the comprehensive policy, with feedback from LDH-OBH along the way. After the BOR adopted the policy in June 2020, LDH-OBH served as liaison between BOR and LGEs to have LGEs serve as the Narcan pick-up site for their regional institutions which reinforces our campus community approach to student substance use prevention.

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

This accomplishment generally addresses the enhancements to substance use disorder treatment the OBH has focused on by making Naloxone accessible and available to individuals, families and communities.

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

This strategy is a recommended best practice in the Office of National Drug Control Policy's 2020 National Drug Control Strategy and should be shared widely with other executive branch departments or agencies and state boards of regents.

Accomplishment #5: Peer Support Specialists (PSS) Expansion:

A. What was achieved?

During SFY20, an additional 50 peers successfully completed the two-week long Peer Employment Training (PET) to become recognized as Peer Support Specialists (PSS). With the safety protocols required due to COVID-19, the PET training also successfully transitioned from an in-person training to a virtual training via Zoom. During SFY20, LDH/OBH also initiated steps to add Peer Support Services to the array of Medicaid reimbursable services for behavioral health services, which has included the development of a Peer Framework and service definition

During SFY20, LDH/OBH also established a Peer Stakeholders Workgroup that included community partners, peer support specialists, and stakeholders to begin the dialogue of obtaining input to guide next steps in the statewide expansion of peer services. LDH/OBH also began drafting a request for information (RFI) to be released in early SFY21 to obtain input from partners and stakeholders on the development of the infrastructure to expand the training and formalize the certification/credential for Certified Peer Support Specialists (CPSS) in Louisiana. LDH/OBH also consulted with several other states and national subject matter experts to obtain additional feedback regarding how the expansion of CPSS and peer services has occurred in other areas of the country.

B. Why is this success significant?

This success is significant for numerous reasons. These steps comply 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 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 PET training to virtual to comply with COVID-19 safety protocols has also helped to increase participation in the training, as participants are not required to leave their homes and families for a two-week period. 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 one (1) virtual

PET training per month, which will allow LDH/OBH to train a minimum of 140 Peers.

D. How was the accomplishment achieved?

These accomplishments were achieved through partnerships 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. Through collaborations with RI International of Arizona, which is the proprietor of the PET curriculum, Louisiana's Advance Facilitator Trainers were provided additional training on how to successfully facilitate the training on-line by utilizing Zoom. The OBH contractor to host and organize the PET Trainings, The Extra Mile Region IV, also participated in trainings and obtained the Zoom platform to transition the trainings to virtual.

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 expanding Peer Support Services and satisfying the DOJ agreement.

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 PSS is primarily associated with behavioral health programs, the use of Peers has also been identified as helpful with many populations and programs, such as Veterans/service Members, individuals with chronic health conditions, parents of children with behavioral health conditions, and child welfare systems.

II. Is your department Five-Year Strategic Plan 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) was on target yet due to the public health emergency, statewide technological challenges, and weather-related incidents that occurred over the fiscal year particular areas of implementation of several of our initiatives relative to our agency's strategic plans were delayed. Nonetheless, we are moving in a forward direction anticipating positive outcomes regarding any impacted initiatives. 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:

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) Requests for Independent Assessments (SFY 2019): 2,903
4) Requests for Independent Assessments (SFY 2020): 3,367

Finally, LDH Transition Coordinators have been performing face-to-face transition assessments with members of the target population. To date, My Choice Louisiana OBH Transition Coordinators have transitioned 49 individuals.

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.

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 planning activities which will occur through Calendar Year 2021.

- **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.

While the scope of the project is vast, with multiple moving parts, OBH is working diligently to adhere to timelines within the implementation plans. In order to offset various external barriers that have occurred since 2019 and the multiple competing priorities of the office, additional staff approved within the SFY 21 budget will allow for more a more focused and targeted approach to implementation of the various components of the DOJ Agreement.

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., malware, 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 planned on revising and updating the strategic plan until the COVID-19 Pandemic occurred.

- **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

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 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.

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.

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. 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. With the inability of our Transition Coordinators to go out in to the community and meet with the residents in these facilities, this process has been impeded, not but 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 (a wireless router that acts as mobile Wi-Fi hotspot) 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 any 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.

However, overall, OBH realized minimum long term impacts after the initial reorganization and realignment with COVID-19 protocols and adjustments.

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?

Department Issue #2: OBH Organizational Structure

A. Problem/Issue Description

1. What is the nature of the problem or issue?
   The organizational structure of OBH doesn't align with our subject matter areas, and is deficient in certain areas of priority.

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

This issue does impact our efficiency, which ultimately reduces our ability to most effectively progress with our strategic plan.

3. What organizational unit in the department is experiencing the problem or issue?
This issue impacts all of the units within OBH.

4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
Due to the decentralized nature of staff working within the same subject matter areas, communications with outside stakeholders such as other LDH offices, LGEs, providers and other state agencies, are at risk of not being transparent or consistent.

5. How long has the problem or issue existed?
This issue has existed, to some degree, since OMH and OAD 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; an increasing prevalence of opioid abuse; and the resulting need for treatment and staff growth associated with those grant related initiatives. 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 may 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 spring 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 is initiating our submission to Civil Service. This has resulted in significant progress with this action, even in light of the pandemic. Our goal is to have the plan ready for presentation to Civil Service no later than the spring of 2021.

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

5. Do corrective actions carry a cost?

   ☒ No. If not, please explain.
   Our business reorganization does not include requests for additional TO or other resources, so we don't anticipate any significant cost.

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

for any additional funds.

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

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

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

☒ **Internal audit**
The 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

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 20120 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: LDH, 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 30, 2019

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 $79,100.00 ($100.00 per compliance check x 791 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 2020 is 11.0%.

7. Major Recommendations:
   OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2020 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 2019 Annual Synar Report is available by hardcopy, and may be accessed online at http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1390.

10. Contact Person:
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1. Title of Report or Program Evaluation**:**
   SAMHSA Block Grant Annual Reporting (SAPT and CMHS)

2. Date completed:
   Louisiana's CMHS and SAPT Behavioral Health reports must be submitted to SAMHSA no later than December 1st of each year. Some components of reporting are completed quarterly with an annual review prior December 1. If OBH misses the statutory date for submitting the reports, it will not receive any federal Block Grant funds for that federal fiscal year.

3. Subject/purpose and reason for initiation of the analysis or evaluation:
   Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. 300x-52(a)) requires SAMHSA to determine the extent to which States and Jurisdictions have implemented the State plan for the preceding fiscal year. States and Jurisdictions are required to prepare annual reporting for submission that consists of multiple components which include data submissions, performance indicators and fiscal tables. The annual reporting needs to include the purposes for which the CMHS and SAPT funds were expended, recipients of grant funds, authorized activities funded, and services purchased with such funds. CMHS and SAPT reports are not combined.

4. Methodology used for analysis or evaluation:
   OBH Quality staff work in collaboration with OBH analytics, program and fiscal staff and LGEs in the development of the annual reports. Some data is submitted quarterly; annual reporting submissions require several months of preparation and typically begin in August of each year.

   OBH Analytics staff problem solve, plan, and develop methodologies for data report analysis. OBH Analytics staff analyze performance/outcome data and prepare and disseminate monitoring and performance reports/dashboards. Additionally, they produce standard URS (Uniform Reporting System; Client Level Data Uploads) tables, performance indicators, and reporting tables. In order to complete data based reports, OBH Analytics staff maintain the operation of the OBH Data Warehouse, maintain the OBH Client Level Data Manual, and oversee LGEs' EHR data submissions. LGE data submissions are continuous, and are sent to the OBH Data Warehouse on a semi-monthly basis.

   Most components of the December 1 reporting are submitted via SAMHSA's online portal, Web Block Grant Application System (WebBGAS). Other submissions are completed through their respective SAMHSA sponsored online portals.

5. Cost (allocation of in-house resources or purchase price):
   There is no cost associated with these reports. These reports are generated in-house; OBH program staff use data from the OBH Data Warehouse to generate client level data based reports.

6. Major Findings and Conclusions:
   The primary purpose of the reports is to track and monitor fiscal, program, service and client variables/indicators across time. No major findings/conclusions.

7. Major Recommendations:
   No major recommendations.

8. Action taken in response to the report or evaluation:
   Data-based decision making relative to programs and services.

9. Availability (hard copy, electronic file, website):
   The data is submitted directly into SAMHSA portals. SAMHSA makes the client level data reporting available to the public in PDF format. The Annual Report from SAMHSA's WebBGAS system is distributed via email to the Louisiana Behavioral Health Advisory Council and upon request.

10. Contact Person:
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Annual Management and Program Analysis Report
Fiscal Year 2019-2020

Department: **Louisiana Department of Health (LDH)**
09-340 Office for Citizens with Developmental Disabilities

Department Head: **Dr. 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: OCDD Implements Wellness Guide and Tools for COVID Related Adaptations:

A. What was achieved?

During the Developmental Disabilities (DD) Council partnership completed FY 18-19, OCDD's Clinical leadership piloted an Emotional Wellness Guide that merged the traditional person centered thinking discovery approaches with a more focused consideration of wellness dimensions and how each of these plays out in the life of every

recipient. During FY 19-20 OCDD's Clinical team partnered with its Waiver division to build these key wellness questions into its required planning elements, and incorporated the wellness guide format as a component of the annual Comprehensive Plan of Care (CPOC) (it is also programmed into the developing eISP (electronic Individual Service Plan)). This Guide can be used, as appropriate, for each individual. The core uses of the wellness guide include:

a) Communication between the individual/family and the paid support structure,
b) A daily guide to any staff supporting the individual about the core components/activities that MUST be present throughout the individual's day/week as the guide becomes the individual's dynamic list of non-negotiables, and
c) A prelude to any professional involvement such that these important aspects of a good day/life for the individual can be communicated with the professionals and work synergistically with any needed clinical treatment.

