

Bobby Jindal
GOVERNOR



Kathy H. Kliebert
SECRETARY

State of Louisiana
Department of Health and Hospitals
Office of the Secretary

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

FROM: Kathy Kliebert
Secretary 

RE: FY 2015 Annual Management and Program Analysis Report (AMPAR)

DATE: December 3, 2015

In accordance with Louisiana Revised Statutes 36:8, the Department of Health and Hospitals is submitting its Annual Management and Program Analysis Report (AMPAR) for the 2014-2015 fiscal year. These reports summarize the activities of each office relating to management and program analysis, outstanding accomplishments, areas where we are making significant progress and specific management/operational issues that exist within the agency.

If there are any questions regarding these reports, you may contact Elizabeth Davis at 225-342-5608 or the contact persons listed for each agency.

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
09-300 Jefferson Parish Human Services Authority

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

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:

Integration of Primary Care and Behavioral Health Services

A. What was achieved?

Jefferson Parish Human Services Authority (JPHSA) achieved comprehensive integration of Primary Care and Behavior Health services within its JeffCare program, a Federally Qualified Health Center. Initiated with a co-located model, JeffCare quickly moved to a fully integrated model to best meet the needs of the individuals and families of Jefferson Parish. Staff received cross-training to assure a more holistic approach to the provision of services, and care coordination was instituted as a component of the program. JPHSA's philosophy of recovery and resiliency broadened to also include overall health and wellness.

B. Why is this success significant?

Achieving full integration supports the statewide initiative on the part of the Department of Health and Hospitals' Office of Behavioral Health. Of the highest importance, the integrated model is fully compatible with the principle of universal design and is helpful to individuals with a serious mental illness and/or an addiction and/or a developmental disability in more easily accessing services, in most cases through providers with whom they are already familiar. Secondly, successful implementation of this model provided increased access to funding sources other than State General Fund.

- C. Who benefits and how?
Individuals with serious mental illness and/or addictive disorder and/or developmental disability benefit, in particular those who are without insurance or who are underinsured. Intervention produces positive outcomes for overall improved health and lower utilization of hospital emergency department services.
- D. How was the accomplishment achieved?
Two grants helped support this transition: one from New Orleans Charitable Health Fund and the other from Health Resources and Services Administration. Buy-in was crucial to success and was achieved with the JPHSA Board of Directors and with all levels of staff...from the executive offices to the front line. Additionally, ongoing and continuous training was required.
- E. Does this accomplishment contribute to the success of your strategic plan?
Yes. Full integration of behavioral health and primary care services supports JPHSA's Mission and supports both Goals of the Strategic Plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?
Yes. The integration model is recognized by the Substance Abuse and Mental Health Services Administration. The Department of Health and Hospitals' Office of Behavioral Health endorsed the model and held a series of Integration Summits throughout the State. JPHSA co-sponsored one of the Summits with Metropolitan Human Services District.

Expansion and Enhancement of Peer Services for Adults

- A. What was achieved?
Jefferson Parish Human Services Authority (JPHSA) broadened the scope of services for adults provided by peer specialists by embedding them in both community-based programs and the fully integrated primary care and behavioral health care JeffCare Health Centers. The peers also facilitate the effectiveness of the multi-level referral process (referrals from JeffCare to community-based case management and other contract services).
- B. Why is this success significant?
Embedding the peers in the JeffCare Health Centers and community-based programs ensures rapid and more effective connection to needed services, hence improving access across the delivery system. Peer support services have matured, diversified, and increased across the United States during the past decade with peers becoming more recognized as service providers. Third-party payors are now developing methods of reimbursement for these services as they are recognized as evidence-based, effective, and as a cost saving measure.
- C. Who benefits and how?
Bridging the gap between health center-based services and community-based services

providers through peer support helps ensure individuals are connected with the services they need; and, assists the providers in both service delivery areas to engage in more effective communication about the status and progression of those they jointly serve.

D. How was the accomplishment achieved?

JPHSA restructured the supervisory approach to managing the peer support program and redeveloped Peer Support Specialist job descriptions. The expectations of the staff regarding their traditional role were broadened to include more of a comprehensive wellness along with a recovery-oriented approach.

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

Yes. Expansion of the scope of services provided by peer support specialists improves personal outcomes through effective implementation of best practices.

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

Yes. The program uses prescribed practices and systematic processes that are evidence-based to achieve positive outcomes.

II. Is your department 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.**

Jefferson Parish Human Services Authority (JPHSA) remains on target toward achieving Strategic Plan Goals and Objectives. Strategies outlined in the current Strategic Plan continue to be effective and continue to be strengthened by a strong commitment to continuous Performance and Quality Improvement throughout every program and activity within the Authority.

♦ **Where are you making significant progress?**

JPHSA reports continued progress on Strategic Plan Goals based on available quantitative and qualitative data, including client level data, survey research, guided discussion, and comparative data.

Goal I: Provide coordinated 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.

Goal II: Improve personal outcomes through effective implementation of best practices and data-driven decision-making.

All strategies identified in the current Strategic Plan are utilized with ongoing emphasis on continuous performance and quality improvement for both service delivery and

business processes.

a. To what do you attribute this success?

JPHSA attributes this success to the following: a supportive and knowledgeable Board of Directors; a strong and forward thinking Executive Management Team; a solid strategic management framework; good infrastructure; focus on staff development and consistent positive supervision; ongoing interaction with key stakeholders; ongoing compliance with Council On Accreditation Standards; a deep commitment to continuous performance and quality improvement; consistent and ongoing utilization management; integrated and holistic service delivery; a focus on “customer” service; and data-based decision-making.

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

Progress is not the result of a one-time gain; rather, it is an ongoing process. JPHSA utilizes division-specific annual business plans and annual Performance & Quality Improvement Initiatives (PQI) as well as targeted PQI work groups to support the Strategic Plan and ensure progress. Support from the Board of Directors is essential and ongoing as well.

- ♦ **Where are you experiencing a significant lack of progress?** 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?

The Jefferson Parish Human Services Authority Board of Directors, after intensive discussion and consideration, revised the Mission Statement to include the integrated services:

Individuals and families in Jefferson Parish affected by Mental Illness, Addictive Disorders or Developmental Disabilities shall live full, independent and productive lives to the greatest extent possible for available resources, including the integration of primary care into clinical services.

Activities reflect the organizational restructuring accomplished during the previous year.

The revision to the Mission Statement became active July 1, 2015. It should be noted during the next Fiscal Year, the Board is going to reconsider Priorities.

- ♦ **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?

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

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

Each Division Director is required to develop and implement an annual division-specific business plan in support of the JPHSA Strategic Plan. Directors report progress to the Executive Director on a quarterly basis. Progress reports are accessible to all employees on the shared drive of the JPHSA computer network, and through discussion during division staff meetings.

Additionally, the JPHSA Performance & Quality Improvement Committee develops, adopts, and implements annual cross-divisional Performance & Quality Improvement Initiatives to further support Mission and Priorities and achievement of the Strategic Plan. Quarterly progress reports are delivered during committee meetings and reported in the employee electronic newsletter.

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

Division Directors involve staff in data collection, analysis, and reporting of Performance Indicator outcomes and in work groups formed to enhance performance and quality. The Executive Director schedules two all-staff meetings each Fiscal Year. Performance and quality improvement is a routine part of the interactive agenda. Additionally, during Fiscal Year 2014-2015, the Chairperson of the Performance & Quality Improvement (PQI) Committee developed a new web-based in-service on JPHSA's PQI Plan that is mandatory for all staff.

Bi-weekly Executive Management Team meetings are used as group supervision and 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 & Quality Improvement Initiatives as well as on their degree of success in accomplishing their Annual Business Plan objectives.

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

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

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

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

A. Problem/Issue Description

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

None.

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?

Internal audit

JPHSA's Management Services Division provides ongoing monitoring of clinical, 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 Management Services Division audits Authority performance using benchmarks set forth in Council on Accreditation standards. Improvement and/or corrective action plans are developed and executed as needed. The Division monitors progress on plan implementation as well. Each JPHSA Division establishes an annual business plan containing measurable outcomes in support of the Authority's Strategic Plan. Outcomes are tracked and reported on a quarterly basis with performance and quality improvement and/or corrective action initiated as needed.

- 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 Department of Health and Hospitals' Office for Behavioral Health and Office for Citizens with Developmental Disabilities audit JPHSA as set forth in the Accountability Implementation Plan, i.e. ongoing data reporting, annual peer review, and annual on-site audit.
- Policy, research, planning, and/or quality assurance functions in-house JPHSA's Management Services Division has overall accountability for policy development and management as well as for the Authority's quality assurance functions. With regard to policy development and update, the Management Services Division Director consults with the in-house attorney on an as-needed basis. The Executive Management Team, headed by the Executive Director, is responsible for short- and long-term planning. She informs and seeks consultation from the JPHSA Board of Directors as appropriate according to Board policies and the Carver Policy Governance Model. The Performance & Quality Improvement (PQI) Committee, a chartered committee chaired by the Management Services Division Director, is responsible for the review and update of JPHSA's PQI Plan and for the collaborative development and ongoing monitoring of annual PQI Initiatives.
- Policy, research, planning, and/or quality assurance functions by contract JPHSA has **no** contracts for policy, research, planning, and/or quality assurance functions.
- Program evaluation by in-house staff Performance is monitored on an ongoing basis utilizing the JPHSA Strategic Plan, Operational Plan, Division-Specific Annual Business Plans, Annual Performance & Quality Improvement Initiatives, Utilization Management Plan, Staff Development & Supervision Guidelines, and position-specific expectations. All have clearly stated goals/objectives and performance targets. The Executive Director, Executive Management Team, Supervisory Staff, and

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

- Program evaluation by contract
JPHSA has **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. Detailed 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 Department of Health & Hospitals' (DHH) Office for Citizens with Developmental Disabilities (OCDD) and the Office of Behavioral Health (OBH) on an ongoing basis and as requested. JPHSA is compliant with the DHH Human Services Accountability and Implementation Plan, which contains an extensive array of outcome/output measures, many of which OCDD and OBH utilize in compiling data for their own LaPAS reports.
- In-house performance accountability system or process
JPHSA utilizes the following to model its performance accountability process: Council On Accreditation Standards and Rating System; JPHSA Staff Development & Supervision Guidelines in conjunction with the Louisiana Department of State Civil Service Performance Evaluation System; JPHSA's Performance & Quality Improvement monitors in conjunction with Performance & Quality Improvement Initiatives; ongoing internal monitoring with appropriate follow-up activity; and, ongoing data collection, mining, and analysis for decision support. The JPHSA Executive Management Team meets bi-weekly to discuss progress and any need for performance and quality improvement and/or correction action. Further, the Executive Director meets one-on-one with each member of the Executive Management Team for reporting on annual plan progress and any need for performance and quality improvement and/or corrective action.
- Benchmarking for Best Management Practices
JPHSA adopted its own electronic health record – Greenway Success EHS – with implementation initiated in January 2015 and completed in March 2015. Decision support remained difficult, as JPHSA was now working between two systems and having to take extra steps to assure data points matched and avoid duplication of data. 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. 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, program requirements, performance measures, required administrative oversight, and reporting mandates clearly spelled out. Further, required monitoring plans all include timeframes, performance measures, and assigned clinical/service delivery and financial monitors. JPHSA provides technical assistance to contractors as needed per monitoring reports.
- Peer review
The JPHSA Medical Director leads comprehensive multi-disciplinary peer review in cases of a service recipient suicide or death not associated with a physical disease or chronic condition. He also schedules peer reviews during quarterly meetings of the Medical Staff. JPHSA participates in the Office of Behavioral Health annual peer review with a sister Local Governing Entity. These reviews alternate focus on program and administrative functions. The peer review for FY 2015 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
JPHSA completed year three of a four-year full organization accreditation by the Council On Accreditation, an international accrediting body for human services organizations. Further, JPHSA successfully completed the third year Maintenance of Accreditation review with no recommendations or findings.
- Customer/stakeholder feedback
JPHSA participates in annual satisfaction surveys sponsored by the Office of Behavioral Health and the Office for Citizens with Developmental Disabilities. Additionally, JPHSA fields a proprietary survey within its Health Centers on a quarterly basis in order to identify opportunities for improvement. Comment boxes are available in all Health Centers; and, JPHSA invites feedback on its internet site. JPHSA requires contractors delivering community-based behavioral health services to field satisfaction surveys with their service recipients and to share results with JPHSA. JPHSA partners with the Office of Behavioral Health to hold an annual addictive disorders community forum for the citizens of Jefferson Parish. The members of the Board of Directors, per the Policy Governance Model, actively engage in “community linkages” and report the outcomes of these community stakeholder interactions during each Board meeting. Additional feedback is obtained through active participation in the monthly Jefferson Parish Behavioral Health Task Force meetings and in the quarterly Regional

Advisory Committee meetings for Behavioral Health and Developmental Disabilities. JPHSA also participates on the Child and Youth Planning Board and Jefferson Parish Alliance for Concerned Citizens. The Executive Director and the Chief Administrative Assistant make regular calls on local and state elected officials as well as community partners.