Providers and support coordinators received training on using the Emotional Wellness Guide and it is now featured as one of the core CPOC attachments.

As Louisiana's Office for Citizens with Developmental Disabilities worked with individuals, providers, and families throughout this pandemic, several themes emerged including:

a) It is difficult to support someone and to focus on wellness or positive actions when you (family member or caregiver) are struggling with the same concerns,
b) When you need help even in good times to meet your wellness and self-care needs, the tips on wellness and self-care in a challenging time become even more important so they do not get missed,
c) Misconceptions exist about what an individual with Intellectual/Developmental Disabilities (I/DD) is able to understand, and thus sometimes people misunderstood the importance of shifting focus (i.e. how things were discussed with and in front of the individual, how much news was watched, and how to best give control to the individual in the situation), and
d) Everyone struggled with how to maintain wellness and connect with others when life became very different.

To support individuals, their families and providers, OCDD Clinical Team focused on two primary areas: 1) building and maintaining emotional wellness, and 2) using positive psychology practices to support individuals proactively. To this end the OCDD Clinical Team implemented two key efforts to address these areas: 1) modified guidance available to all individuals, families, and providers on using the Emotional Wellness Guide while considering physical distancing needs, including regular updates (rooted in the core wellness areas from the National Wellness Institute) and 2) development of a daily *learned hopefulness* plan to guide family/staff in supporting the individual each day (adapted from Dan Tomasulo's *Learned Hopefulness* work and Caroline Miller's research on developing *grit*). OCDD's behavioral health staff integrated both tools to set a positive contextual daily framework that could support any formal treatment, and act as the proactive/preventive component. Because the approach offered modifications to

evidenced-based strategies for individuals without I/DD, the tips and guidance were equally applicable to family/staff as it was to the individual they were supporting. Piloting of the tool occurred with select OCDD behavioral health clinicians and recipients they served. Clinicians reported success with both of these tools from an outcomes perspective, and from a staff engagement perspective, the following were experienced:

- Positive reports from staff (ideas and things that can be done today),
- De-escalation of growing symptoms (anxiety, depression, irritability),
- Clarification of some thinking for staff (some things were ok that maybe they assumed were not, such as going through a drive-through)
- Guidance/direction to other partners to use, and
- Maintenance of 98% rate of remaining in most integrated setting during these uncertain situations and with move to telehealth model.

In the upcoming fiscal year, OCDD's Clinical Team is partnering with its Waiver division to incorporate both of these plans into the person-centered planning process to ensure the following wellness and positive psychology supports are foundational for all recipients:

- Building in *times of crisis/disruption* adjustments to the guidelines for supporting emotional wellness,
- Building a combined *Daily Game Plan* and the *Daily Learned Hopefulness Plan* for broader implementation, and
- Outlining of guidance on use of the Emotional Wellness Guide in conjunction with formal health/behavioral health services.

B. Why is this success significant?

Through this approach Louisiana's OCDD is reshaping planning for an individual from a focus on the *help* they need from a basic supports standpoint, and a focus on more traditional approaches to health and safety to a focus on what a well and meaningful life looks like for each individual. With this shift several important changes occur in the role of supports and support staff. First, basic supports of day-to-day activities of life are shifted from the forefront of that day's focus to viewing these more appropriately as the necessary (but not sufficient) things that must occur so one can go out into the day/world and engage in ways that are meaningful and promote wellness. Secondly, the *health and safety* focus shifts away from the "what's wrong or what might go wrong" approach to "what can we go out and get right today." In this manner, health (absence of *illness*/diagnoses and *problems*), resilience, and the core essentials of a positive psychology approach both naturally emerge as wellness becomes more present. This aligns with a proactive and preventive approach that both supports individual positive outcomes, and reduces use and reliance on high cost more urgent/emergent services.

The success of this effort highlights the outcomes that are possible for individuals when these agencies are provided with foundational guidance and key tools aimed at supporting individuals even in the most challenging times. It also offered dual support in that families/staff can use similar strategies to support their own wellness because the tools are rooted in wellness and positive psychology principles that apply to all individuals. Guided adaptations were added following Hurricane Laura as well.

C. Who benefits and how?

The provider and the participants supported by the provider benefit most directly with enhanced outcomes including significant improvement in quality of life. As the project shaped systems recommendations and as OCDD is able to develop methods for expansion and sustainability, the larger Developmental Disabilities Services System—and all participants and their families—will benefit through improved supports and outcomes. As individuals experience improved outcomes, cost shifting and avoidance may occur as individuals will not need to access costlier, acute services as frequently, and some individuals will gain independence resulting in less reliance on paid services.

D. How was the accomplishment achieved?

OCDD's Clinical Services Leadership developed a guided tool for supporting Emotional Wellness. The tool is rooted in the wellness considerations identified by the National Wellness Institute, SAMHSA, and published research. The tool was initially implemented as part of the DD Council provider partnership OCDD completed in FY 19, and the implementation of the Emotional Wellness Guide as a CPOC attachment is the extension of learning from that project to enhance OCDD Home and Community Based Services (HCBS). As the state began to address COVID and the subsequent storm impacts, OCDD's clinical team developed an additional daily focused tool rooted in positive psychology principles and based on newly emerging guidance from experts during the early days of the pandemic. The tool offered daily guidance that family and/or staff could use to support an individual experiencing challenges in these uncertain situation in a manner that maximizes the ability to maintain wellness, needed flexibility and adjustments, maintain important connections, and avoid increased symptoms/behavioral challenges. OCDD's lead Resource Center clinicians supported use of these tools for individuals as they offered treatment/consultation using telehealth and the tools were made widely available with guidance for use and access to virtual engagement tips and alternatives via OCDD's COVID webpage.

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

Yes. Components are aligned with goals II, III, and IV of OCDD's Strategic Plan.

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

Yes. OCDD uses evidence-based approaches in person-centered thinking, wellness, and positive psychology. Tools developed for provider agencies support the implementation of these evidenced-based approaches and allow for integration with clinical/professional treatment approaches when those are also needed. Supporting individuals with complex needs in community-based settings is consistent with national best practices.

Accomplishment #2: Home and Community Based Waiver Improvements:

- **Development of Value-Based Payment Model for I/DD Long-Term Supports and Services**

A. What was achieved?
OCDD, with assistance from the Centers for Medicaid and Medicare Services (CMS), created a Value-Based Payment Model (VBP) for home and community based waiver services for the state's developmentally disabled population. The value-based model will increase independence at home and in the community for individuals in the waiver programs by increasing—and then expanding—the number and types of services used. This change in service mix would be from increased or enhanced person-centered discussions at the planning level, which OCDD believes will lead to a better quality of services to participants, and ultimately in a better quality of life. The state hopes to achieve this by offering a financial incentive to providers who met pre-established goals established by a rubric created by OCDD, with significant input from CMS, providers, and developmental disabilities community. Program funding will come from savings generated in the Louisiana Medicaid budget through efficient management of waiver service opportunities through OCDD's tiered waiver system.

B. Why is this success significant?

The significance of the VBP model is that there are currently no other programs of this kind for home and community based services. Louisiana's program can be used as a template for other states in creating an incentive program that will help to drive quality of life, and quality of planning, for HCBS recipients.

C. Who benefits and how?

This program will benefit waiver recipients. OCDD believes that the focus on person-centered planning goals, and using the entire service spectrum to achieve those goals, would allow the participant to live their lives to the maximum of their capabilities.

D. How was the accomplishment achieved?

The VBP model was accomplished by the creation of a program matrix and rubric, with CMS providing technical assistance. This rubric was then presented to developmentally disability stakeholders who gave invaluable input into the program design by identifying strengths and weaknesses in the initial model, and making suggestions on areas to be considered in the evolution of the VBP concept.

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

Yes. The VBP program represents OCDD's starting point in moving toward improving the quality of service provision in its home and community based programs.

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

should be shared with other executive branch departments or agencies?

Yes. The Value-Based Payment Program is a Best Management Practice per Centers for Medicare and Medicaid Services, and the methodology will be shared with other states and departments to illustrate how value based payment models can be achieved.

- **Approval of Complex Care Add-On for HCBS Waiver Recipients with Complex Medical and Behavioral Support Needs**

A. What was achieved?

OCDD received final approval from the Centers of Medicaid and Medicare Services (CMS) to provide supplemental payments to New Opportunity Waiver (NOW) recipients of Individual and Family Support Services (IFS). The supplemental payment provides additional reimbursement to IFS providers who accrue extraordinary costs in providing these services to individuals whose level of care is greater than the normal IFS recipients. This generally requires direct support workers (DSWs) to have a higher skill level to take care of their individual clients, whose medical needs are higher, but not high enough to require skilled nursing care or behavioral health care.

B. Why is this success significant?

This achievement is significant because providers have often lamented having very high needs clients that require specialized support staff and training that often places the cost of care above the reimbursement. This supplemental payment allows OCDD to identify these cases, and provide relief to the providers in this situation without having to raise the rate for the entirety of the service population that can be served under the current IFS rate.

C. Who benefits and how?

The providers benefit by having additional reimbursement to cover the actual cost of providing the necessary service. Both the provider and the participant benefit because the additional funds could create higher wage rates for their workers and appropriate training. This should lead to higher staff stability and consistency in the provision of services to higher need level clients.

D. How was the accomplishment achieved?

The supplemental payment was accomplished by application and approval from CMS, approval of the developmental disability stakeholders and providers, and funding secured from the New Opportunity Waiver Trust Fund (which allowed versatility in the use of the dollars).

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

Yes. This complex care supplemental payment serves as an effective measure of providing funds to help stabilize the provider workforce serving high needs waiver recipients. In recent years, providers would often choose not to the serve high needs population, or complex clients, because they could not afford the cost of services. This supplemental payment helps

to eliminate this barrier. It also helps eliminate the shortage of providers, and that of direct support staff who can be reimbursed at higher rate.

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

The complex care supplemental payment represents an accomplishment that has no bearing on other state offices, and does not need to be shared with other agencies.

Accomplishment #3: EarlySteps' Success in Exceeding Performance Standards related to Development and Implementation of the State Systemic Improvement Plan

- **Development of Individual Family Service Plans (IFSPs) within 45 days of referral:**

A. What was achieved?

One of the primary program purposes of EarlySteps is to enhance the capacity of families to meet the needs of their infants and toddlers with disabilities. A key measure of success for addressing family needs is timely service delivery to eligible infants and toddlers.

A focus on improving the State's compliance related to this requirement has been in place since 2008. A performance indicator (#24664) is included in OCDD's Strategic Plan and Operational Plan to monitor compliance with this requirement. The current performance standard for this indicator is 97%. In FY 2019-2020, this standard was exceeded with achievement of 99%.

B. Why is this success significant?

The success is significant because it means that children and families will receive supports related to their child's developmental needs timely and in accordance with best practices.

C. Who benefits and how?

The benefit is direct to children and families. Since the children exit the program at age three, timely development of the Individual and Family Services Plan (IFSP) maximizes the time children spend in early intervention, and the subsequent developmental improvement measured from entry to exit.

D. How was the accomplishment achieved?

This EarlySteps goal was accomplished by careful monitoring of system performance. EarlySteps can generate reports from its data system and closely track timelines for completion of IFSPs by its entry offices. During the previous fiscal years, monitoring was triggered to determine the reason for the delay when performance was less than 100%, monitoring was triggered to determine the reason for the delay. The system now tracks delays that are due to family reasons, as compared to system or internal office reasons; if the delay is due to a system reason, a finding is issued and the entry office receives technical assistance in managing its timelines. As a result of this continuous review process, there

were no system reasons for timeline delays identified in FY 2019-2020.

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

Yes. Annually, the US Department of Education, Office of Special Education Programs (OSEP), reviews state performance data against targets. Louisiana has shown continued improvement in meeting expected performance resulting in a higher determination from *needs assistance* to *meets requirements* for the second consecutive year. This accomplishment aligns with OCDD goals.

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

Yes. This accomplishment represents a best practice in terms of tracking and monitoring service delivery for individuals.

- **Implementation of the EarlySteps State System Improvement Plan (SSIP)**

A. What was achieved?

Fiscal year 2019-2020 marked Year 5 of the state's Individuals with Disabilities Education Act (IDEA), Part C Statewide System Improvement Plan (SSIP) to improve child outcomes through early intervention supports that are focused on family concerns, priorities, and resources and provided through a team-based approach. As a result of targeted implementation, EarlySteps has maintained the increase in the number of children who exit the system at the level of their typical peers as well as successful implementation of early intervention evidence-based practices, the Division of Early Childhood Recommended Practices (DECRPs, 2016), specifically in the teaming and collaboration practice area.

B. Why is this success significant?

A key outcome for families whose children are in early intervention is that families report that early intervention helped the family be able to help their children develop and learn. The EarlySteps SSIP uses evidence-based practices directed to family priorities to support this outcome. In a survey assessing this outcome, 91% of families responding reported that this was a benefit of early intervention for their family.

C. Who benefits and how?

Children and families participating in EarlySteps benefit from this success. Prior to implementation of the SSIP, service delivery in EarlySteps was fragmented and lacked coordination and communication across Individual and Family Services Plan (IFSP) team members. The focus on improving team practices using evidence-based practices of the DECRPs will continue to support child development and family priorities

D. How was the accomplishment achieved?

To accomplish improvement, EarlySteps targeted two main areas of system support: infrastructure improvements and practice area improvements.

- An improved child outcome measurement process was implemented in March 2017. This process was designed to result in a more sensitive measure of child improvement from entry to exit from early intervention. The previous calculation used was not sensitive enough to measure improvement resulting in too many children not showing measurable progress. The new measurement process resulted in a 20% improvement in the number of children exiting the system at the level of their typical peers in FY 2017-2018 and this level was maintained in FY 2019-2020. EarlySteps increased the number of "entry to exit" scores available by 70%, or 41% of those children exiting with comparison scores in 2019-20. These changes align Louisiana's results with those of other states in these measures resulting in an improved results accountability rating from OSEP for data quality.
- The focus on team-based decision-making increased such that IFSP teams were trained and implemented a standard process for making service decisions based on child needs and family-identified priorities. The teaming and collaboration focus area of the DECRPs has resulted in a 30% increase in IFSP team meeting participation compared to initiation of the improvement activities in 2014-15.

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

Yes. During the planning phase of the SSIP, EarlySteps developed an implementation and evaluation plan to assess its performance results. The outcomes achieved to date contribute to its ongoing success, as shown by the determinations and results accountability ratings received from OSEP and positive feedback from EarlySteps families and other stakeholders.

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

Yes. EarlySteps used specific components of the National Implementation Research Network Implementation Science methodology to implement this practice change using the DECRPs. This methodology posits that effective practice change depends on the key features of: stakeholder involvement and communication, careful practice selection and design, adult training practices including coaching, and ongoing measurement for fidelity of implementation.

Accomplishment #4: State-Wide Employment Initiative through the Vision Quest Grant:

A. What was achieved?

Four OCDD sheltered workshop providers were able to receive 200 hours of technical assistance in the area of Provider Transformation through the training and technical assistance received as both a Vision Quest State and a Core State under the United States Department of Labor's (USDOL), Office of Disability Employment Policy (ODEP) Employment First State Leadership Mentoring Program (EFSLMP) Provider Visionary Opportunities to Increase Competitive Employment (VOICE) grant. OCDD chose to work with two regions (Region 3 and 4) and within each region, two provider agencies agreed to work with the Subject Matter Expert (SME). Each provider completed a provider self-assessment, participated in an onsite visit with the SME, submitted information and

documents pertinent to the provider transformation, participated in ongoing phone calls and webinars, and submitted quarterly data on specific points of interest. After each onsite visit, the subject matter expert provided a written report and an analysis of the agency along with recommendations to each agency on how to move forward in being a community employment provider. From this agreed upon report, the agency worked to identify goals that they agreed to focus on to bring them closer to transforming from a sheltered workshop into a community employment provider. Also, in both Region 3 and Region 4, a SME facilitated an in-person regional meeting that brought together all stakeholders including individuals, families, provider agencies, state and local government agencies, support coordination agencies among other agencies to discuss how, as a region, they could improve employment outcomes for individuals with disabilities. A report was provided to each region and also follow-up phone conferences for the group. Each region formulated a plan for their region to move forward and keep the group focused on improving employment outcomes. The EFSLMP Core Grant ended August 30, 2019.

B. Why is this success significant?

The EFSLMP was very beneficial to those who participated in the provider transformation piece as well as the regional capacity building. The four providers have plans of how they will continue to move forward in the area of providing individual community employment services to those they support. This progress is due to the subject matter expert's technical guidance and assistance. OCDD has received technical guidance and assistance from the SME as well, which is helping to guide efforts in the redesign of the vocational services. Without this grant, OCDD would not have been able to provide this type of guidance. OCDD will work with other providers to assist them in their continued transformation efforts. The Regional Capacity Building efforts can be taken to other regions to assist other regions in enlisting stakeholders to boost the efforts for improving employment outcomes for people with disabilities.

C. Who benefits and how?

The results from this EFSLMP grant opportunity specifically benefitted the four agencies that received the one on one technical assistance from the SME as well as the two regions that received the technical assistance for regional capacity building. However, OCDD continues to share the information that was received through this grant with providers across the state in an effort to increase individual community employment. With this effort, and in combination with other initiatives in the Department and State, OCDD expects progress to continue in the area of community employment. Also, OCDD expects the regional teams to continue to grow and expand in support of improving individual community employment. This effort is in full support of the CMS Settings Rule intent, and OCDD's goals, which are to ensure that individuals have full access to the benefits of community living and are able to receive services in the most integrated setting.

D. How was the accomplishment achieved?

Through a partnership with the Governor's Office of Disability Affairs, Louisiana applied for, and was selected to receive, Training and Technical Assistance (T/TA) as both a Vision Quest State and a Core State for FY 2019 under the United States Department of Labor's

(USDOL) Office of Disability Employment Policy (ODEP) Employment First State Leadership Mentoring Program (EFSLMP) Provider Visionary Opportunities to Increase Competitive Employment (VOICE). This was the second year to receive this grant.

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

This effort is in full support of the CMS Settings Rule intent and OCDD's goals which are to ensure that individuals have full access to the benefits of community living and are able to receive services in the most integrated setting and also in support of the Department's goals.

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

Yes, more partnerships among stakeholders and working on the same initiatives only improves the success of the initiative set forth by the agency.

Accomplishment #5: Stakeholder Outreach to Advocates and Providers for System Change to Improve Outcomes for People Supported

A. What was achieved?

OCDD developed an outreach strategy aimed at improving the overall quality of waiver services through targeted engagement and feedback from waiver recipients, families, advocates, and providers. As a major part of the strategy OCDD intends to hold two large stakeholder summits per year. In these meetings, OCDD will provide information about OCDD major initiatives, and receive feedback from stakeholders, participants, and families about desired changes in the system.

B. Why is this success significant?

Stakeholders have indicated an interest in providing input and feedback regarding system development and the need for ongoing process improvement. OCDD believes outside engagement in the process and strong communication channels between the office, advocates and providers will have a long-term positive affect on the quality of services delivered.

C. Who benefits and how?

The recipients of home and community based services (HCBS) will benefit from this recreated outreach strategy by becoming more involved in the process as a whole. Allowing participants to be more vocal in determining the quality of the service they receive will result in better outcomes for participants.

D. How was the accomplishment achieved?

OCDD actively worked to establish and facilitate engagement with stakeholders on a routine and regular basis, including in-person visits to provider agencies from OCDD leadership

staff and regularly held provider meetings. OCDD then evaluated the information from these interactions, identified gaps, and developed a strategy that would allow the office to take better advantage of feedback from new and longtime stakeholders.