Other (please specify):

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.

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

Contact person for more information:

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Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
09-301 Florida Parishes Human Services Authority

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Executive Director: Melanie Watkins

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

For each accomplishment, please discuss and explain:

Same Day/Next Day Access– FPHSA consulted with the National Council for Behavioral Health to implement the Same Day/Next Day Access initiative in FY 2015 to improve and enhance our delivery service system. Through grant funding from Baptist Community Ministries and the Northshore Foundation, and in collaboration with the St. Tammany Parish Government and the Louisiana Public Health Institute, FPHSA was able to move forward with developing plans for enhanced access to care and services, as well as strengthening our working relationship with our community partners. The accomplishment contributes to FPHSA’s strategic plan to provide comprehensive services and supports which improve the quality of life and community participation for persons with serious and persistent addictive disorders, developmental disabilities, and/or mental illness, while providing effective limited intervention to individuals with less severe needs. FPHSA has assessed and redesigned our intake and assessment processes to reduce client wait times. Improved access to care has been proven to reduce no-shows and cancellations and to enhance engagement of persons in treatment and recovery.

FPHSA acquired its own IT domain – FPHSA took on the management of its own IT operations. This enabled us to have more local control over IT administration, functions, and operations. This allowed more rapid resolution to network issues, enhanced the transmission of data because of increased bandwidth availability, and shortened the time to create email accounts. This accomplishment also contributes to FPHSA’s strategy of

increasing the efficiency of the operations.

FPHSA implemented a new electronic health record for Behavioral Health Services – In June, 2015, FPHSA implemented a new electronic health record for Behavioral Health services with a more accessible/robust reporting system that will afford the agency more reliable data to use for decision making. This accomplishment contributes to FPHSA’s goal of improving the quality and effectiveness of services and/or treatment through the implementation of best practices and the use of data-based decision-making.

FPHSA continues to merge Mental Health and Addictive Disorders Services into Behavioral Health Services – FPHSA has continued towards the merging of services into behavioral health services in accordance with the proposed change in licensure. FPHSA has restructured and streamlined its Executive Management to include a Behavioral Health Director, an Assistant Behavioral Health Director, and a Practice Manager. This accomplishment contributes to FPHSA’s goal of improving the quality and effectiveness of services and/or treatment through the implementation of best practices and the use of data-based decision-making.

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.

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

FPHSA has continued to strive to assure comprehensive services and supports to improve the quality of life of those individuals served. Progress has been made for individuals served through Developmental Disabilities Waiver Supports and Services. In FY 2015, 1,386 individuals were served through waiver supports and services compared to 1,288 in FY 2014. Progress has not been as significant with regards to mental health and addictive disorders services due to budget constraints; however, the agency continues to provide direct clinical services and coordinates an array of services designed to provide treatment on an outpatient basis as well as an ASAM III.5 residential treatment program for addictive disorders.

Goal 2: To improve the quality and effectiveness of services and/or treatment through the implementation of best practices and the use of data-based decision making.

FPHSA has made progress toward implementation of data-based decision making. Progress has been impeded over the last few years due to the limited ability to pull valid data and information from Clinical Advisor. However, in FY 15 FPHSA was

provided additional data from Clinical Advisor and Magellan affording the agency the ability to use the data for decision making. Area Supervisors (Addictive Disorders Services, Developmental Disabilities Services, and Mental Health Services) met regularly with the Executive Director to discuss services and client data. In June, 2015, FPHSA implemented a new electronic health record for Behavioral Health services with a more accessible/robust reporting system that will afford the agency more reliable data to use for decision making.

The agency has made headway toward treatment of co-occurring disorders as all of FPHSA's Mental Health and Addictive Disorders facilities have now been co-located.

Goal 3: To promote healthy and safe lifestyles 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 the localized community problems.

FPHSA is meeting this goal in several ways. Major educational initiatives include the Addictive Disorders Services Prevention program. FPHSA provides funding and contracts with providers to teach LifeSkills training and Kid's Don't Gamble in the schools located in the agency's catchment area. FPHSA Prevention Services promotes healthier lifestyles throughout the community by supporting participation in healthy initiatives such as *Red Ribbon Week*, *Wellness Week*, *Recovery Month*, *Alcohol Awareness*, *Suicide Prevention Awareness*, *Family Day*, etc. Prevention Services also bring training to the communities to empower individuals and groups to learn about the issues in the community (driven by data) and develop strategic plans to address those issues to promote healthier communities. Such training includes *ASIST* (Applied Suicide Intervention Skills Training); *safeTALK* (a suicide awareness program); *Strategic Planning Framework* (training in a process to strategically assess and address community issues); *Cultural Diversity*; *Preventing Mental, Emotional, and Behavioral Disorders in Young People*; *Ethics*; *Facilitation and Coalition Building*; etc.

FPHSA staff participate in numerous community led efforts across the agency's five-parish service area including *St. Helena Human Services Coalition*, *Tangipahoa Social Services Coalition*, *St. Tammany Commission on Families*, *Washington Parish Commission on Human Services*, *TRACC* (Tangipahoa Reshaping Attitudes for Community Change), *Livingston Youth and Family Together*, *LACES* (Louisiana Alliance Creating Economic Success), etc. In addition, FPHSA staff participate in the *Regional Child Mortality Death Review*, and advise, collaborate, and monitor two Drug Free Community grantees (*ADAPT in Washington* and *TRACC in Tangipahoa Parishes*). Staff are advising the *LYFT Prevention Taskforce* who are funded as a designated High Needs Community by the Louisiana Partnership for Success in Livingston Parish (LYFT). FPHSA staff also participate in numerous health and wellness resource fairs throughout the five-parish service area.

Objective 1: Florida Parishes Human Services Authority/Addictive Disorders Services (ADS) will provide quality treatment services to individuals with addictive disorders and prevention services in a cost effective manner.

FPHSA met this objective in FY 15 as 64,778 individuals were served through addictive disorders treatment and prevention services, which is twelve percent of the population of FPHSA's catchment area.

FPHSA also contracted with the Department of Corrections (DOC) as it relates to ACT 389. This contract affords FPHSA the opportunity to expand services to include individuals referred to the agency from DOC and provides an additional revenue source.

Objective 2: Each year through June 30, 2019, Florida Parishes Human Services Authority/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.

FPHSA continues to have success towards this objective. The percentage of individuals receiving Flexible Family Funds/Cash Subsidy and the percentage of individuals and families receiving family support who remain in the community versus being institutionalized were both 100 percent again in FY 15. The total number of individuals served through waiver supports and services increased from 1288 in FY 14 to 1,386 in FY 15.

Objective 3: Each year through June 30, 2019, Florida Parishes Human Services Authority/Executive Administration will increase the efficiency of the operation and management of public, community-based services related to addictive disorders, developmental disabilities, mental health, and permanent supportive housing in the parishes of Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington.

FPHSA continuously works to increase the efficiency of operations and services. In FY 15, FPHSA hired a Practice Manager to assist in streamlining operations. The Executive Management Team reviewed and implemented a new workflow for Behavioral Health services across the area to create efficiencies and avoid duplication of efforts.

In June, FPHSA implemented a new electronic health record. The agency anticipates that with the implementation of the new record, many efficiencies will be realized and services will be enhanced.

♦ **Where are you making significant progress?**

FPHSA has made significant progress by expanding Behavioral Health outreach services in the community which has increased access to care more locally for the clients we serve.

FPHSA submitted an application for the Primary and Behavioral Health Integration grant through SAMSHA. Although, we were not awarded this grant, it has afforded FPHSA much information to assist the agency in moving forward with this initiative in the future.

♦ **Where are you experiencing a significant lack of progress?**

FPHSA continues to experience difficulty in recruiting and retaining qualified, licensed clinical staff and prescribers. In an effort to enhance recruiting, the agency became a NHSC (National Health Service Corps) site to assist prescribers with student loan repayment.

♦ **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?

FPHSA's strategic plan has not changed; however, the agency's working business plan continues to evolve with the ever changing demands of the behavioral health and developmental disabilities fields. The agency continues to address the changes brought forth through the LBHP, System Transformation, requirements of an electronic health record, required self-generation of revenue, electronic billing, accreditation compliance, healthcare reform, and provide more effective and efficient access to person-centered services. In FY 15, FPHSA contracted with a consultant to facilitate a retreat/planning meeting with FPHSA's board and executive staff to modify and develop the agency's business/strategic plan.

How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?

FPHSA has monthly meetings with its Board of Directors and conducts routine Executive Management Team meetings. The managers of each service area hold regular meetings with their staff at which information related to the agency's overall

plan and strategies are discussed.

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

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.

Due to budget constraints and the increased population in the Florida Parishes area, FPHSA has increased its reliance on Self-Generated Revenue.

In FY 15, the agency made the decision to move forward with the implementation of a new electronic health record which was implemented in June 2015.

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.

The investment in another electronic health record will enable FPHSA to implement a record more suited to the agency's needs. This will offer greater flexibility to clinical staff to enter and track services provided, will allow billing staff to efficiently bill Magellan and all other payers for services rendered, and will provide the necessary data needed for decision making.

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

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

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

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

- Internal audit (HR)
- External audits (Office of Risk Management; Louisiana Department of State Civil Service, Magellan, Department of Health and Hospitals Accountability and Implementation Plan (AIP), etc.)
- 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)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback: ADS Public Forum
- Other (please specify): Annual Financial Reports

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

- a. Human Resources
- b. Office of Risk Management – Compliance Review
- c. Louisiana Department of State Civil Service
- d. Magellan Treatment Record Reviews
- e. Louisiana Performance Accountability System (LaPAS)
- f. Contract Monitoring
- g. DHH--The Human Services Accountability and Implementation Plan (AIP) Annual On-site Monitoring Final Report
- h. ADS Peer Review
- i. DHH—Office of Aging and Adult Services

2. Date completed

- a. Annually for each facility
- b. February 19, 2015
- c. April 28, 2015
- d. November 13, 2014
- e. October 2015
- f. Quarterly
- g. March 26, 2015
- h. June 18, 2015
- i. June 11, 2015

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

- a. FPHSA Procedure 540.1 Time Administration
- b. FPHSA Risk Management Policy and Procedure (ORM Requirement)
- c. Compliance to State Civil Service requirements
- d. Requirement of the LBHP Partnership
- e. Compliance to LaPAS requirement
- f. FPHSA Contract Regulations and Procedures
- g. Compliance with MOU with DHH
- h. Block Grant requirement
- i. DHH Permanent Supportive Housing Program contract requirements

4. Methodology used for analysis or evaluation

- a. FPHSA Procedure 540.1 Time Administration

- b. Compliance Review completed by ORM, LP Officer
- c. Civil Services policies and rules
- d. Review completed by Magellan
- e. DOA-required methodology; performance indicators developed by FPHSA and approved by DOA
- f. FPHSA Contract Regulations Policies and Procedures
- g. Accountability and Implementation Plan (AIP)
- h. Peer Review
- i. Monitoring by DHH PSH Program Project Coordinator

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

- a. Not calculated
- b. Not calculated
- c. Not calculated
- d. Not calculated
- e. Not calculated
- f. Not calculated
- g. Not calculated
- h. Not calculated
- i. Not calculated

6. Major Findings and Conclusions

- a. None
- b. None
- c. None
- d. None
- e. None
- f. None
- g. DHH Findings for AIP:
 - a. Performance standard for Indicator 8 – Percentage of Individual and Family Support funds expended for individuals and families was not met.
 - b. Performance standard for Indicator 10 – Percentage of people in community-based employment was not met.
 - c. Performance standard for Indicator 28 – Percentage of requirements in compliance with the Louisiana Quality Management Strategy was not met.
 - d. Performance standard for Indicator 25 – Percentage of Waiver records maintained as required was not met.
- h. None
- i. DHH Findings for PSH Monitoring:
 - a. 3 files contained incomplete support plans which did not include the full date, lacked action steps for goals, and contained goals that were seen as vague and/or difficult to measure.
 - b. 7 files did not have a crisis plan on file and/or stopped completing crisis plans after the legal-sized assessment/plan

documentation packet was no longer an agency form.

7. Major Recommendations

- a. None
- b. None
- c. None
- d. None
- e. None
- f. None
- g. None
- h. None
- i. None

8. Action taken in response to the report or evaluation

- a. Audit results are discussed at management team meetings and trouble shooting is done.
- b. None
- c. None
- d. None
- e. None
- f. None
- g. Corrective action plans were completed for each performance standard not met. A committee meets quarterly to review progress towards meeting the steps in the plans and to determine if revision or additional steps are required to meet the standard.
- h. None
- i. FPHSA purchased a new electronic behavioral health record. The PSH staff have been thoroughly trained on the new system which also meets CARF requirements. All PSH support plans were brought into compliance: specifically with dates, action steps, and measurable goals, in accordance with PSH standards. PSH staff were trained on and started using the FPHSA Behavioral Health Crisis Plan in July 2015.

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

- a. Electronic files
- b. Hard copy
- c. Hard copy
- d. Hard copy
- e. www.doa.louisiana.gov/opb/lapas/lapas.htm
- f. Hard copy
- g. Hard copy
- h. Hard copy
- i. Hard copy
- j. Hard copy

10. Contact person for more information, including

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Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: **Department of Health and Hospitals**
09-302 Capital Area Human Services District

Department Head: **Kathy Kliebert, Secretary**

Undersecretary: **Jeff Reynolds**

Executive Director: **Jan Kasofsky, PhD**

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

CAHSD PROGRAM AT WOMAN'S HOSPITAL SHOWS IMPRESSIVE RESULTS

The recent expansion of a Capital Area Human Services District (CAHSD) program at Woman's Hospital LSU Clinic has shown impressive results to screen pregnant women for substance use, depression and domestic violence, according to a LCSW with Child/Adolescent Behavioral Health program (CABH), who is providing co-located behavioral health services at the clinic.

Prevention of substance use during pregnancy and early intervention services for infants who were exposed to substances before birth are critical components CAHSD's efforts to improve the health of children and families in the region.

In their work, the LCSW uses a multidisciplinary, evidence-based approach to promote optimal behavioral health of pregnant women and to improve birth outcomes by reducing the harmful effects of substance use, depression, and domestic violence. The Prenatal Screening, Brief Intervention, Referral and Treatment (SBIRT) program began at the Woman's Hospital LSU Clinic in May 2014.

As of March 2015, 908 screens were completed with 280 (31%) women screening positive for substance use or at-risk for depression or domestic violence. Women who screen positive and enroll into the program are provided brief counseling, education and referral to community resources.

Additional Program Successes

SAMHSA funding in 2004 enabled CAHSD and a collaborative of more than 40 agencies, including Woman's Hospital, to develop and offer comprehensive SBIRT care for pregnant women. Over the past 11 years, approximately 11,000 pregnant women have been screened, and more than 2,000 women have received counseling and support services using SBIRT. The program was expanded statewide in 2006.

Additional services were introduced in 2007, including comprehensive assessment and treatment of children from birth to 6 years of age who are in foster care or who were prenatally exposed to alcohol or other drugs. More than 600 children and their families have been served through CAHSD's early intervention services at the Infant, Child and Family Center (ICFC). A specialty of the ICFC is the infant mental health services designed to strengthen the caregiver-child relationship that promotes young children's development and emotional well-being.

CAHSD PEER SUPPORT SERVICES AT EBR PARISH PRISON: *Magellan Awards Second \$5,000 Grant; and EBR Parish Council Approves \$76,000 Contract to Expand Services*

Based on the success of a previous grant, CAHSD has been awarded another \$5,000 from the 2015 Magellan Seed Grant to continue its peer support services in the East Baton Rouge Parish Prison.

The pre- and post-release services, funded July through November, will be provided to offenders with mental illness and addictive disorders. CAHSD Certified Peer Tonja Myles will coordinate a team of peer volunteers to provide the following essential services:

- Person-centered transition planning
- Wellness Recovery Action Plan educational groups
- Expedited access to integrated primary care and behavioral health services
- Application for disability benefits through a legal aid program
- Priority for supported housing (for those chronically homeless)
- Linkages to community services and re-entry programs for education or employment
- Connection or reconnection to behavioral health care providers

In 2014, CAHSD received its initial grant of \$5,000 from Magellan for much-needed peer support services at the prison. Between April and December of that year, CAHSD helped 383 participants in the prison. Of those, 242 (63%) were released during the grant period, and 82 (33%) kept their outpatient behavioral health treatment appointments, connected with the local recovery community, and were not re-arrested.

In other significant action, the East Baton Rouge Parish Council voted in May for a \$76,000 contract to expand CAHSD peer support services at the Parish Prison. Among other CAHSD services and help afforded at the prison, the new contract has allowed a CAHSD Social Worker to work at the prison on a full-time basis.

NEW CONTRACTS TOTALING \$158,494 ARE PROVIDING MORE HELP FOR INDIVIDUALS IN AREA PRISONS

Thanks to new contracts from the East Baton Rouge Parish Council and the Louisiana Department of Public Safety and Corrections, CAHSD will be able to help more individuals who are in area prisons.

EBR Parish Prison

The EBR Parish Council recently approved a \$76,000 contract with CAHSD to continue and expand its work at the EBR Parish Prison and to improve outcomes for male and female inmates with mental health and/or substance use disorders. The EBR program will begin in July and will continue through December 2015.

Under the terms of the contract, a CAHSD Social Worker and CAHSD peer specialists will help participants and prison staff with discharge planning before release and will be involved in case management after release.

The efforts emphasize connecting participants to outpatient behavioral health treatment and to the local 12-step recovery community (Narcotics Anonymous & Alcoholics Anonymous).

State Prisons

The Louisiana Department of Public Safety and Corrections has contracted with CAHSD to help improve outcomes for 75 male and female offenders with co-occurring mental health and substance use disorders.

The program, which began in April and continues through September 2016, is designed to help inmates at the Elayn Hunt Correctional Center for Men and the Louisiana Correctional Institute for Women, both located at St. Gabriel.

With funding from an \$82,494 contract, CAHSD is providing two Certified Peer Recovery Specialists to help participants and prison staff with pre-release discharge planning and post-release case management.

The services are designed to ensure smooth reentry by connecting participants to outpatient treatment, residential programs, training programs, jobs, and the local 12-step recovery community.

CAHSD ANNOUNCES NEW SERVICES FOR YOUNG CHILDREN WITH AUTISM

CAHSD Applied Behavioral Analysis (ABA) program is now officially open to children ages two to five years old with a diagnosis of autism. Autism is a medical condition that impacts a child's normal development of the brain and affects talking, thinking and interacting with others in leisure, learning and play activities.

The new program, called ASCEND (Accelerated Supports for a Child's Evolving Neuro-

Development) provides up to six hours per day of comprehensive therapy to children and incorporates the family in its plan of care. ASCEND was designed by the CAHSD Division of Developmental Disabilities to address unmet needs in preschool children who lack access to comprehensive services and programming to achieve the greatest benefits.

“Many children are not identified with a developmental disability until after entering school, yet we know that early intervention, before school age, can have a significant impact on a child’s ability to learn new skills as well as reduce the need for costly interventions throughout life,” said ASCEND Program Director Jim LeVelle, Ph.D., BCBA-D.

The ASCEND team consists of professionals that include applied behavioral analysts, speech therapists, occupational therapists, nutritionists, social workers, physical therapists, neurologists or developmental neurologists. The program is offered at the CAHSD Children’s Center for Behavioral Health, 4615 Government St., Building 1, and operates Monday through Friday, 7:30 a.m. to 3:30 p.m.

"MOJO IS POISON" CAMPAIGN CONTINUES

CAHSD continues its campaign against the use of deadly synthetic marijuana, aka "MoJo" and "Spice." To raise awareness during holiday celebrations, CAHSD sponsored 57 radio commercials between June 29 and July 6 on the popular WEMX MAX 94.1. The radio station also featured a June 30 interview by on-air personality A.J. Boogie with CAHSD Certified Peer Tonja Myles.

CAHSD and EBR Coroner's Office Join Forces in Campaign Against Heroin and "MoJo" Use



Heroin deaths are seven times higher than in 2012

Deaths from heroin use in East Baton Rouge Parish totaled five in 2012, but rose to 35 in 2013 and could surpass 35 by December, EBR Coroner William "Beau" Clark, MD, announced at the

Aug. 27 Behavioral Health Collaborative meeting.

CAHSD hosted the Collaborative meeting to launch a new public awareness campaign with the EBR Coroner's Office that warns against the deadly effects of heroin and synthetic marijuana, also known as "Mojo" and "Spice." The campaign includes 30-second videos for television and social media, radio public service announcements, billboards, posters for schools and workplaces, and fact sheets.

The goals of the campaign, according to CAHSD Executive Director Jan Kasofsky, Ph.D., are to raise awareness about the dangers of the drugs, to prevent their use, and to inform people that CAHSD can help.



Anti-heroin billboard and poster design

The campaign's messages are real and straightforward: "Heroin is Deadly" and "MoJo is Poison." The materials feature the tagline, "Don't let this be your last ride," with images of the coroner and his van. Dr. Clark noted that heroin use rose sharply in recent years as a result of the new prescription monitoring program that allows tracking of prescriptions of patients in order to reduce overprescribing of opiate pain medications. He said that change was well intentioned, but had the effect of drying up prescription opiate supplies on the streets, causing users to turn to another opiate, heroin. Also, around the same time, laws changed to reduce prison sentences for heroin dealers, which led to an increase in heroin supplies.



Anti-synthetic marijuana billboard and poster design

According to the coroner, synthetic marijuana was created originally in laboratories for beneficial, medicinal purposes, but the chemicals started to be made for illegal street use and formulas constantly changed to avert the law. Poisonous additives in synthetic marijuana cause

users to experience symptoms including hallucinations, paranoia, heart attacks and death.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment? To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

The District operates under two separate five-year strategic plans. We, as part of the Department of Health and Hospitals, participate in the state-wide LaPAS Performance Based Budgeting and Planning process which establishes goals and objectives by specific programmatic areas 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 Strategic Plan is a daily operations guide that establishes internal goals that are aimed at improving the quality of life for our clients and improving operational efficiencies. This plan has three major goals and the District has made significant progress on accomplishing many of the objectives covered under these goals. Progress on meeting our annual goals is reported semi-annually to the CAHSD Board.

- ♦ **Where are you making significant progress?** If you are making no significant progress, state "None." However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
 1. To what do you attribute this success? For example:
 - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
 - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
 - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
 - Other? Please specify.

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

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

CAHSD Plan: The District continues to make great strides toward meeting its goal of implementing a fully functional and DHHS-HIT approved electronic health record and has successfully reformed its internal clinical and billing practices to that of a Practice Management model.

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

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

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

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

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

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

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

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

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

A. Problem/Issue Description

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

resolve the problem or issue?

None.