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

Yes, it provides for a Developmental Disabilities Service System that affords people access to information about what services and supports are available and how to access the services.

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

OCDD believes this strategy serves as best practice and aligns with one of the goals of the Department to keep community first by including the community in the discussion.

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

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

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

  OCDD is making timely progress in its current five-year Strategic Plan, particularly with those initiatives that support the following strategic plan goals: 1) To provide a Developmental Disabilities Services System that affords people access to information about what services and supports are available and how to access the services; 2) To provide a person-centered system that supports person-centered thinking and planning approaches such that supports identified via needs-based assessments are provided in a manner that focuses on the person's goals and desires and addresses quality of life; 3) To increase the capacity of the Developmental Disabilities Services System to provide opportunities for people to live, work, and learn in integrated community settings; 4) To increase the capacity of the Developmental Disabilities Services System to support people with complex behavioral, mental health, and/or medical needs in all service settings; 5) To implement an integrated, full-scale data-driven quality enhancement system; and 6) To rebalance the Developmental Disabilities Services System in an efficient and equitable manner such that resources are allocated to enable people to live in the most integrated setting appropriate to their needs. These initiatives also support OCDD's priorities which relate to system transformation, as well as effective and efficient service delivery. Effective utilization of available funding enabled Office accomplishments in FY 2019-2020. Progress on objectives remained steady, 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 2019-2020 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?

Significant Progress #1:

Supporting Individuals with Complex Behavioral Health Needs to Live in their Community

The OCDD Resource Center has continued to shift services to supporting individuals with the most complex behavioral needs, and currently acts as a service of last resort. The primary reason(s) for high-cost institutionalization within the OCDD system are presentation of behavioral health needs, and/or legal involvement. A performance indicator (#24259) is included in OCDD's Strategic Plan and Operational Plan to monitor the success of this initiative. This year the OCDD Resource Center Behavioral Health staff supported 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.

Significant Progress #2:

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. This fiscal year's efforts resulted in 98% satisfaction from the providers and professionals. Additionally, this fiscal year OCDD and the Office of Behavioral Health (OBH) completed the joint Transformation Transfer Initiative (TTI) grant to develop expertise among behavioral health professionals to provide treatment for persons with co-occurring developmental disabilities and mental health needs. The TTI grant engaged behavioral health provider agencies across the levels of care in the behavioral health system. The following outcomes were achieved in this grant:

- Two Local Governing Entities (LGE) successfully completed the grant activities.
- Additionally, one LGE, a multi-area psychiatric residential treatment facility (PRTF), a therapeutic group home (TGH), and three mental health rehabilitation facilities completed training on IDD/MH.
- A core training series for independent clinicians was completed with 34 clinicians across the state.
- Identified crisis providers completed a virtual IDD/MH training series offered by the Center for START Services.
- OCDD clinical staff have developed a clinician self-study series including the following modules:
    - Emotional Wellness and IDD,
    - Diagnosis and Assessment of Behavioral Health Conditions for individual with IDD,
    - Trauma and IDD, and
    - Treatment and Therapeutic Modifications for Individuals with IDD.

These self-study modules were developed as an extension of the joint OBH-OCDD TTI grant. OCDD is working with OBH to use the remaining grant funds to produce additional materials to be shared with LGE clinics and Health Plans, and to offer a proposed collaborative partnership between these entities and OCDD clinicians for their clinical staff development and mentoring.

In FY 2019-2020, OCDD's Resource Center clinicians offered two independently organized multi-disciplinary professional Continuing Education presentations, and a third in partnership with OBH. Resource center clinicians also delivered two presentations as part of the Louisiana American Association on Intellectual and Developmental Disabilities (AAIDD) annual conference. OCDD's clinical director co-chaired the National Association on Dual Diagnosis (NADD)'s annual conference held in New Orleans in 2019 and the clinical director and associate clinical director presented at the conference. In the area of nursing outreach and training, the OCDD Resource Center nursing staff enhanced its activities with a specific emphasis on provider agency nursing consultants. OCDD employs a Resource Center registered nurse in each local area of the state, and these nurses completed over 500 outreach/training events to HCBS provider nurses each quarter in FY 2019-2020 (including during the COVID-19 crisis using virtual technology). With regard to dental needs, OCDD continued formal outreach and coordination with Medicaid health plans and stakeholder groups.

1. To what do you attribute this success?

   OCDD employs clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral and medical support needs. OCDD and OBH have developed more formal partnership approaches to address the needs of individuals with co-occurring needs.

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

   Progress is expected to continue. Recent emergent situations—and their lingering effects—will impact pace and volume, but the Resource Center and Clinical Staff have adapted trainings by offering virtual alternatives to in-person training, and they are currently in process of planning training for FY 20-21. Resource Center and Clinical staff are already in process of developing content to present virtually at Louisiana AAIDD and NADD. 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 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.

Significant Progress #3:

Movement toward compliance with State-Wide Transition Plan for Home and Community-Based Services Settings Rule, including developing consistent service definitions

Since 2016, OCDD has been working in conjunction with the Local Governing Entities (LGEs) across the state to meet compliance with the Home and Community Based Services (HCBS) Settings Rule. The rule supports enhanced quality in HCBS

programs, adds protections for individuals receiving services, and reflects the Center for Medicare and Medicaid's (CMS) intent to ensure that individuals have full access to the benefits of community living and are able to receive services in the most integrated setting.

OCDD central office staff, in conjunction with the LGEs, have been conducting ongoing onsite visits with providers, and providing technical guidance and assistance. OCDD has provided training and hosted meetings to share information and ideas. These meetings were also used to facilitate discussions between providers who were making progress with those who continue to need assistance to meet compliance. Efforts FY 2019-2020 have been to assist providers with the development of a workable transition plan, and providing specific guidance for each provider in how to accomplish compliance. OCDD continues to provide information on online resources and webinars to providers in an effort to help them with compliance.

1. To what do you attribute this success?

OCDD has been able to bring in technical guidance and assistance through a grant opportunity, which provided technical assistance to four providers on provider transformation. Additionally, the grant included regional capacity building, and this allowed the regions to form teams and help strengthen the efforts of community employment for people with disabilities. Through another partnership, OCDD was also able to obtain funding for online training in community employment to over 450 people including providers, OCDD state office staff, LGE staff and Support Coordinators. OCDD continues to look for other means to assist the providers in coming into compliance.

The progress that has been made towards compliance with the Statewide Transition Plan for Home and Community Based Services Settings rule has been significant over the last year. OCDD continues working to ensure that individuals have full access to the benefits of individual community living, including individual community employment, and are able to make individual choices and receive their services in the most integrated setting. This progress is leading the services system in the right direction—bringing us closer to compliance with the HCBS Settings Rule.

In July, 2019, OCDD joined the State Employment Leadership Network (SELN). The SELN is a membership-based network of state intellectual and developmental disability agencies committed to making changes in their service systems. The SELN was onsite in September, 2019 to meet with various stakeholder groups to gather the necessary information about Louisiana in order to be able to make recommendations and move Louisiana forward. OCDD continues to meet with the SELN on a monthly basis to work on specifically defined goals. They are assisting OCDD in redefining employment and day services. The SELN is an excellent resource for our providers as they work towards compliance with the HCBS Settings Rule.

In October, 2019, OCDD met with vocational providers to discuss in depth the need to revamp nonresidential services in order to meet compliance with the HCBS Settings Rule. From this large meeting a smaller group was formed with representatives from each region of the state to move forward in redefining of services, including the revision rates. This group has made progress in defining the new services, and is currently working on the rate revision. This group will continue to meet on a regularly scheduled basis to continue to work on redefining employment and day services for the waivers (that will ultimately be the services in the single waiver). This group of providers understands that a total makeover of the current service delivery system is necessary to provide participants with a meaningful life. They are willing to put in the time and effort to move this to the forefront.

The other part of the HCBS Settings Rule is residential services. Louisiana had less work to do in this area, only services that are provided in the community are currently covered services. OCDD is currently working with the Provider Owned/Controlled housing providers to ensure that services are delivered appropriately, and that the participant is in control of their services. More efforts will be focused in the area of residential providers this year.

OCDD continues to work with various stakeholders including the Developmental Disabilities Council, Families Helping Families, Disability Rights Louisiana, Governor's Office of Disability Affairs, Office of Behavioral Health, Louisiana Rehabilitation Services, and Department of Education to strengthen the partnerships across agencies in order to provide a more responsive system for the individuals we serve.

OCDD continues to work in conjunction with the state Medicaid office to prepare a final Statewide Transition Plan for Centers for Medicaid and Medicare Services' (CMS) approval.

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

   The efforts to obtain an approved Statewide Transition Plan will continue at an accelerated pace until final approval from CMS is achieved. OCDD will continue to work with the state Medicaid office until this is achieved.

   OCDD will also continue efforts to bring providers into compliance with the HCBS Settings Rule. Ultimately, the individuals that are supported by the revamped services system will benefit the most from these efforts as they will have the benefit of understanding what going to work and achieving a meaningful life can mean for them.

   The progress that has been made toward compliance with the HCBS Settings Rule reflects best practices and aligns up with the CMS guidance and the Employment First philosophy. OCDD will continue to ensure that individuals have full access to

the benefits of community living and are able to receive the services they choose in the most integrated setting.