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)
- 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)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review: Magellan annual certification/review and CARF accreditation annual reporting and recertification conducted September 2015
- Customer/stakeholder feedback
- Other (please specify): State Licensure (BHS and Public Health-Department of Health and Hospitals)

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

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

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

1. Title of Report or Program Evaluation
Louisiana Performance Accountability System (LaPAS)
2. Date completed
Quarterly July 01, 2014 through June 30, 2015
3. Subject or purpose and reason for initiation of the analysis or evaluation:
Legislative requirement
4. Methodology used for analysis or evaluation
LaPAS: Standard methodology required by the DOA; actual performance indicators developed in conjunction with program offices and approved by the DOA
5. Cost (allocation of in-house resources or purchase price)
LaPAS: Cost uncalculated
6. Major Findings and Conclusions
LaPAS: None
7. Major Recommendations
LaPAS: None
8. Action taken in response to the report or evaluation
LaPAS: None
9. Availability (hard copy, electronic file, website)
LaPAS: www.louisiana.gov/opb/lapas/lapas.htm
10. Contact person for more information, including

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Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: **Department of Health and Hospitals**
09-303 Developmental Disabilities Council

Department Head: **Kathy Kliebert, Secretary**

Undersecretary: **Jeff Reynolds**

Executive Director: **Sandee Winchell**

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

For each accomplishment, please discuss and explain:

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

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 two grassroots advocacy networks, Louisiana Citizens for Action Now (LaCAN) and Louisiana Together Educating All Children (LaTEACH) numerous policies were changed to improve and/or increase community services. Significant policy and practice changes influenced by LaCAN and Council advocacy related to community-based services include the Department of Health and Hospitals (DHH) increased the array of therapies provided under Children's Choice waivers; surveyed individuals on waiver waiting list to determine the extent of needs being met or not through other venues; expanded eligibility criteria for and increased the number of emergency slots in the New

Opportunities Waiver (NOW); and, agreed that Act 378 funds must be used exclusively for services to individuals with developmental disabilities and their families, not civil service salaries or other administrative costs. Advocacy efforts were successful with increasing Legislators' awareness and support for funding to fill all DD waiver slots, restoration of funding for the Individual and Family Support Program, and Families Helping Families Centers.

Educational policies influenced by the advocacy efforts of LaTEACH and the Council leadership include changes in rule and guidance clarifying pathways for students with disabilities to be promoted to higher grade levels and graduate with a high school diploma; increased funding to the high cost pool for students with disabilities; calculating state funding for charter schools based on characteristics of enrolled students, similar to how funding is calculated for traditional school systems in the Minimum Foundation Program (MFP).

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?
- ♦ **Where are you making significant progress?** If you are making no significant progress, state “None.” However, if you are making significant progress, identify and discuss goals and objectives that are exceeding the timeline for achievement; identify and discuss strategies that are working better than expected. Be specific; discuss the following for each:
 1. To what do you attribute this success? For example:
 - Is progress largely due to the effects of external factors? Would the same results have been generated without specific department action?
 - Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new polices or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
 - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
 - Other? Please specify.
 2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

While many of the successes in policy and practice changes were a result of collaborations with other agencies, the successes realized are a direct result of

targeted educational campaigns to policy makers, advocates and the general public conducted by the Council. The vast majority if not all of these changes would not have occurred without the specific actions taken by the Council. The Council has expanded its repertoire of strategies and tools to connect with the public and policy makers and has plans to continue to build its capacity to utilize social media networks and tools to conduct education 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 twenty years. It is expected that there will continue to be an increase in the influence the Council and the self-advocates and family members of individuals with developmental disabilities have on decisions by policy makers. The Council's capacity to educate the general public and policy makers about needed changes to existing policies and/or the impact of pending decisions is well established and growing.

- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state "None." However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:
 1. To what do you attribute this lack of progress? For example:
 - Is the lack of progress related to a management decision (perhaps temporary) to pursue excellence in one area at the expense of progress in another area?
 - Is the lack of progress due to budget or other constraint?
 - Is the lack of progress related to an internal or external problem or issue? If so, please describe the problem and any recommended corrective actions in Section III below.
 - Other? Please specify.
 2. Is the lack of progress due to a one-time event or set of circumstances? Or will it continue without management intervention or problem resolution?

None.

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

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

The Council's five year plan is amended yearly as needed to address specific areas of emphasis to target and objectives for each goal area.

- ♦ **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 Department's 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 continued 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?

N/A

No. If not, please explain.

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

Please discuss the following:

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
- b. How much has been expended so far?
- c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?
- d. Will additional personnel or funds be required to implement the

recommended actions? If so:

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- 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)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

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

9. Availability (hard copy, electronic file, website)
10. Contact person for more information, including
 - Name:
 - Title:
 - Agency & Program:
 - Telephone:
 - E-mail:

As required by federal law, the Council submitted a Program Performance Report (PPR) to the federal Department of Health and Human Services, Administration on Developmental Disabilities in December 2014 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 2013-2014. A report covering the remainder of the state fiscal year will be submitted to the federal government in December 2015.

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

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

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

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
09-304 Metropolitan Human Services District

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Executive Director: Gary Mendoza

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

For each accomplishment, please discuss and explain:

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

MHSD provides increased access, engagement and coordination of care for behavioral health and the developmental disabled populations in Orleans, Plaquemines and St. Bernard parishes in a cost effective and efficient manner as follows:

Single Point of Entry; Crisis Continuum and Operational Enhancements

MHSD became strategic partners under the NOPD Consent Decree participating on both the policy and training sub-committees to develop Crisis Intervention Training for NOPD senior

officers as well as new recruits. First training for the incoming class of new recruits occurred August 24-28 with MHSD providing the service training.

MHSD formed strategic alliances with the Downtown Development District (DDD), the City of New Orleans, the University (ILH) Hospital and other key stakeholders to create a blueprint to develop a low-barrier/crisis stabilization unit in Orleans Parish.

MHSD became a partner in several working groups in FY15 leading the conversation for Behavioral Health Adult and Children's Services through activities with the Community Health Improvement Plan, GVRs, and NOLAforLife, the BJA (Bureau Justice Administration) Grant for probation/parole, and the Mayor's Veterans Homelessness coalition.

MHSD merged the Mobile Crisis Response Team (MCRT) for adults and children separate phone number into the Single Point of Entry (SPOE) phone number such that both routine and crisis calls for service occur through one central number 504-568-3130. This change simplified access for clients and allowed MHSD to utilize MCRT staff more efficiently during down times to answer the phone.

MHSD begun establishing a relationship with Plaquemines CARES, to become the Single Point of Entry (SPOE) for Plaquemines parish with the goal of increasing access to services.

MHSD continued its communications efforts to increase the use of the Crisis Continuum and Single Point of Entry.

MHSD also continued to work on projects that increased the efficiency and effectiveness of its operations including:

- MHSD completed a success fiscal and payroll spin-off from the State of Louisiana in FY15. MHSD's first full independent audit was completed for FY15 on August 31, 2015 and MHSD received an unqualified opinion with no findings or recommendations from the auditors.
- MHSD established an agency wide Bayou Health credentialing procedure.
- MHSD passed its State Civil Service Audit with no rule violations found.
- MHSD created a Training and Development Department to develop a comprehensive training program for both internal and external stakeholders.

These accomplishments primarily contribute to Goal V of MHSD's FY2012-2016 strategic plan: To ensure quick and easy access of consumers, family members and the community to an efficient system of care which addresses their addictive disorder, developmental disability and mental health needs.

Developmental Disabilities

MHSD developed an Employment services division, hired a Director of Employment, Job Placement Specialist and successfully negotiated with the Louisiana Rehabilitation Commission (LRS) to become a vendor for Supported Employment for individuals with mental illness, addiction and developmental disabilities. This relationship with LRS is the first of its kind through a LGE (local governing entity) with MHSD and LRS. MHSD has forged relationship with employment programs such as Liberty's Kitchen, Café Reconcile, and Hope Café.

MHSD started a transition program from school to adult programs through its employment unit and the DD Director has met with a number of school programs to discuss transition students into Day Habilitation and Employment programs.

MHSD reduced the volume of late and expiring Comprehensive Plans of Care (CPOC) for Waiver recipients through consistent processes and accountability plans.

MHSD hired a full-time Psychologist who has built capacity of community psychologist to provide clinical services (Positive Behavioral Support) to individuals and families dealing with behaviors that disrupt quality of life, through direct support and oversight, thereby reducing our waiting list.

These initiatives all contribute to Goal III of MHSD's FY2012-2016 strategic plan: To deliver high quality cost efficient community based prevention, early intervention, treatment, recovery supports, individual and family supports that will equip and strengthen individuals, children, youth and elderly to be maintained in the community.

Children's Behavioral Health Services

MHSD provides a continuum of care that is person-centered, evidenced based and focused on early intervention and recovery supports. The following was accomplished this year in our Children's Behavioral Health Services program:

Funded position for a full-time Prevention Coordinator for prevention services. Transitioned monitoring function of school-based prevention services from a consultant to the Coordinator. This fiscal year marked the first time that school-based prevention services were made available throughout the St. Bernard Parish school system.

MHSD's Children's program became a member of the St. Bernard Drug Coalition to help plan direction for SA/MH services in the parish. MHSD is also working with the Orleans Parish Juvenile Court, the Recovery School District on a therapeutic day program, and has joined the YouthShift Steering committee. MHSD is also now a member of the Trauma Informed Collaborative workgroup in the schools and research continues on less exclusionary evidenced

based intervention models. Opportunities to work with FINS and Juvenile court were made possible during the year to plan a coordinated hand off into the CsoC (Coordinated System of Care) for Children.

MHSD implemented the State High Needs Communities Prevention grant in Plaquemines Parish, hired an outreach coordinator for coalition development, and developed and submitted an Action Plan and budget to OBH for FY16 grant funding.

The MST program received the “Whatever It Takes” MST, Inc. National Award and recognition for a program that demonstrates service excellence with the most challenging of cases.

The Youth Support program provided services to students at two alternative high schools with afterschool programming in the visual arts, career exploration, and soft skills development for the workforce. Inroads this year with School Boards in St. Bernard and Plaquemines Parish have created opportunities to expand afterschool program services to an alternative high school in each of these parish districts for the FY16 school year.

In FY15, MHSD provided response to 277 crisis calls involving youth experiencing personal distress in the home, school or community (MCRT). Dispatched trauma response teams to schools that have been impacted by a tragic event involving student(s) or faculty on 19 separate occasions (LA BEST). Combined crisis response and short-term trauma interventions were provided to a total of 1,933 students and school personnel.

These accomplishments primarily contributes to Goal III of MHSD’s FY2012-2016 strategic plan: To deliver high quality cost efficient community based prevention, early intervention, treatment, recovery supports, individual and family supports that will equip and strengthen individuals, children, youth and elderly to be maintained in the community.

Adult Behavioral Health Services

MHSD provides a continuum of care that is person centered, evidence-based and focused on early intervention and recovery supports.

MHSD relocated its Adult Behavioral Health Clinic in New Orleans East into a co-located building with Daughters of Charity FQHC. This pilot will help frame the integration of primary/behavioral health care for individuals in New Orleans East and could serve as a model for further FQHC behavioral health integration efforts across the District.

MHSD has implemented nursing screenings and protocols for primary care referrals for clients without a medical home in each clinic location. Training for all MHSD nurses was conducted by nurses from the New Orleans Health Department.

MHSD entered a collaborative relationship with LPHI on a re-entry project with Hunt Correctional for people with co-occurring disorders.

MHSD submitted its first SAMHSA grant that would underwrite detoxification services in the community as a collaborative effort with OBH.

MHSD engaged the services of a law firm (through Board Resolution and Attorney General approval) to assist clients of expanded mental health services with minor legal issues as well as with obtaining benefits.

MHSD facilitated regional efforts to build/enhance service systems. MHSD staff participated in efforts that helped the service system at large and facilitated service coordination along with raising MHSD's profile in the community. MHSD participated in the Drug Demand Reduction Coalition, the Forensic Mental Health Coalition, and City Hall's Behavioral Health Council.

These accomplishments primarily contributes to Goal III of MHSD's FY2012-2016 strategic plan: To deliver high quality cost efficient community based prevention, early intervention, treatment, recovery supports, individual and family supports that will equip and strengthen individuals, children, youth and elderly to be maintained in the community.

II. Is your department Five-year Strategic Plan/Business Plan on time and on target for accomplishment? To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

MHSD has made significant progress towards the accomplishment of the goals outlined in the five-year strategic plan. MHSD holds annual planning meetings at a number of staff levels and with our Board of Directors. Strategies outlined in our plan and the data we have collected show significant ROI (return on investment) through increased access to services, more community based alternatives and a growing skilled and trained workforce.

- ◆ **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 policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
 - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?
 - Other? Please specify.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

MHSD has made significant progress as evidenced by our Single Point of Entry and linkages and outcomes in our clinics, Adult, Children's and Developmental Disability 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:
 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?

MHSD is not currently experiencing a lack of progress

- ♦ **Has your department revised its strategic plan/business 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?

- ♦ **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 conduct weekly staff meetings where roundtable discussions are held on current projects and timelines. The Executive Director also meets individually on a weekly basis with Department heads from SPOE, Fiscal, Operations, Human Resources, Legal/Compliance, Adult, Children's and DD to obtain status reports.

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.

MHSD has created both fiscal and operational efficiencies when necessary to adjust to the changing environment around us. MHSD like other departments continues to struggle with the external issues challenging us in regards to managed care and the coming managed care for DD and the state of Medicaid expansion in Louisiana.

As a result of the managed care structure MHSD has undergone a business reorganization and changing business model. With these external changes it would be helpful if communication from DHH to Civil Service would occur so that CS would become more knowledgeable regarding the skills, qualifications and titles of staff which are required to work within these new business paradigms.

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 – MHSD has a new program evaluation division
- External audits (Example: audits by the Office of the Legislative Auditor)
- 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)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

1. Title of Report or Program Evaluation
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)

Title of Report/Program Evaluation: CARF/Annual conformance to Quality Report

2. Date Completed: August, 31, 2014

3. Subject/Purpose: Accreditation Condition, MHSD must submit annually a program evaluation update on each anniversary of the accreditation term.

4. Methodology: Collect & analyze information to guide organization planning from persons served.

5. Cost: None

6. Major Findings/Conclusions: MHSD has systems in place that will initiate performance improvement whenever an area for improvement is identified in either business or clinical practice.

7. Major Recommendations: None

8. Action taken in response: Continue program & performance evaluation.

9. Availability: Hard copy & electronic file.

1. Title of Report: AIP/Accountability & Implementation Plan

2. Date Complete: 12/10/2014

3. Subject/Purpose: To guide the delivery of addictive disorders (AD), Developmental Disabilities (DD), and Mental Health (MH) services funded by appropriations from the state.

4. Methodology: Site monitoring consisted of a joint OBH and OCDD Review team to include data reviews, chart audits, and interviews with staff.

5. Cost: Allocation of committed staff time to the process for the day.

6. Major Findings: none

7. Major Recommendations: none

8. Action taken: MHSD responded as needed in writing with a Plan of Correction (POC) to any major findings.

9. Availability: AIP is available in hardcopy and electronic file, report file will be available in same format.

1. Title of Report: Independent Audit

2. Date Completed: August 31, 2015 (for FY15)

3. Subject/Purpose: first full independent audit of MHSD as an independent fiscal entity

4. Methodology: External audit firm selected by LLA and used standard audit approach including A-133 single audit

5. Cost: None

6. Major Findings: No findings – unqualified audit

7. Major Recommendations: No recommendations for MHSD

8. Action: MHSD has shared report with its Board and Leadership staff.

9. Availability: hardcopy and electronic format

10. Contact person for more information, including

Name: Gary Mendoza

Title: Interim Executive Director

Agency & Program: 09-304 Metropolitan Human Services District (MHSD)

Telephone: 504-535-2909

E-mail: gary.mendoza@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: **Department of Health and Hospitals**
09-305 Medical Vendor Administration and
09-306 Medical Vendor Payments

Department Head: **Kathy Kliebert, Secretary**

Undersecretary: **Jeff Reynolds**

Medicaid Director: **J. Ruth Kennedy**

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

For each accomplishment, please discuss and explain:

Accomplishment # 1: Dental Benefit Plan

A. What was achieved?

Through a competitive procurement process, DHH contracted with Managed Care of North America (MCNA) to serve as the Dental Benefits Manager (DBM) to provide dental services for 1.2 million Medicaid and LaCHIP enrollees beginning July 1, 2014.

B. Why is this success significant?

A single DBM serving the full spectrum of Louisiana Medicaid enrollees allows DHH to apply the lessons learned through Bayou Health, focusing on coordination of care that improves access and overall dental health with more efficient and effective use of resources. This managed care model improves upon the original fee-for-service model by allowing benefits to both members and providers and better management of program funding by the state. Incorporating dental into managed care will help position the state of Louisiana in line with the recent Centers for Medicare and Medicaid Services (CMS) Children's Oral Health Initiative to improve children's access to dental care, with an emphasis on prevention.

C. Who benefits and how?

The DBM provides benefits to approximately 1.2 million Medicaid and LaCHIP enrollees who are eligible to receive dental benefits, whether they receive other health care services through traditional fee-for-service Medicaid or a Bayou Health Plan.

Medicaid enrollees benefit from numerous member outreach efforts, including gap alerts to initiate follow up with members who are in danger of falling behind on preventative treatment. Network adequacy requirements and a real-time provider network search online facilitate ease of access to providers within certain time and mileage restrictions. Dedicated call centers for dental needs for both members and providers ensures shorter wait times and a knowledgeable staff focused on specific service areas. Providers also have the advantage of electronic claims and prior authorization submissions which, in turn, assists DHH in timely assessment of performance or adequacy issues. Custom fraud identification and detection rules and alerts drive provider- or event-specific profiling analysis in an effort to evade fraud, waste and abuse. DHH benefits through greater budget predictability and working toward quality improvement goals.

D. How was the accomplishment achieved?

Successful implementation of the DBM was the result of numerous factors including:

- Provider input throughout the design and implementation phase including a statewide forum for input and weekly calls with providers to address issues of concern.
- A thorough readiness review requiring MCNA show a robust network of providers in place to treat patients, sufficient support staff to handle administrative process and provider relations and the ability to meet all deliverables specified in their proposal.
- Regional training, provided by MCNA, in eight locations around the state, as well as 10 separate online webinars for those unable to attend in person.
- Financial incentives for reimbursement to assure provider network adequacy.
- Centers for Medicare and Medicaid Services (CMS) approval of the MCNA contract.

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

The performance indicators of the strategic plan are included in the dental plan contract as performance measures that the plan must meet annually or be subject to monetary penalties. Contract deliverables support the Department's effort of increasing the Medicaid and LaCHIP enrollees that obtain appropriate preventive and primary oral healthcare.

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

The Department has found the methods used to accomplish the start-up of this program highly effective in implementing contracts. Stakeholder input, particularly member and

provider when establishing a new program; readiness reviews to determine contractor preparedness; and regular/periodic/frequent status reports from the contractor are crucial.

Contact person for more information:

Name: Cordelia Clay

Title: Program Manager 1A

Agency & Program: DHH/BHSF/MVA Health Plan Relations

Telephone: 225-342-4182

E-mail: cordelia.clay@la.gov

Accomplishment # 2: Take Charge Plus

A. What was achieved?

DHH replaced the Take Charge program, which provided family planning with the enhanced Take Charge Plus program. The state began accepting new applicants on Sept. 1, 2014, with active Take Charge enrollees who still qualified being transferred to the new program on Oct. 1, 2014.

B. Why is this success significant?

Louisiana ranks in the top tier among all 50 states for sexually transmitted infections (STIs) – first in congenital syphilis, second in gonorrhea, third in primary and secondary syphilis and fourth in chlamydia.

The enhancements made to family planning services through the Take Charge Plus program directly address these concerns. The most notable improvements include providing coverage for males, in addition to females; increasing the number of family planning visits per year from four to seven; paying for testing as well as treatment of sexually transmitted infections (STIs); and providing transportation to family planning appointments.

Additionally, the enhancements make the family planning services provided through Medicaid more attractive to a wider provider audience. Providers with initial concerns over lack of treatment options in Take Charge may now follow up on diagnoses. Additionally, doctors that traditionally focus on men's health issues, such as urologists, can now provide family planning services to their patients.

C. Who benefits and how?

Take Charge Plus is available to both males and females. Eligible individuals cannot be pregnant and must have income that does not exceed 138 percent of the Federal Poverty Level (FPL). Coverage includes family planning and family planning-related services, including:

- Seven office visits (per calendar year) for care related to family planning or family planning related services
- Prescriptions and lab work related to family planning or family planning-related services

- Birth control (including pills, patches, implants, injections, condoms, diaphragms, and IUDs)
- Contraceptive counseling and education
- Diagnostic procedures, prescriptions, and follow-up visits to treat STIs (other than HIV/AIDS and hepatitis)
- Treatment of urinary tract infections
- Treatment of genital lesions for women and men
- Treatment of major complications from certain family planning procedures
- Voluntary sterilization for men and women (age 21 and older)
- Vaccines for both males and females for the prevention of HPV
- Transportation to family planning appointments

Through the offering of enhanced family planning services, the anticipated outcome is a decrease in the proliferation of STIs that keeps Louisiana among the top five in STI diagnoses.

D. How was the accomplishment achieved?

Take Charge Plus began as an internal Medicaid initiative to increase STI treatment and testing. It took the dedication of numerous departments and contractors to achieve the implementation of the new program, including:

- Systems changes to address eligibility;
- Revisions of the Medicaid state plan;
- Communications with providers (through provider calls, web postings and remittance advice distribution) and potential members with the development of a new logo and messaging plan.

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

Yes. The strategic plan references the improvement of birth outcomes and the health of women by increasing child spacing intervals. It also stresses the importance of providing family planning counseling and education. By bringing attention to Take Charge Plus and working to expand the provider base that will deliver family planning services, the program addresses the concerns outlined in the strategic plan and reaches a broader audience.

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

The implementation of new programs requires the understanding and interest of both members and providers. Outreach through a variety of methods – conference calls, one-on-one meetings, web postings and mailed notices – are all useful resources for any program launch.

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Accomplishment # 3: New Managed Care Organization Contracts

A. What was achieved?

On Feb. 1, 2015, DHH initiated contracts with five Managed Care Organizations (MCOs) to administer the Bayou Health Program. These contractors – selected through a competitive procurement process – deliver services for the Bayou Health program. The most significant change for Bayou Health from the first contracting period (Feb. 1, 2012- Jan. 31, 2015) was the consolidation of its shared savings and prepaid models into one risk-bearing MCO model. MCOs are paid a monthly flat fee for managing the care of Medicaid enrollees, which allows greater budget predictability and the opportunity for improved health outcomes through the MCO's ability to emphasize value over volume of services. There is also a corresponding accountability provided by clinical performance measures, primarily HEDIS (Healthcare Effectiveness Data and Information Set), including those backed by financial penalties for failure to meet the outlined goals.

The winning proposers include:

- Aetna Better Health of Louisiana (new entrant)
- AmeriGroup Louisiana, Inc. (prepaid incumbent)
- AmeriHealth Caritas Louisiana, Inc. (prepaid incumbent)
- Louisiana Healthcare Connections (prepaid incumbent)
- UnitedHealthcare Community Plan (shared savings incumbent)

B. Why is this success significant?

This accomplishment resulted in the transition of 490,000 Medicaid enrollees into the risk-bearing MCO model, more than doubling previous enrollment. At the end of SFY15, 71 percent of all Medicaid enrollees were in a Bayou Health risk-bearing plan. Other contract changes such as the inclusion of additional services (EPSDT-PCS and hospice), mandatory inclusive of certain eligibility groups who were previously able to opt out of Bayou Health, and payment of PMPMS for retroactive eligible months, further reduced the Medicaid fee-for-service scope and contributed to the goal of achieving better budget predictability. For SFY15, 28 percent of total Medicaid expenditures were made through the Bayou Health program.

Under the new contract, MCOs are permitted to offer value added benefits that are outside the scope of core benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and/or member's family, the potential for improved health status of the member and functional necessity. The scope of these services go beyond what is offered in the traditional fee-for-service Medicaid program and were a major component of the proposal selection. Examples include adult dental care, vision care, circumcisions, specialized case

management services and wellness incentive programs.

C. Who benefits and how?

Medicaid and LaCHIP enrollees who qualify for Bayou Health will benefit from the continuation of the program. Bayou Health represents a departure from fee-for-service Medicaid through the provision of case and disease management; outreach and education efforts for both members and providers; 24-hour nurse lines and dedicated customer service call centers; added value benefits outside of the core scope of service for Medicaid; and monetary and wellness incentives for healthy behaviors, among other benefits. The MCO structure and management of care provides the state of Louisiana and DHH with better budget control as well as greater medical resources through the five MCOs and their parent companies.

D. How was the accomplishment achieved?

The implementation of the second phase of MCO contracts was the result of numerous factors including:

- The revision of a request for proposals (RFP) that focused on MCO attributes and used lessons learned in the first three years of Bayou Health to create a new contract.
- A competitive procurement that opened the field to all interested parties, including new contractors.
- Staff dedication to assessment of the proposals.
- A thorough readiness review of the MCO's infrastructure, policies, systems and network to ensure preparedness for the Feb. 1, 2015 go live date.