Significant Progress #4:

Training and technical assistance to ICF/IID providers through the ICF/IID Programmatic Unit

In 2018 the ICF/IID Programmatic unit began to develop an oversight process to help improve the quality of life and the outcomes for individuals residing in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), particularly those individuals with medical challenges. The program goal was to ensure that private ICF/IID facilities were providing supports and services in a person-centered manner, and that supports and services were having the desired outcomes. The OCDD Programmatic Unit successfully implemented a pilot program, and in Phase 2 the Programmatic Unit began working with new providers, and accepted crisis cases. In FY 2019-20 the Programmatic Unit worked with six providers using the process implemented in Phase 2, and provided technical assistance to providers, as well as continued availability for emergency consultations. An emergency consultation with Andover Community Home was also completed by the unit. In Phase 3, the unit successfully trained more than 524 provider staff across the state, and scheduled another round of trainings for the beginning of year 2020. Due to the COVID-19 emergency, trainings for year 2020 have been postponed.

During the COVID-19 event, the unit staff members have improved upon their skillset through extensive trainings in the areas of person centered thinking and process, professional development, and technological areas.

During implementation of each phase of the program, the unit was able to impact a large number of provider staff statewide. This resulted in positive cultural shifts in these agencies and resulted in a more person-centered service delivery. After the Covid-19 event has ended, the unit will continue to provide technical assistance and training to ICF/IID providers statewide.

Each year the unit has met the progress expected in each phase of the program's development.

1. To what do you attribute this success?
   OCDD dedicated resources to ensure the success of the ICF/IID programmatic unit through dedication of staff, clinical guidance from the department, and other resources such as laptops and transportation. The partnerships created between private ICF/IID providers and OCDD were also a main factor in the unit's success of increasing ICF/IID quality.

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 as the unit continues to reach more private ICF/IID providers statewide with technical assistance and training. As the Programmatic

Unit's reputation grows within the provider community, more providers are expected to embrace the possibility of partnership with the ICF/IID Programmatic Unit. This will create more demand for unit services, and therefore increase the overall unit impact for outcomes statewide.

Significant Progress #5:

Maintenance of most appropriate waiver process to allow those with urgent/unmet needs to receive waiver opportunities

In 2012, OCDD began working to reduce the Request for Services Registry waiting list and to better help people in the state with meeting any unmet needs. OCDD worked with stakeholders and workgroups to help guide OCDD's system transformation. In 2017, OCDD began to implement the Screening for Urgency of Need (SUN) tool, which was developed to identify the needs a person has, review the person's current supports, and to determine the urgency of any unmet needs of the person. This screening assigned a score to each person, to help OCDD prioritize the most urgent needs and ensure that those with unmet needs are given the most appropriate services. Since its implementation, OCDD has continued to evaluate and refine the SUN process.

1. To what do you attribute this success?

   This success can be attributed to the creation of more systematic and efficient procedures for individuals seeking Waiver services through OCDD. This progress is the result of OCDD's streamlining of the Screening Urgency of Need process. A concerted effort was made by the Request for Services Registry Manager and the Screening Urgency of Need Supervisor to streamline the Request for Services Registry procedures to establish an organized and uniform process for identification and assessment of individuals who request Waiver services through OCDD. These efforts have led to training opportunities as well as guidance on the process and information that is needed to complete in a timely manner.

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 development and implementation of the new procedures have already led to the establishment of a more efficient system of identification and assessment of individuals who have urgent/emergent needs and have enabled us to continue to meet proposed timelines.

- **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; however, there are many issues OCDD must resolve before the database is complete. One barrier 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. Additionally, the Louisiana Office of Technology Services (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 last year 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. 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 OCDD's goals, program objectives, strategies and indicators to reflect the office's direction, to build on successes, to provide strategies in areas where success has not been as substantial or where changes in program direction indicate such, and to improve performance assessment.

- **How does your department ensure that your strategic plan is coordinated throughout**

the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation? Use as much space as needed to explain fully.

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

Within OCDD, objectives are assigned to specific staff members who are responsible for management and oversight of the accomplishment of each objective and related performance indicators. Additionally, a variety of management tools (i.e., databases, project charters, etc.) and task/initiative specific workgroups/committees are utilized to track, review, and provide feedback for utilization in decision making and resource allocation. Progress or lack of progress (along with support/resources needed to achieve assigned objective) is reported to OCDD Executive Management. Performance data is also reported in Louisiana Performance Accountability System (LaPAS) and available for both management and stakeholder review.

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

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

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

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II

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

B. Corrective Actions

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

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

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

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

4. Do corrective actions carry a cost?

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

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

Problem/Issue Description #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. OCDD's system transformation efforts are being hampered 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, all of the six goals are negatively impacted in some way 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?
   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 IT 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 hindered by the lack of funding. Although funding was requested for the IT Project during the state budgeting process, the project was not chosen as one of the Department's priorities.

7. What are the consequences, including impacts on performance, of failure to resolve

the problem or issue?

Development and implementation of person-centered software such as OCDD's electronic Individual Support Plan (eISP) and the Office's Quality Enhancement system remain priorities and are critical to the OCDD's next steps in system transformation. These efforts will be delayed and will significantly affect progress in meeting established OCDD goals and objectives if additional funding is not secured.

B. Corrective Actions

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

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

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

   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.

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

   Funding was requested in the FY 2019-2020 budget.

4. Do corrective actions carry a cost?

   ☐ No. If not, please explain.
   ☒ Yes. If so, what investment is required to resolve the problem or issue? (For example, investment may include allocation of operating or capital resources—people, budget, physical plant and equipment, and supplies.)
   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 Description #2:
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 fourteen years, eight former state-operated, supports and services centers for people with developmental disabilities have either privatized their operations or closed in ongoing efforts to serve people in the least restrictive settings in their communities. However, OCDD continues to bear responsibility for the ongoing costs associated with six of these eight facilities. These costs generally include: (1) acquisitions and major repairs, the payment of risk management premiums, building and grounds maintenance, utilities, and/or loss prevention/ security, (2) ongoing, or legacy costs, including the employer share of group insurance benefits for retirees, (3) and the supports and services offered through statewide Resource Center operations that formerly ran from each facility. Some of these services have been refined to include the ICF/DD Programmatic Unit, and Monitoring and Analytical Support activities. In addition, OCDD continues to maintain responsibility 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. These non-facility activities are not part of the cost reporting that determines the per diem rates for the facilities. The activities are funded from a combination of both State General Fund and pooled Interagency Transfer (IAT) Revenues derived from any over-collections that may be available from facility operations. As the last remaining state-operated facility through FY 2020, the Pinecrest Supports and Services Center (PSSC) has absorbed expenditures once spread across nine facilities. 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. As facility operating expenditures increase, the ability of Pinecrest to support non-facility activities is diminished.

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 resources are required to manage vacated properties and non-facility activities without a dedicated funding stream. These resources could be better utilized to further progress toward one or more of its Strategic Plan goals.

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

   OCDD is managing the problem by continuing to allocate available resources to the costs associated with maintaining the properties and fulfilling both Office of Risk Management (ORM) and other state requirements.

4. Who else is affected by the problem?

   The PSSC 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 by the operation of the PSSC revenue stream. Though vacated or operating with significantly reduced occupancy, the properties require appropriate effort to keep the physical plant in good condition and prevent theft or destruction of property. A retirement benefit includes medical coverage for employees who retired under one of the qualifying retirement systems. The benefit paid by the state for participating retirees depends upon a number of factors based on their participation in the Group Benefits program.

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

   The consequence of this issue is the continued expenditure of funds to maintain properties that are no longer used by OCDD. These expenditures may cause cash flow shortfalls in future fiscal years.

B. Corrective Actions

- 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.

1. 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.

2. 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.

3. Are corrective actions underway?

   Yes. Corrective actions are underway.

   - Closed Facilities. With respect to ongoing facility maintenance and upkeep at closed facilities, the Office is working to identify potential alternate uses for all properties not occupied or those planning to be vacated due to ongoing downsizing efforts.
     - During the fiscal year, action was taken on two closed facilities:
       - Leesville: OCDD began expending toward the upkeep of this facility during the fiscal year upon expiration of a cooperative

endeavor agreement with the Town of Leesville. Act 342 of the 2019 Regular Session of the Legislature authorized the transfer of certain parcels of land that include the former Leesville Residential and Employment Services facility to the Museum of America's Training Ground.

- Southwest: The responsibility for the property has been transferred from OCDD-Pinecrest Supports and Services Center to OBH-Eastern LA Mental Health System (ELMHS). The property will be maintained by ELMHS for evacuation destination for its patients should the need occur. An inquiry has been made to ORM regarding the transfer of ORM costs from Pinecrest to ELHMS.

- 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.

- 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.

- Non-Facility Activities (Resource Center, ICF/DD Programmatic Unit, Monitoring and Analytical Support): With respect to the operational costs associated with statewide non-facility operations, 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 amount appropriated represents the estimated gap between the ability of Pinecrest to fund these obligations under its existing revenue stream and the anticipated expenditure obligation. Since the consolidation of the appropriation of Resource Center operations under one budget, and a subsequent breakout of the ICF/DD Programmatic Unit and Monitoring and Analytical Support activities, OCDD has taken significant measures to reduce expenditures and preserve the delivery of critical services. Specifically, OCDD

eliminated vacant positions, eliminated some contractual services, eliminated lease expenditures by consolidating four hubs to two hubs prior to implementing a telework policy, and restructured positions within a new statewide service delivery model. To the extent allowable, OCDD is further pursuing the possibility of matching funding from Medicaid for those services provided through these activities that may be Medicaid-eligible.

4. Do corrective actions carry a cost?

☒ No. If not, please explain.

No. There are no anticipated direct costs related to researching and developing amendments to existing legislation, as these actions would be completed by existing staff. However, as mentioned above, failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings/facilities. Additional resources are necessary to the extent that the revenue stream for the state-operated facilities are not able to fund the costs over and above the State General Fund appropriation.

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

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

b. How much has been expended so far?

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

d. Will additional personnel or funds be required to implement the recommended actions? If so:

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

Problem/Issue Description #3:

Community settings lack adequately trained professionals and direct support staff to deliver needed (1) behavioral services, including qualified persons to deliver applied behavior analysis to people with autism, and (2) services and supports, including skilled nursing service and community nursing service, to individuals who are medically fragile

A. Problem/Issue Description

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

There continues to be a lack of adequately trained professionals and direct

support staff to deliver needed behavioral and medical/nursing services to individuals with complex needs in community settings, including a lack of qualified professionals to deliver applied behavior analytic therapies to persons with autism. There is a shortage of trained staff to provide services and supports for individuals with significant medical needs, including skilled nursing services, and the shortage of trained nurses who work either full time, part time, and contract for the agency/provider for individuals who are medically fragile and reside in community settings.

Adequate behavioral supports can be very effective in improving quality of life and reducing behavioral symptoms/challenges for individuals with intellectual/ developmental disabilities. Applied behavior analysis can be very effective and can significantly alter the course of autism for many individuals. Complex medical support needs, particularly those requiring nursing supports throughout significant periods of the day, can be managed in community settings; however, it is very difficult to locate and secure trained staff to meet these needs. Continued challenges in this area contribute to institutional admissions, hospital admissions, emergency room use, increased illnesses, increased medication usage and costs, and other negative health outcomes.

While specific departmental and OCDD initiatives have been implemented this fiscal year to continue addressing this barrier, improvements have occurred in some areas. However, a general problem continues to exist, as it is believed that a multi-faceted and multi-year approach is required to resolve the problem.

2. Is the problem or issue affecting the progress of your strategic plan? (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 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 generally conduct, and are not required to conduct, training with direct support staff on positive behavior supports and medical/nursing needs.

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

   Consequences include: 1) a significant number of people with intellectual/

developmental disabilities having unmet needs, 2) a continued need for costly institutional admissions to the higher treatment cost supports and service center, 3) continued high utilization of high-cost acute services, and 4) an inadequate number of practitioners to positively impact the developmental trajectories of children with autism, other behavioral challenges and/or complex medical needs leading to increasing service costs over the course of their lifespan.

B. Corrective Actions

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

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

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

   The following are recommended actions to alleviate the problem:

   - Implement Complex Care Supplemental Payment Option for individuals with complex needs via the OCDD waiver options now that CMS approval and legislative funding have been secured.
   - Evaluate benefits of 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.
   - Complete self-study partnership extension from the Transformation Transfer Initiative grant in partnership with OBH to promote routine education in intellectual and developmental disabilities/mental health within LGEs and managed care organizations (MCOs).
   - Develop statewide guidelines for meeting complex health, behavioral health and allied health needs for individuals with intellectual/developmental disabilities.
   - Evaluate other state's practices in areas like START, which may offer opportunities for new and expanded services.
   - Continue and enhance nursing and dental outreach efforts to improve outcomes for individuals with complex medical/dental needs.
   - Continue collaboration with OBH on development of crisis framework and services.

2. 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.

3. Are corrective actions underway?

   Yes. The following actions are underway:
   - Implementation planning is underway for the Complex Care Supplemental Payment Option. OCDD completed the rulemaking process, and submitted a Notice of Intent (published in the September 2020 Register). A public hearing has been set for October 10, 2020 (if necessary). The program will go into effect on November 20, 2020.
   - OCDD has implemented an Emotional Wellness Guide in its HCBS program (modified for use during COVID and pre-storm), and is in process of building into its core support coordinator and provider training.
   - OCDD continues its statewide offering of Medical/Nursing Direct Service Worker (DSW) training via Money Follows the Person (MFP) Rebalancing Demonstration.
   - OCDD continues to offer Board Certified Behavior Analysts (BCBA) continuing education opportunities, as well as other behavioral and psychological continuing education options.
   - OCDD has continued professional continuing education across disciplinary areas.
   - OCDD continues to provide consultation and technical assistance via the OCDD Resource Center.
   - OCDD has implemented routine outreach to full time, part time, and contract nurses for HCBS providers via the OCDD Resource Center.
   - OCDD continues to work with Medicaid to support Applied Behavior Analysis (ABA) services via the State Plan and has increased routine coordination with Office of Behavioral Health (OBH) related to mental health needs for individuals with intellectual/developmental disabilities.
   - Joint Transformation Transfer Initiative with OBH was completed and a self-study extension option was developed for continued education options.

4. Do corrective actions carry a cost?

   ☒ No. If not, please explain.

   Most of these actions do not carry a cost. Implementation of training and capacity building efforts approved in the MFP Rebalancing Demonstration (My Place Louisiana) Operational Protocol are funded with federal demonstration dollars through FY 2020. While other corrective actions could carry a cost insofar as additional clinicians and/or technical assistance staff are recruited into state service systems, they do not carry a cost as most new positions in OCDD are existing positions diverted from institutional services. They do not incur a cost when the focus is on community, non-public capacity building. Costs are associated with new services such

as ABA and enhanced waiver services. However, 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. The Transformation Transfer Initiative was funded via grant dollars from the National Association of State Mental Health Directors and Substance Abuse and Mental Health Services Administration (SAMHSA).

☐ 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 and 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:

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

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

1. Title of Report or Program Evaluation:
   National Core Indicators Project

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:

   Final reports for the survey cycle that ended on June 30, 2019 were made available to the State by HSRI and the NASDDDS in January 2020.

   The 2019/2020 survey cycle began in December 2019 with pre-survey activities including: 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 tools, preparing the State Work Plan for NCI, customizing the survey tool for Louisiana and preparing LDH reviews and approvals for printing. The surveys were mailed to respondents on June 24, 2020. Responses were collected and entered into the NCI on-line database until July 31, 2020.

   Timelines for completing pre-survey and survey activities were significantly impacted by the restrictions imposed by the COVID-19 quarantine. NCI extended the due date for final response entries to surveys from June 30, 2020 to July 31, 2020.

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 2019/2020 cycle, OCDD chose to conduct the Child Family survey. The Adult Family survey, the Family Guardian survey and the In-Person Interview survey were not conducted for this cycle.

   OCDD participated in the 2019/2020 NCI Staff Stability Survey (NCI-SSS) for the second 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 center around wages, benefits, career opportunities, work environment and educational opportunities for the work force of care-givers. The NCI-SSS is an on-line survey through an NCI 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 primary tool used for the service participant satisfaction evaluation was the Child Family Survey. The analysis reports both the number and percentage of responses to each question. The NCI averages contained in the national report are "weighted," meaning their calculations reflect the relative population sizes of all participating states, as well as the sample size. The weights used in calculations of this report were developed by NCI using each participating state's number of survey respondents and its total survey-eligible population. NCI tests for statistical significance as well as effect sizes. Effect sizes are used in addition to statistical significance because statistical significance of a state's result depends in part on the size of the state's sample. Comparisons are compiled in an NCI national report that includes all of the participating states who submit a minimum of 400 surveys. NCI produces state reports for each participating state; if a state is not eligible to be included in the national report, that state will still have a state report available. In FY 2019/2020, OCDD mailed NCI Child Family surveys to all of the families of individuals with developmental disabilities under the age of 18 who were participating in Medicaid waiver developmental disability programs, as well as families participating in the EarlySteps program at the specific point in time of July 1, 2019. Child Family survey participants were mailed the full paper survey and a postage-paid return envelope for submitting the competed survey. NCI also offers a web-based survey response site that provides the families who were chosen to participate in the child family survey 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. OCDD has experienced a diminishing rate of return of surveys, which has resulted in this Office pulling larger samples and mailing more survey packets in order to achieve the target of a minimum of 400 completed Child Family surveys. 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 2018/2019 (previous year) data were available in January 2020.

   Reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services and delivered to OCDD in 2020:

   - *National Core Indicators Child Family Survey 2019 Final Report*: This report provides an aggregated summary of the results of the survey that 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 June 30, 2020 with a return rate of approximately 16%.

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

   The Child Family mail-out surveys were printed by State Printing for $13,005 and mailed by Office of State Mail Operations for $3,341. All other activities were performed using OCDD material resources and Central Office and Resource Center personnel. Approximately 75 hours of staff time were used to obtain the random sample and verify contact information for families for the mail-out surveys and participant interviews. Entering family survey data and consumer interview data into the NCI database took approximately 95 hours of staff time.

6. Major Findings and Conclusions:
   Findings in the 2018/2019 Family Survey reports were extensive.
   - The Adult Family survey results are available at https://www.nationalcoreindicators.org/upload/core-indicators/LA_AFS_2018.pdf.
   - Family Guardian survey results are available at https://www.nationalcoreindicators.org/upload/core-indicators/LA_FGS_2018.pdf.
   - Child Family survey results are available at https://www.nationalcoreindicators.org/upload/core-indicators/LA_CFS_2018.pdf.

   Final analysis by OCDD of the reports produced by NCI has not been completed. Preliminary review suggests feedback from family members of service participants remains consistent with previous years. OCDD Performance Review Committee will continue to analyze the data to establish potential focus points for Office initiatives.

7. Major Recommendations:

   OCDD should tie participant feedback to Office initiatives designed to strengthen the system in order to demonstrate to participants/families that feedback is used constructively and does impact state and federal decisions regarding the direction of services. OCDD should consider contracting out the mail return processing of surveys and the In-Person Survey activities to an entity that would remove any conflict of interest concerns that occur with OCDD surveying its own services.

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

   Information from the surveys was cross-walked to Centers for Medicare & Medicaid Services (CMS) measures for the Home and Community-Based Services (HCBS)

Settings Rule, which addresses community participation and employment goals for persons with developmental disabilities who are receiving HCBS.

OCDD's quality improvement process includes review of NCI data as well as data from other sources, such as data on regional performance indicators as part of the Human Services Accountability Plan, 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: OCDD, Quality Management Section
    Telephone: 225-342-5714
    E-mail: Dolores.Sarna@LA.GOV

Annual Management and Program Analysis Report
Fiscal Year 2019-2020

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.