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

Yes. The strategic plan focuses on goals that are directly related to efforts made through Bayou Health including increased access to appropriate care, improving quality of care and innovative payment reform that ensures savings and cost containment. Additionally, areas that address a reduction in the rate of growth from expenditures on drugs, increased preventive health care, improved quality and performance measurements and a better patient experience are all in line with Bayou Health objectives.

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

Yes. Staff throughout the Medicaid agency took an active role in leveraging lessons learned from our experience with the original Bayou Health contract and our knowledge of best practices across states to improve our MCO program through this re-procurement.

Contact person for more information:

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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 being realized?

The award to five risk-bearing fully capitated managed care organizations in February 2015 has better positioned the Department to realize results for the Strategic Plan, particularly toward the stated goal to improve health outcomes by operating a healthcare delivery model that emphasizes coordination of care. The fully capitated model of managed care has transitioned primary responsibility for members' health care to a single entity, moving away from the segregated delivery model associated with the Shared Savings plans. All five of the MCOs have designated staff whose primary responsibilities are case management and care coordination, which did not exist prior to the implementation of Bayou Health in 2012.

The implementation of the Dental Benefit Plan has put us on course to meet the projected goals and objectives set forth in the Dental Activity. The execution of the dental home strategy, stakeholder involvement and the development of a real-time online provider network engine facilitate the increase of oral health awareness and dental care access. The strategies listed were aimed to ensure the greatest return on investment.

The Dental Benefit Plan has also made considerable progress in the accomplishment of the dental objective by meeting or exceeding dental contract performance measures – including call center metrics, network adequacy, claims processing requirements, and member education activities. In addition to carrying out multiple strategies of the strategic plan, MCNA was determined to be 97% fully compliant during the 2015 annual External Quality Review Organization (EQRO) Compliance Review.

- ◆ **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:

An area of significant progress in the Medicaid Managed Care activity, which aims to increase budget predictability while providing for a service delivery model of high quality, medically necessary health services, and avoiding unnecessary duplication of services.

Examples include the following:

ADOLESCENT WELL-CHILD VISITS and ADULT ACCESS

For FY 2015, the rates for adolescent well-child visits and adults' access to preventive/ambulatory health services showed an increase that nearly meets/and/or exceeds the 2015 benchmarks and continues to demonstrate improvement.

For Adolescent Well-Care Visits, all health plans exceeded the Pre-Bayou Health Baseline (2012) 25.16%. The DHH 2015 goal of 42.36% was met by all health plans. For Adult Access, the Pre-Bayou Health Baseline (2012) was 78.35%. The DHH 2015 goal of 82.95% was met only by UnitedHealthcare while the remaining health plans were only off ranging from .78 to 2.13% off from designated goal.

COMPREHENSIVE DIABETES and CHLAMYDIA SCREENING

For FY 2015, the rates for comprehensive diabetes care (Hemoglobin A1c) showed an increase that exceeded the initial Pre-Bayou Health Baseline (2012) of 70.21%. Measuring performance against the HEDIS guidelines was accomplished through analyzing administrative claims data by ULM. The Comprehensive Diabetes Care HgbA1c testing measure reveals an increase in the overall aggregate score from 70% in 2012 to 84% in 2015 for all health plans. The DHH goal of 80.37% was met by all health plans.

The Incentive measure results for Chlamydia Screening shows a slight increase from 2014 to 2015. The 2012 Pre-Bayou Health Baseline of 56.88% and the "new" 2015 Benchmark of 59.25% shows that two of the five health plans (Community Health Solutions) and AmeriHealth Caritas exceeded the DHH benchmark and the remaining three health plans were only 1% to 3% off designated goal for 2015.

Important Caveat: The report references New Managed Care Contracts (Aetna and UHC). We do not have the data for these new plans. 2015 is the measurement year.

Additionally, significant progress has been made in the achievement of the dental activity by the execution of various strategies, such as contracting with a dental management organization and the development of the dental home concept. The dental home concept is important as it sets the stage for an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, and coordinated way which promotes the increase of access to dental services.

1. To what do you attribute this success? For example:

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

The strategies (to expand enrollment and services under Medicaid Managed Care) associated with this objective were implemented through (1) the consolidation of the two Bayou Health models into one risk-bearing MCO model, (2) inclusion of additional services such as EPSDT-PCS and hospice, (3) mandatory inclusion of certain eligibility groups who were previously able to opt out of Bayou Health, and (4) payment of PMPMS for retroactive eligible months, further reducing the Medicaid fee-for-service scope.

Louisiana Medicaid outlined basic quality monitoring requirements in the contracts with the managed care organizations and contracted with Island Peer Review Organization (IPRO), the state's External Quality Review Organization (EQRO) to assist with the review and reporting of the MCOs quality outcomes. During 2014 – 2015, DHH Medicaid was able to focus on adherence to policies. Encounter data quality has improved. DHH Medicaid required reporting on nine incentive measures including adults access to preventive/ambulatory health services, adolescent well-care visits, and well-child visits in third, fourth, fifth and sixth years of life.

Factors that attributed to the Dental Benefit Plan include the following:

- Transition of delivery of dental services for Medicaid and CHIP state plan services through the procurement of a Prepaid Ambulatory Health Plan (PAHP) to manage the Medicaid Dental Benefit Program.
- Centers for Medicare and Medicaid Services (CMS) approval of the Dental Benefit Plan contract with MCNA.
- Stakeholder input throughout the design and implementation phase of the contract.
- Contractual requirements incorporated to ensure the development of the dental home concept.

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

The progress related to Managed Care is a one-time gain achieved through changes implemented in the February 2015 Bayou Health contracts.

With the upcoming integration of behavioral health into the managed care model, efforts to monitor quality of care in the behavioral health population are a new focus of attention. We continue to enhance quality standards and have added requirements for all plans to utilize hybrid methodology in HEDIS reporting in cases where either hybrid or administrative is acceptable to NCQA.

There has been significant progress with the implementation of the Dental Benefit Plan. The progress is expected to continue as a result of the incorporation of Strategic Plan goals and objectives as contractual requirements.

- ♦ **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?
Performance indicators have been updated in order to more accurately reflect realistic expectations.
 - 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 Department conducts quarterly business reviews with each of the five managed care plans, with attendance from all program offices, as well as DHH Secretary participation. Each of these quarterly meetings focuses on progress toward integrated

care and improved health outcomes, and identifies areas of concern from all stakeholders. Suggestions for policy changes or simplification measures are presented to DHH in an effort to ensure that the goals of the strategic plan are met or surpassed. Medical professionals and subject matter experts from within the Department also provide suggestions and clarifications to aid the MCOs in addressing any challenges being experienced.

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.)

No significant department management or operational problems or issues exist.

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

A. Problem/Issue Description

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

B. Corrective Actions

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

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

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

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

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

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

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

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

Internal audit

External audits (Example: audits by the Office of the Legislative Auditor), including but not limited to:

- An external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract carried out by an External Quality Review Organization (EQRO).
- Annual Validation of encounter data to assess the completeness and accuracy of encounter data submitted by the dental plan.
- 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, including but not limited to:
 - Annual Independent evaluation of dental benefit plan to evaluate:
 - the accessibility of services as compared to services available prior to the implementation,
 - the impact of the quality of services provided, and
 - the cost effectiveness of plan, including program benefits and administrative costs to ensure cost are not greater than the cost of providing services prior to implementation.
- Performance Progress Reports (Louisiana Performance Accountability System)
- In-house performance accountability system or process, including but not limited to:

Act 158 of the 2015 Regular Session of the Louisiana Legislature requires the Department to submit annual reports concerning the Bayou Health program to the Legislature's Senate and House Committees on Health and Welfare. The Bayou Health Transparency Report is intended to provide all information outlined in Act 212 with additional requirements added in ACT 158. DHH may impose administrative actions, corrective action plans, monetary penalties, and sanctions when it is determined the dental plan is deficient or noncompliant with requirements or deliverables of the contract.
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring), including but not limited to:

Clinical Performance Measures were developed to duplicate Strategic Plan Performance Indicators to ensure success in the accomplishment of goals and objectives. Measures are reviewed quarterly to monitor progress and demonstrate changes in performance outcomes. Benchmarks were created using statewide data of the Medicaid Fee for Service population from 2013 with the expectation that performance improves by a certain percentage toward the benchmarks.
- Peer review
- Accreditation review
- Customer/stakeholder feedback

The dental plan reports the status of all provider and member complaints along with resolution to DHH on a monthly basis. Reoccurring complaints are investigated by the Department.
- 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: **Monthly Chisholm Court Reporting/ BHSF Project Status Report for Applied Behavior Analysis, (ABA), Quarterly ABA Dashboard**
2. Date completed:
Chisholm Reporting is Monthly. BHSF Project Status Report for ABA is Weekly. Quarterly ABA Dashboard.
3. Subject or purpose and reason for initiation of the analysis or evaluation:
Court Order Compliance (Note: Since this program is new, reporting for program management purposes is still being developed. Management gets weekly reports regarding task completed and areas of concern. Currently, a dashboard that shows statistics on the program by quarter is being developed. In addition, under the terms of the settlement agreement with opposing counsel, DHH reports to opposing counsel data about the provision of ABA therapy to class members, including: the number of BCBAs enrolled in Medicaid; the number of class members with ASD receiving ABA therapy; and the amount of Medicaid expenditure for ABA therapy for class members with ASD.)
4. Methodology used for analysis or evaluation:
Manual Review.
5. Cost (allocation of in-house resources or purchase price)
6. Major Findings and Conclusions:
The program is in compliance CMS rules and regulations and the Court order. The program shows steady monthly growth and is within the budget allocation.
7. Major Recommendations:
Continue to pursue Emergency Contract with outside entity.
8. Action taken in response to the report or evaluation:
None
9. Availability (hard copy, electronic file, website):
Electronic copy.
10. Contact person for more information:
Name: Rene Huff
Title: Program Manger 1-A
Agency & Program: DHH/ BHSF
Telephone: 225-342-3935
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1. Title of Report or Program Evaluation: **Children's Health Insurance Program (CHIP) Annual Report FFY14**