Accomplishment #1: Opening of Cameron Parish Outreach Clinic

A. What was achieved?
In January 2020, Imperial Calcasieu Human Services Authority (ImCal has) opened the Cameron Parish Outreach Clinic within the Parish Health Unit in Cameron, LA. The outreach clinic provides outpatient psychiatric services for adults, ages 18 and older, and adolescents, ages 5-17. Historically, residents of the Lower Cameron Parish Area had to travel to receive services in Lake Charles or Sulphur. With the recent industry expansion in SWLA, the Lower Cameron Parish catchment area has seen a boom in population growth.

B. Why is this success significant?
ImCal HSA partnered with the Region V of the Office of Public Health (OPH) to host a community meeting in order to get an understanding of the public health and behavioral needs of the area. A number of issues were raised in that meeting, one of which was the need for mental health services, specifically psychiatric services in the parish. As of that date, there were no behavioral health providers in Cameron Parish. As a result of the meeting, we established the outreach clinic to provide these needed

services to residents. Region V OPH provided the needed office space within the Parish Health Unit and ImCal HSA staffed the new outreach clinic with an advanced practice psychiatric nurse practitioner, along with nursing and administrative support.

C. Who benefits and how?
Prior to the opening of Cameron Outreach Clinic, residents of lower Cameron Parish had to travel over an hour to receive mental health services. They now have access to mental health treatment within their local community. These services improve their daily functioning and enhance their quality of life.

D. How was the accomplishment achieved?
ImCal was able to partner with the Region V of OPH and Cameron Parish Police Jury to secure a location. ImCal HSA is able to utilize the space at no cost. With some available Mental Health block grant funding, ImCal expanded an existing professional services contract for psychiatric prescribers which resulted in the availability of shared staffing between ImCal HSA's Behavioral health facility in Lake Charles and the new Cameron Parish Outreach.

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

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

Accomplishment #2: Increased access to Medication Assisted Treatment (MAT) for Opioid Use Disorders

A. What was achieved?
Under the State Opioid Response Grant (SOR) for Opioid Use Disorders (OUD), a number of enhancements in the area of increased access to prevention and treatment of OUD have occurred this fiscal year. In the arena of prevention services, NARCAN kits were distributed community-wide to local law enforcement agencies, fire departments, food banks, homeless shelters and man camps. Medication lock bags were also distributed. Treatment access was also enhanced through the continuation of a contract with a local suboxone provider which begin last fiscal year. Under this contract, ImCal was able to continue to fund MAT clinical services for individuals with OUD. In addition, ImCal HSA funded the training of one of their own advanced psychiatric nurse practitioners in order to provide MAT services in-house. ImCal 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?
The prevention work under the State Targeted Response (STR) grant enhanced public awareness and education regarding OUD and also increased access to MAT services

which were not available previously to individuals who have Medicaid or who are indigent. Prior to the implementation of the SOR grant, methadone treatment was not a covered service under Louisiana Medicaid nor was clinical treatment services for suboxone. This success was significant because it opened the door for individuals with OUD who could not afford MAT services to access those services.

C. Who benefits and how?
The implementation of the SOR grant benefitted individuals who suffer from Opioid Use Disorders in the ImCal catchment area by increasing their access to treatment services.

D. How was the accomplishment achieved?
Prevention efforts were achieved through the ImCal Prevention Unit under the direction of our Community Services Director who also serves as our Opioid Use Disorder Specialist. Prevention staff completed community wide outreach to distribute NARCAN and medication lock. ImCal was able to get an in-house provider trained in order to increase access to suboxone clinical 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

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 (ImCal HSA) is on time and on target to meet the goals and objectives set within our five year strategic plan. The mission of ImCal HSA is that citizens with mental health, addictions, and developmental challenges residing in the parishes of Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis are empowered, and self-determination is valued such that individuals live a satisfying, hopeful, and contributing life. This mission is accomplished through ImCal's Administrative, Behavioral Health and Developmental Disability Activities. ImCal HSA makes use of best practices in implementing, evaluating, monitoring, modifying existing services so that quality is

assured; services meet the needs of those served; and the variety of services available adequately address the range of behavioral health issues identified and are further developed to address service gaps.

ImCal Agency Goals:

I. To increase public awareness and to provide access to care for individuals and their families who are in need of behavioral health and developmental disabilities services.
II. To ensure that services provided are responsive to client needs, based on evidence-based best practices, and that programs afford the client a continuum of care taking into consideration cultural diversity and abide by all State and Federal guidelines.
III. To promote healthy, safe lives for people by providing leadership in educating the community on the importance of prevention, early detection and intervention, and by facilitating coalition building to address localized community problems.

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

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

    ImCal HSA continues to make steady progress in all three Program Activity areas. Outside of the two accomplishments described in Section I. above, while ImCal has not significantly exceeded any stated objectives and strategies, we have made steady and efficient progress in all objectives and strategies as indicated in our five year plan which gets more and more difficult to accomplish with continuous budget cuts every fiscal year.

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

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

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

   None.

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

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

  No adjustments have been made because ImCal has made steady and efficient progress in all objectives and strategies as indicated in our five year plan despite budget cuts.

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

  ImCal Executive Management Team utilizes the Five-year Strategic plan to develop ImCal HSA's annual operational goals and objectives within the Annual Business Plan as well as develop its annual budget. Performance measure data outlined within the Five-year Strategic Plan is collected quarterly and shared with the Executive Management Team. Performance measures are adjusted as needed.

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

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

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

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

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?

Recruitment and retention of professional and qualified staff under a Civil Service System and limited budgetary resources

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
      Imperial Calcasieu Human Services Authority (ImCal HSA) struggles with recruitment and retention of licensed professional staff and limited access to funds to compete with the private sector. Under a behavioral health Managed Care environment, ImCal HSA is expected to operate similar to the private sector in order to generate revenue to support the budget.

   2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
      No, not at this time.

   3. What organizational unit in the department is experiencing the problem or issue?
      The Behavioral Health Division within ImCal HSA.

   4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
      The individuals served by ImCal are affected by waiting lists to access services.

5. How long has the problem or issue existed?
   Since ImCal's inception.

6. What are the causes of the problem or issue? How do you know?
   The cause of the problem appears to be recruitment and retention of licensed professional staff and limited access to funds to compete with the private sector.

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

☒ **Customer/stakeholder feedback**
ImCal HSA participates in the C'est Bon program of the Louisiana Office of Behavioral Health through the State Behavioral Health Planning Council. The program employs a specially trained team of behavioral health peers and family members who evaluate services from the persons served point of view. The team interviews some of those served at the clinic regarding the quality of services. The team then analyzes the information obtained. The data is reviewed by the Louisiana Office of Behavioral Health and then presented in a report as feedback to facility managers and their staff. The purpose of the *C'est Bon* survey is continuous quality improvement of both services and facilities. Our greatest goal is to help the behavioral health system work for all by encouraging those involved to work together.

☐ Other (please specify):

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

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

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

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.

Annual Management and Program Analysis Report
Fiscal Year 2019-2020

Department: **Louisiana Department of Health (LDH)**
09-376 Central Louisiana Human Services District

Department Head: **Dr. 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: Increased Access to Care:

A. What was achieved?

Expansion of Tele-health and Crisis services by all Central Louisiana Human Services District (CLHSD) operated programs.

B. Why is this success significant?

Although CLHSD has utilized technology to provide tele-health services as a means to increase access to psychiatric medical services, access to the array of counseling

supports was limited to face-to-face encounters. Face-to-face encounters are the preferred methods of service delivery for behavioral health. However, barriers to many in the population served by CLHSD are evident. Persons served by CLHSD often encounter difficulties in transportation, childcare, and other physical challenges in attending clinic appointments face-to-face. In the wake of the COVID-19 emergency response, the State of Louisiana permitted the expansion through reimbursement of services not previously allowed. Thus, tele-health has been expanded allowing persons served increased access. Barriers to care which previously existed, such as transportation, have been reduced. Through the use of technology, CLHSD clinicians have increased their level of comfort in the use of specific technology utilized while providing services. CLHSD was also able to expand its crisis services through a federal grant called the Crisis Counseling Program (CCP) that were implemented to assist our 8 parishes by providing brief crisis services and resource linkage.

C. Who benefits and how?

All clients served by CLHSD's clinical services programs. Existing barriers in transportation have been minimized through the use of the new technology. In addition, clinical staff have experienced less "down time" that exists when face-to-face encounters are utilized. During the COVID-19 pandemic, increased safety results by reducing possible exposure. All persons served across the CLHSD's geographic area benefit from the CCP program that provides crisis outreach and services to persons affected by the COVID-19 pandemic.

D. How was the accomplishment achieved?

The federal and state third-party insurers changed policies regarding payment for tele-health services, expanding access for persons requiring services. State Licensing Professional Boards sent notification of changes which expanded/allowed for the delivery of services through tele-health which had previously not been permitted. In the advent of these changes, the following activities were accomplished:

- staff were educated on the changes and legal use of technology in the delivery of services by technological methods selected
- research on available technology for the delivery of services was conducted
- phone surveys with persons served were conducted to determine each person's ability to access technology/type of device that could be utilized
- equipment was purchased and/or issued to the clinical staff for use
- Appointments were re-scheduled as indicated by the surveys of persons served
- Clinic processes and procedures were re-designed to incorporate the above changes.
- Crisis counselors and resource linkage staff were hired to implement the CCP program
- All forms of media are used the promote the CCP program

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

Yes.

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

No.

Accomplishment #2: Integration of Service Delivery:

A. What was achieved?

Final phase of relocation for CLHSD operations was completed. The new facility that was secured in the prior fiscal year accommodates administrative, behavioral health and developmental disabilities services.

B. Why is this success significant?

Relocation of the operations eliminated the physical distances of prior operations which were in separate locations and improved the ease of access for the people served in the District. In addition, the facility was newly renovated and improved the safety of the facility, decreased maintenance issues, and improved the general atmosphere of the treatment milieu. In addition, bilocation of services increases the efficiency of service delivery, and eases management and communications for staff. Further, it allows CLHSD to have one culture with one collective morale, which benefits management and the staff equally. CLHSD expects that the completion of the relocation establishes a basis for increasing awareness and access to program services as the new location is established on a main thoroughfare which increases visibility.

C. Who benefits and how?

All clients within the CLHSD's 8-parish service area (Grant, Winn, LaSalle, Catahoula, Concordia, Avoyelles, Rapides and Vernon) benefit from this achievement. The new location was designed with our three divisions in mind, so it is extremely efficient and meets our needs for service delivery perfectly. Being new imparts a value to our consumers that our previous locations failed to do. It also allows for increased efficiency of service delivery, increased effectiveness of management and communication for CLHSD's staff.

D. How was the accomplishment achieved?

Relocation of the administrative and clinical services programs required the transfer of the licensed and accredited programs operated by CLHSD. Safety inspections, applications, notifications to all oversight agencies were conducted by the required oversight agencies such as the Office of the State Fire Marshal, Office of Public Health, and the CLHSD safety and compliance officers. The clinical programs required application for licensing of the new location. The clinical programs were issued new license to operate. Sufficient time was allowed for notification through flyers and other

public media platforms with the purpose of informing persons enrolled in the clinic programs pertinent to the move. Contracts were developed for the procurement of supports necessary to support the move were established and approved. All CLHSD policies and procedures were reviewed.

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

Yes.

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

No.

II. Is your department Five-Year Strategic Plan 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?

- **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?

Central Louisiana Human Services District (CLHSD) has made significant progress using the strategic plan. The District has successfully completed the move of the administrative, developmental disabilities office, and the primary licensed clinic program to the new facility which is located in a highly visible area of the city. Access to the clinic is supported by the public transportation system, and public information for the District services is available through the use of roadway signage, the District website, the District face-book page, and through community forums through educational presentations and community coordination activities by District employees. In addition, CLHSD had the opportunity to utilize technology expanding access to clinical therapeutic telehealth activities beyond use only by physicians to also other clinical staff reaching persons who may otherwise be unable to access services. In addition, the use of new technology has decreased inefficiencies inherent in face-to-face activities, and has been utilized in management team meetings to coordinate activities across the District eliminating unnecessary travel. Thirdly, the District continues to maintain programs that are licensed by Louisiana and accredited by CARF International. CLHSD has met with challenges due to the COVID-19 pandemic, demonstrating an increase in the number of persons served in prevention activities. Federal grants attached to the pandemic also made an expansion of crisis services possible

- **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?

    In the implementation of CLHSD inpatient Addictive Disorder services programs, the District has experienced some challenges with the change of contract providers. During the first quarter of FY 2020, the District established a contract with a new provider and services began in the second quarter of the Fiscal year. In three months, the new provider established two geographic locations for operations and obtained new license to operate the facility beginning services within the second period. The adolescent inpatient program (Gateway Treatment Center) has discontinued admissions to the program as a result of concerns related to the facility utilized for the program complicating aggression management for clients. The

Women's specific services previously through the Phase II program cannot be re-established with challenges external to the organization. Temporary Assistance for Needy Families (TANF) funds utilized to operate the program offer financial support that is below the cost of operation of the program, and local resources of a suitable facility at a conservative cost are not available.

- **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. CLHSD's strategic plan continues to be revised to address accomplishments and future goals and objectives. Each year the plan is reviewed by the Executive Director. The plan is developed in light of the needs of persons served within the District as well as financial limitations to allow growth.

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

CLHSD shares the strategic plan with the Executive Management team, the CLHSD Board of Directors, and allows access to the plan through postings in the clinic locations for those wishing to review the plan.

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?

Problem/Issue Description

1. What is the nature of the problem or issue?
   The Women's specific services, previously through the Phase II Residential program, has not been re-established. The challenges identified are both internal and external to the organization. TANF funds utilized to operate the program offer financial support that is below the cost of operation of the program, and local resources of a suitable facility at a conservative cost are not available.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
   Yes. The Gateway Treatment Program for adolescents was closed during the 2020 fourth quarter period. Referrals to this program were significantly decreased during the pandemic.
3. What organizational unit in the department is experiencing the problem or issue?
   The Gateway Treatment Program
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?
   The causes of this problem centered around the location of Gateway and issues handling aggressive behaviors within the program.
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?

   Currently, TANF funding is not designated to the CLHSD for operations of the Phase II women's specific program. Discussions with the current inpatient program contractor include plans to re-open the Gateway Adolescent program in

FY2021 at a new location. Planning includes operation of all inpatient programs, both adult and youth, in a new geographic location that are on the same campus.

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

   No.

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

      Yes, the contractor for the Gateway Adolescent program has located a new facility, and has nearly completed the renovations to the new location that would accommodate the needs. The contractor indicates the new location will be ready for licensing during the first quarter of the FY2021.

   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?

      Not applicable.

5. Do corrective actions carry a cost?

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

the upcoming fiscal year or in previous department budget requests?

The corrective action for the continuation of Gateway and Red River carry the cost of the lease of the new facility. These costs can be managed in the existing budget.

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.

☒ **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.

Central Louisiana Human Services District (CLHSD) Compliance Department conducts regular monitoring and identifies/reviews areas of concern. The findings are communicated to the management team and a corrective action plan is established for problem areas.

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

Licensing reviews are conducted on an annual basis by the LDH Health Standards staff to certify providers abide by established guidelines.
CLHSD Board's reviews: The Board in conjunction with the Executive Director reviews the District operations and endorses Business and Strategic Plans.

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

Policy, research, planning, and/or quality assurance functions in house: Performance Improvement and Critical Incident Review Committees, Continuous Quality Assurance (CQI) process is implemented by providers and reviewed by monitors, on an ongoing basis.

☐ Policy, research, planning, and/or quality assurance functions by contract
☒ Program evaluation by in-house staff
Program evaluation by in-house staff: CLHSD Division of Corporate Compliance conducts quarterly assessments of District and Contract Programs.

☐ Program evaluation by contract

☒ **Performance Progress Reports (Louisiana Performance Accountability System)**
The LDH Division of Planning and Budget coordinates and reviews entries of the Louisiana Performance Accountability System (LaPAS) data on a quarterly basis for 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
Independent Peer Reviews are conducted annually as required by the SAPT Federal Block grant.

☒ Accreditation review
Annually, review and certification is accomplished by the Executive Management Team to CARF International for the Behavioral Health Services programs.

☒ Customer/stakeholder feedback
Customer/stakeholder feedback is achieved through the use of satisfaction surveys of all persons served by the clinical programs of the Districts and Client surveys are offered to persons served to determine program outcomes. This feedback is reviewed by the District Management team and utilized in the performance improvement activities.

☐ 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 2019-2020

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: Many Behavioral Health Clinic:

A. What was achieved?
An increase in our annual funding allowed us to renovate the state-owned building in Many, Louisiana and hire most of the staff needed to re-open the clinic. However, because of the COVID-19 pandemic, the clinic would have been open before the end of the fiscal year. For now, the additional staff are supplementing our Natchitoches Behavioral Health Clinic until the COVID-19 pandemic recedes and we can re-open the Many Behavioral Health Clinic.

B. Why is this success significant?
The Many Behavioral Health Clinic 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. Re-opening the clinic will significantly improve client access to services.

C. Who benefits and how?
The clients of Sabine Parish will have access to behavioral health services without the need for significant travel. But most importantly, the health and welfare of our clients will be 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 most of the staff needed to operate the clinic.

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

Accomplishment #2: Primary Care Nurse Practitioner:

A. What was achieved?
A primary care nurse practitioner was brought on board in the prior year using grant funding. The addition was very beneficial in integrating care for our clients but with the grant funding ending, the nurse practitioner position was in jeopardy. An increase in our annual funding allowed us to permanently add the primary care nurse practitioner position to our Shreveport Behavioral Health Clinic staff.

B. Why is this success significant?
The ability to transition this position from grant funding (which was temporary and ending) to a permanent status significantly improves our ability to maintain integrated primary care and behavioral health services going forward.

C. Who benefits and how?
The clients of our Shreveport Behavioral Health Clinic will have access to a primary care nurse practitioner as part of their assessment and care. The health and welfare of our Shreveport clients will be significantly improved by access to integrated primary care and behavioral health services.

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 transition the temporary, grant-funded nurse practitioner position to a permanent position.

E. Does this accomplishment contribute to the success of your strategic plan?
Yes. Integration of primary care and behavioral health services is 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 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?

  Significant improvements were able to be made due to the allocation of an additional one million dollars to our district. The funding has been used to significantly expand services, improve district infrastructure, and enhance public awareness of our district services. We believe this infusion of additional funding has allowed our district to better meet the needs of our clients and make significant steps toward 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:

  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 is due to internal factors, specifically, the additional funding allocated by the legislature. Without this additional funding, progress would have been limited.

- Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

  Progress is directly related to the allocation of additional funds by the legislature. No new technologies, methodologies, or resources were used to achieve this progress.

- Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?

  No.

- Other? Please specify.

  No

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

   It is not a one-time gain. Progress is expected to continue with the expansion of services.

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

  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?

  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, as it covers fiscal years 2020-2025.

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

  The areas of focus for the strategic plan were based on stakeholder input and the District's End Statement developed by the Northwest Louisiana Human Services District (NLHSD) Board of Directors. The NLHSD Senior Leadership Team then adjusted the goals and objectives of the plan based on input from management staff. The final draft has been disseminated to staff via e-mail and posted on the NLHSD shared folder for all staff to reference when needed. Review of the plan is set to occur twice a year with a summary report to the Board of Directors for their review and input.

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

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

There are no significant department management or operational problems to report.

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

A. Problem/Issue Description
   1. What is the nature of the problem or issue?
   2. Is the problem or issue affecting the progress of your strategic plan? (See Section

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

B. Corrective Actions

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 and 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)**
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☐ 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?

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