2. Date completed: 1/1/15
3. Subject or purpose and reason for initiation of the analysis or evaluation:
This annual report is required by CMS to be completed using the template provided by them.
4. Methodology used for analysis or evaluation:
(1) Input from program staff, (2) Enrollment and expenditure data extract from the Medicaid Management Information System via the MARS Data Warehouse, (3) Contract payments and administrative costs extracted from ISIS, (4) Healthcare Effectiveness Data and Information Set (HEDIS) performance measures calculated by University of Louisiana at Monroe (ULM), and (5) the 2013 Louisiana Health Insurance Survey.
5. Cost (allocation of in-house resources or purchase price): Not calculated
6. Major Findings and Conclusions:
 - By Jan. 1, 2015, more than 900,000 Medicaid and LaCHIP enrollees were receiving health care through the Bayou Health Plan, implemented in February 2012. Bayou Health offers five statewide health plans that give enrollees a choice in their healthcare delivery system and is focused on improving health outcomes, reducing strains on the state budget, fighting fraud and abuse, and offering safe, accessible and sustainable health care for Medicaid recipients and low-income uninsured Louisiana residents.
 - Louisiana eligibility caseworkers continued to close an extremely low percent (0.8% at the end of SFY15) of CHIP children at renewal for procedural reasons (failure to complete renewal process, unable to locate, etc.). This impacts not only overall enrollment numbers but stability and continuity of coverage for eligible children.
 - Louisiana continued to utilize Express Lane Eligibility (ELE), authorized by Congress in 2009, to enroll children receiving benefits through the Supplemental Nutrition Assistance Program (SNAP). In addition to initial enrollment, Louisiana took advantage of the technological savings afforded by ELE to renew children's certifications. As of June 2015, approximately 46,237 children have been enrolled using ELE. A total of 11,691 cases were renewed through ELE in SFY 15. This process provides a time savings to field eligibility staff.
7. Major Recommendations: None at this time
8. Action taken in response to the report or evaluation: None at this time
9. Availability (hard copy, electronic file, website): Report is available online at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2324>
10. Contact person for more information, including
Name: Steffan Rutledge
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1. Title of Report or Program Evaluation: **LaCHIP Annual Report for the Legislature (SFY14)**
 2. Date completed: September 2015
 3. Subject or purpose and reason for initiation of the analysis or evaluation:
This annual report is sent to the Louisiana Legislature to provide an overview of program enrollment and cost.
 4. Methodology used for analysis or evaluation:
Enrollment and expenditure data extract from the Medicaid Management Information System via the MARS Data Warehouse as well as input from program staff.
 5. Cost (allocation of in-house resources or purchase price): Not calculated
 6. Major Findings and Conclusions:
 - As of July 1, 2015, there were 125,331 children and Phase IV enrollees in LaCHIP.
 - SFY 15 program costs were \$249,556,004 with a per member per month rate of \$163.71.
 7. Major Recommendations: None at this time
 8. Action taken in response to the report or evaluation: None at this time
 9. Availability (hard copy, electronic file, website): Report is available online at <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2238>
 10. Contact person for more information:
Name: Damiane Ricks
Title: Medicaid Program Manager
Agency & Program: BHSF-Medicaid
Telephone: 225-342-7877
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-
1. Title of Report or Program Evaluation: **Medicaid Purchase Plan Annual Report for the Legislature (SFY15)**
 2. Date completed: Sept. 8, 2015
 3. Subject or purpose and reason for initiation of the analysis or evaluation:
This annual report is sent to the Louisiana Legislature to provide an overview of program enrollment and cost.
 4. Methodology used for analysis or evaluation:
Enrollment and expenditure data extract from the Medicaid Management Information System via the MARS Data Warehouse as well as input from program staff.
 5. Cost (allocation of in-house resources or purchase price): Not calculated
 6. Major Findings and Conclusions: Since the inception of MPP, 8,916 individuals have enrolled in the program. As of July 2, 2015, enrollment was 731.
 7. Major Recommendations: None at this time
 8. Action taken in response to the report or evaluation: None at this time
 9. Availability (hard copy, electronic file, website): Hard copy only.
 10. Contact person for more information:
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 Agency & Program: BHSF-Medicaid
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1. Title of Report or Program Evaluation: **ACT 212 Report – Bayou Health Transparency Report**
2. Date completed: January 2015
3. Subject or purpose and reason for initiation of the analysis or evaluation: Act 212 of the 2013 Legislative Session calls for a high level of transparency in reporting, ensuring Medicaid managed care operates in the most efficient and sustainable method possible. The Act calls for 24 separate reports on Health Plan performance, many compared to pre-Bayou Health Medicaid data. This report outlines responses to the request made by the legislature in Act 212 relative to Bayou Health management and performance.
4. Methodology used for analysis or evaluation: Analysis of encounter data submitted to DHH by MCOs was performed by DHH employees and contractor Myers and Stauffer. Information not captured on claims was obtained by referencing one of DHH's more than 50 required health plan reports. Information required by Act 212 but otherwise not reported was submitted by MCOs upon request.
5. Cost (allocation of in-house resources or purchase price): \$89,946 contracted resources through Louisiana State University and Myers and Stauffer, CPA.
6. Major Findings and Conclusions: The January 2015 Bayou Health Transparency report captured data from Calendar Year 2013. Notable findings during that time included:
 - All Bayou Health Plans have obtained the necessary accreditation from one of two optional national accrediting bodies – NCQA or URAC.
 - Myers and Stauffer determined that 2013 encounters data submissions were substantially complete, but did identify discrete areas of concern and recommended corrective action which has been applied and completed.
 - In 2013, Bayou Health enrolled over 1 million Medicaid recipients across the five Health Plans, with UnitedHealthcare Community Plan of Louisiana serving the most members (28 percent of all Bayou Health enrollees).
 - All five health plans paid the large majority of claims across all provider types in approximately two weeks, with the average number of days being less than one week for many provider types.
 - Most claims (69 percent for four out of five Health Plans) were denied for failure to meet Health Plan administrative requirements. The second most common (for three out of five Health Plans) was lack of prior authorization on file for services provided.
 - The proportion of Medicaid members who actively chose their Health Plan, instead of being auto-assigned, ranged from 51 percent (AmeriGroup) to 74 percent (UnitedHealthcare).

- Over \$1.4 billion was paid to the five Bayou Health Plans in calendar year 2013. These payments represent 18.7 percent of all Louisiana Medicaid payments for health care services (\$7,691,528,982 for CY 13). The remaining 72.3 percent of Medicaid expenditures represent payments to providers for services to members enrolled in the shared savings plans, Medicaid enrollees excluded from Bayou Health and supplemental payments to providers.
 - During CY 2013, three sanctions were levied against Bayou Health Plans totaling \$550,700.
7. Major Recommendations: An informational audit by the Louisiana Legislative Auditor found that the January 2015 version of the report addressed much of the auditor's concerns from the original January 2014 report. However, a few areas for improvement were noted, including:
 - DHH should continue to improve upon its collection and validation of self-reported data, following guidance recommended by contactor Myers and Stauffer.
 8. Action taken in response to the report or evaluation: DHH has continued to increase its internal validation processes already in place. Additionally, DHH has taken steps to provide additional levels of verification to future reporting for Act 212 through its contract with Myers and Stauffer, beginning with this January 2015 submission. DHH also contracted with LSU to assist in report preparation to reduce the enormous burden this report places upon permanent staff. Also, DHH recognizes the complexities of the encounter collection task and the transition to a managed care environment, and remains dedicated to improving our collection and validation of encounter data. This is demonstrated by our contract with Myers and Stauffer as well as through internal controls put in place to improve collection. This includes a more robust report monitoring effort with direct and timely feedback to Health Plans.
 9. Availability (hard copy, electronic file, website): The Bayou Health Transparency Report can be found online at <http://new.dhh.louisiana.gov/index.cfm/page/2086>
 10. Contact person for more information:

Name: Mary TC Johnson
 Title: Medicaid Section Chief
 Agency & Program: BHSF-Medicaid
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 E-mail: mary.johnson@la.gov
1. Title of Report or Program Evaluation: **Compliance Review Report**
 2. Date completed: July 29, 2015
 3. Subject or purpose and reason for initiation of the analysis or evaluation: Independent review of the quality outcomes, timeliness of, and access to the services of dental benefit plan
 4. Methodology used for analysis or evaluation: Draft tools and the methodology for the audit determinations used to assess compliance were created. Determinations of “full compliance,” “substantial compliance,” “minimal

compliance,” and “compliance not met” were used for each element under review. IPRO auditors reviewed MCNA’s policies, procedures and materials and assessed their concordance with the Department’s requirements using audit tools.

5. Cost (allocation of in-house resources or purchase price): \$39,951.80 (per IPRO contract)
6. Major Findings and Conclusions: MCNA was 98% fully compliant with 11 elements substantially met.
7. Major Recommendations: MCNA to submit a corrective action plan for each of the 11 elements determined to be less than fully compliant along with a timeframe of completion.
8. Action taken in response to the report or evaluation: MCNA implemented a corrective action plan for the areas identified for improvement in the report, but the corrections were made after the audit was completed and were not applicable to the audit’s review period.
9. Availability: (hard copy, electronic file, website): Electronic File
10. Contact person for more information:
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Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
09-307 Office of the Secretary

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

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

For each accomplishment, please discuss and explain:

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

Accomplishment # 1: Health Standards: Reduction of Antipsychotic Medication Use

- A. What was achieved?

The Health Standards Section has been an active member of the Louisiana Dementia Partnership, working on a CMS initiative to improve dementia care and decrease the use of antipsychotic medication in nursing facilities.

- B. Why is this success significant?

Louisiana nursing homes have shown a steady decline in antipsychotic medication use since this initiative first began in 2012. The statewide average has declined from 29.7% to 24.8% (end of June, 2013). The data is continually monitored by the State Agency and

action plans have been developed and implemented based upon identified barriers to the success to reduce antipsychotic medication use.

C. Who benefits and how?

Residents of nursing homes and nursing home staff can benefit from this achievement, as more than half of nursing facility residents are diagnosed with some form of dementia. Many of these residents experience behavioral and psychological symptoms associated with dementia. Antipsychotic drugs have many legitimate uses including treatment for psychotic disorders such as schizophrenia, psychotic symptoms such as delusions and hallucinations, and behavioral and psychological symptoms of dementia (BPSD) in certain situations. However, they are often used inappropriately in nursing facilities to treat BPSD, and evidence documenting their clinical efficacy for BPSD is variable.

D. How was the accomplishment achieved?

This accomplishment was achieved through Health Standards staff efforts to communicate, educate, and motivate the provider community to provide care and services that meet the current standards of practice and meets the regulatory compliance standards. Health Standards provided significant educational outreach to the nursing home industry to maximize the efficacy of this initiative.

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

Yes, this accomplishment directly relates to the mission of the Department, “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 is a practice that should be shared. Collaboration with other entities and education opportunities has proven to be beneficial.

Accomplishment # 2: DHH Audit Investigations

A. What was achieved?

The DHH Audit Section investigated and/or closed 28 cases involving fraud, misconduct, or workplace issues. In addition, the unit consulted with the DHH Legal Department and the Medicaid Fraud Control Unit (MFCU) to provide a framework of action to assist in the reclamation on the CMS 64 of overpayments totaling \$2,742,882 from 7 providers. One of these cases had been outstanding since 1995.

B. Why is this success significant?

These efforts allowed the Department to meet auditing goals and to recoup significant funds.

C. Who benefits and how?

DHH benefits through reduced risk to fraud, waste and abuse through auditing function. DHH benefits from recouped funds and a more effective process to identify funds to be recouped in the future. Statewide, stakeholders benefit through increased availability of recouped funding.

D. How was the accomplishment achieved?

This accomplishment was achieved through an annual risk assessment process and audit plan.

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

Yes, the number of audits and reviews completed is a key component of the strategic plan for the Internal Audit Section.

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

Yes, this accomplishment does represent a Best Management Practice, but it is only limited to audit sections.

Accomplishment # 3: Health Standards: Exceeded Projected Workload

A. What was achieved?

The Health Standards Section (HSS) exceeded its planned workload for the fiscal year in multiple areas, and especially in the non-long term care arena. HSS was able to add additional survey workload to its original planned workload proposal submitted to CMS at the beginning of the FFY by putting in place efficiencies regarding the survey process, scheduling adjustments, training of additional qualified surveyors, and the designation of a supervisor to oversee the scheduling and supervision of staff.

HSS also conducted 99.6% of abuse investigations received within two days after receipt.

B. Why is this success significant?

Because staff far exceeded projected workload, HSS was awarded additional funding from Centers for Medicaid and Medicare Services (CMS) to schedule additional surveys in all levels of priority.

C. Who benefits and how?

Since the facilities inspection intervals are within the CMS guidelines, this will ensure improved compliance to regulatory standards thus improving the quality of care delivered to recipients and resolving more health care facility complaints.

D. How was the accomplishment achieved?

This accomplishment was achieved by assigning a field supervisor to a body of work; and the field supervisor then directed his staff accordingly to improve the overall scheduling of the workload. In conjunction to this commitment, more efficient report writing, and adjusted staffing assignments, they were able to more efficiently handle complaints and to minimize duplication of services. This led to being able to increase the amount of surveys and investigations that were being performed.

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

Yes. Since HSS is entrusted to the task of enforcing state licensing standards and federal certification regulations through licensing and certification surveys of health care providers, exceeding projected workloads will mean that more reviews and investigations of health care facilities will have been done, which will improve the quality of care to the patient.

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

Yes. The approach is that HSS continues to utilize industry practices in conjunction with States in the CMS Region 6 area to streamline its operations. The effective method better addresses long intervals between onsite inspections.

Accomplishment # 4: Health Standards: On-Line Medication Administration

A. What was achieved?

An on-line medication administration training program was developed for direct service workers who serve waiver clients in the self-direction program. The training is scheduled to be piloted in two DHH regions. This may also be considered for release to our licensed Home and Community Based Services (HCBS) providers at a

later date depending on the feedback received after implementation in the self-direction program.

B. Why is this success significant?

Clients in self direction are not linked to a licensed provider so this afforded a mechanism to provide a systematic unified approach of training to those workers statewide.

C. Who benefits and how?

Clients benefit because it provides a mechanism to assure health and safety to those in the self-direction program and it satisfies the La. Board of Nursing requirements regarding medication administration. This endeavor was also in response to Bailey's Law from 2014 Legislative session which stated that all licensed nurses had to be trained in order to perform prescribed tasks.

D. How was the accomplishment achieved?

A work group consisting of representatives from Health Standards and RN's from OCDD and OAAS worked collaboratively to develop the specific training modules for self-direction.

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

Overall yes, it ensures the quality of services provided, ensures the health, safety and welfare of clients served in this population.

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

Yes. The development of online modules creates a more efficient mechanism for providing training. These modules can be accessed as needed, eliminating the need for structured classes.

Accomplishment # 5: DHH: Well Spots and Well-Ahead Louisiana Website

A. What was achieved?

Business owners, schools, and higher education institutions joined the Louisiana Department of Health and Hospitals (DHH) in implementing WellSpots across the state. WellSpots are places and spaces that have made sustainable changes to make it easier for Louisiana residents to live healthier lives. The Department also launched a website at www.WellAheadLa.com that makes it easy for users to find WellSpots in their community.

Of the current WellSpots, the Our Lady of the Lake Hospital is the first hospital to receive a Level One designation, which is the highest level. Xavier University in New Orleans was the first university to receive the WellSpot designation, followed by the Our Lady of the Lake College. Since 2014, DHH has provided assistance on the design and implementation of healthy policy or programs to 586 organizations in 169 cities in all 64 parishes across the state.

B. Why is this success significant?

At little cost to the state, the Department has been able to create a strong incentive and recognition program that encourages multiple industries to collaborate to improve the health of employees and patrons. Organizations have the opportunity to change our community for the better, to improve our overall health, teaching our children to be physically active and to eat healthy or by allowing our employees to incorporate healthy choices into the workspace.

C. Who benefits and how?

The citizens of Louisiana as a whole benefit from these initiatives. Louisiana residents and leaders are given the tools they need to make their communities healthier. Well-Ahead Louisiana promotes and recognizes smart choices in the spaces and places we live and work every day that make it easier for us all to live healthier lives, from going tobacco-free to ensuring healthy lunch options or supporting workplace fitness programs.

Well-Ahead promotes voluntary changes without imposing new taxes or creating new rules. This is about Louisiana's people, leaders, businesses and organizations taking action because it is the right - and healthy - thing to do.

D. How was the accomplishment achieved?

Well-Ahead Louisiana is an initiative started by the Louisiana Department of Health and Hospitals aimed at improving the health and wellness of Louisiana citizens. In establishing Well Spots, DHH staff work closely with restaurants, schools, worksites, local governments, hospitals, and universities and colleges to help them identify and meet benchmarks for wellness. Once DHH verifies an organization has completed enough benchmarks, they are identified as a Level One, Level Two, or Level Three Well Spot, depending on the extent to which the organization has adopted health-promoting policies.

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

Yes, these initiatives are a core component to building foundational change for better health outcomes.

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

This accomplishment could serve as a blueprint for low-cost, high-impact initiatives throughout the state.

Accomplishment # 6: Health Standards: Home and Community Based Services providers On-Line Training Program

- A. What was achieved?

The Health Standards Section implemented a web based on-line training program for Home and Community Based Services (HCBS) providers on HCBS licensing standards.

- B. Why is this success significant?

This program dramatically increases training accessibility for new and existing HCBS providers and eliminates the need for HSS office staff to schedule face to face training with providers

- C. Who benefits and how?

Both Providers and HSS staff benefit from this accomplishment. Due to the training being made available to providers on the HSS HCBS web page under Provider Training and Resources at: <http://dhh.louisiana.gov/index.cfm/directory/detail/719>, the providers do not have to wait to schedule their training with HSS staff, instead they can do it as their time permits. The time that HSS staff was using to provide these face to face trainings are now being utilized for other workload mandates.

- D. How was the accomplishment achieved?

HSS developed the program in conjunction with IT staff who made it an on-line training.

- E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes, this accomplishment does represent a Best Management Practice as it is a great time management tool. This frees up time for the HSS staff and makes the training more accessible to Providers with it being web-based and can be accessed at any time

- 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 online training enables access to information in a timely fashion without having to wait for organized classes to be provided.

Accomplishment # 7: DHH: Announcement of Transition for Health Care Options in Mid-City Baton Rouge

- A. What was achieved?

The Louisiana Department of Health and Hospitals (DHH), along with leaders from Baton Rouge General Medical Center (BRG), the Baton Rouge Area Foundation (BRAAF) and Our Lady of the Lake Medical Center (OLOL), announced plans to collaborate on a new model of health care for Mid-City Baton Rouge. These plans resulted in the expansion of the LSU Health Baton Rouge urgent care clinic on North Foster Drive and the creation of a second, permanent location. These clinics were crucial to providing care in the Mid-City following the closure of BRG's Mid-City Emergency Room. In addition, information was sent out to area residents detailing their options for access to health care.

- B. Why is this success significant?

This success is significant because it provided expanded care options in the Mid-City area. DHH is committed to providing health care access to the citizens of the state.

- C. Who benefits and how?

Everyone in the community benefits, as this collaborative effort between the Baton Rouge General, Baton Rouge Area Foundation, and other community partners get together to maintain services in the Mid-City area and help plan for the long-term sustainability of this health care facility.

- D. How was the accomplishment achieved?

DHH worked closely with the BRG, BRAAF, OLOL and community partners to conduct the necessary community education and outreach surrounding the transition.

As part of the transition plans, Baton Rouge General expressed support for the collaborative plans, following their Board's decision to close emergency room operations in Mid-City. The State provided additional funding to BRG as reimbursement for the care provided to the uninsured in the summer of 2014, which allowed additional time for the BRG and community members the ability to craft this long-term plan. In that time, the Mid-City Emergency Room continued to experience high volumes of uninsured patients and unsustainable levels of financial losses.

BRG has committed to work with BRAF and other partners to identify an industry consultant to study the long-term potential of the campus for preserving this vital community asset.

- E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes, this accomplishment does contribute to the success of the agency's strategic plan. The Department of Health and Hospitals is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner.

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

Yes, this accomplishment represents a Best Management Practice, as it represents collaboration between multiple entities. This new model of care is comprised of the full complement of healthcare services including primary, specialty and surgery services.

Accomplishment # 8: DHH: Announced Plans to Integrate Behavioral Health Services into Managed Care Plans

- A. What was achieved?

The Louisiana Department of Health and Hospitals (DHH) announced plans to integrate specialized behavioral health services into the benefits coordinated by Bayou Health plans for more than 920,000 Medicaid recipients. Currently, these services are provided separately in a program called the Louisiana Behavioral Health Partnership (LBHP). The Department is working with five managed care organizations contracted to provide care to Louisiana's Medicaid recipients, as well as providers, recipients and stakeholders on the transition that was implemented on Dec. 1, 2015.

- B. Why is this success significant?

Integration of behavioral health services into Bayou Health allows Medicaid recipients to have a single MCO manage both their behavioral and physical health services. This change will create a stronger continuum of care and better referrals of individuals in need of services.

C. Who benefits and how?

DHH Bayou Health plans have the national experience and local track record to build upon the successes of the LBHP and will continue to expand the provider network. Health care providers and policy makers know that behavioral health needs have a tremendous impact on overall health outcomes and costs. Integrating responsibility for coordinating these services into one entity allows DHH to better manage an individual's care and to promote improvements.

D. How was the accomplishment achieved?

The Louisiana Behavioral Health Partnership was designed to better coordinate care provided to individuals in need of behavioral health services. Often mental health needs and addictive disorder needs are co-occurring; meaning individuals with one need also often have the other. Before the creation of the LBHP more than three years ago, fewer doctors, inpatient facilities and service providers were available to Louisiana residents whose services are reimbursed through Medicaid. The LBHP expanded access to providers by more than double - from 800, to 1,700 providers. There has also been an 87 percent increase in available inpatient beds since the LBHP was implemented.

"Integrating behavioral health care into the acute medical care for Medicaid recipients is the best way for us to serve Louisiana residents. We have to care for the individual as a whole person rather than compartmentalizing types of services by the provider type," said DHH Office of Behavioral Health Assistant Secretary Dr. Rochelle Head-Dunham said. With careful planning and working closely with our providers and advocacy organizations, coordinating care for primary, acute and behavioral health care needs of our residents will help the Department improve outcomes.

Rather than accept a bid for a new three year LBHP contract that would have begun March 1, 2015, DHH is fully integrating behavioral health services into Bayou Health effective Dec. 1, 2015. DHH is negotiating a shorter-term contract with the one entity that responded to the recent request for proposals (RFP), the current incumbent Magellan of Louisiana. That contract is expected to last for nine months while the transition occurs.

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

Yes. The LBHP is also responsible for coordinating behavioral health services for certain non-Medicaid populations. .

Other new services and provider types available since the implementation of the LBHP include:

- Psychiatric residential treatment facilities,
- Therapeutic group homes;
- New crisis intervention providers;
- Providers of independent living skills;
- Addiction disorder services, including all levels of residential care, counseling

and intensive outpatient;

- New outpatient therapy provider types such as family counselors and other licensed mental health professionals;
- Evidence-based programs for youth such as functional family therapy and homebuilders;
- Behavioral health services provided by schools and school systems;
- Wraparound services for youth at risk of out-of-home placement in the Coordinated System of Care (CSoC);
- Family support for youth in the CSoC; and
- Youth support for youth in the CSoC.

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

Yes. The Department named an advisory group of key stakeholders, including partner state agencies, local governing entities, providers, advocates and others to provide ongoing guidance and feedback as specific contract language for the addition of behavioral health services to Bayou Health is developed.

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?

Strategic Plan: Yes, the strategic plan for the Department of Health and Hospitals is on time for accomplishment. Our 5-Year Strategic 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 past few 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.

Business Plan: When we released our first business plan in September of 2010, we recognized that it would not alone solve our state's health care challenges, but rather show that the Department of Health and Hospitals was ready to challenge the notion of "business as usual" in Louisiana. As we moved forward from that first business plan, we have worked

tirelessly as an agency to transform the delivery of and access to health care and services in the state of Louisiana, challenging decades of old models for how things are done.

Our priorities as an agency now 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 business 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:

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

- **Where are you making significant progress?**
The Health Standards Section has made significant progress related to the quality of documenting deficiencies.

A. To what do you attribute this success?

Through the Continuous Quality Improvement (CQI) Process, Health Standards has been able to evaluate both the efficiency and effectiveness of its survey work. Concerns identified through this process have provided Health Standards the opportunity to ensure the quality of the documentation of survey results prior to issuing a provider a Statement of Deficiency.

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

This progress would not be considered a one-time gain. By utilizing a CQI process on an ongoing basis, the unit expects to be able to refine its process related to documenting efficiencies and sustain this process for continued success.

Significant Progress #2: Internal Audit: Exceeding Expectations in Reviews

- **Where are you making significant progress?**

Internal Audit Section reviews have consistently exceeded expectations in terms of number of reviews conducted.

- A. To what do you attribute this success?**

This success is largely attributed to a good working relationship with Legal and the Office of State Human Capital Management (OSHCM) and a skilled team. Attention to successful completion of review has been emphasized. Cooperation and efforts of other sections in DHH is essential to the success of audits and reviews.

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

Progress in the area of reviews is expected to be steady.

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

1. To what do you attribute this lack of progress? For example:

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

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

NONE

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

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

The Office of the Secretary did not revise its strategic plan in FY 2015, as we are in the planning stages of a new five-year strategic plan that is due in July of 2016.

Strategic Plan: The Department revised its 5-Year Strategic Plan in July 2013. In the revised plan, agencies incorporated a section titled, “Executive Summary” and have implemented new outcome performance indicators. The Executive Summary is intended to highlight the vision of each agency’s assistant secretary. The revised plan contains a brief overview and information on where the agency is headed in the next five years, major goals, recent accomplishments, and a general discussion of strategies and resources they will use to achieve their goals.

Business Plan: Since the first DHH business plan was introduced in FY 2010, DHH leadership has used each year’s plan as a guide and accountability tool to ensure our day-to-day work is aligned with the Department’s broad priorities and initiatives.

The business plan is designed to serve as a resource to our constituents to better understand the structure of the Department of Health and Hospitals. The business review portion of the document provides a general review of the programs and services we provide or facilitate, and the following sections outline our priorities for improving the health of our state. The following transformative initiatives are grouped into three major areas and represent the Department’s focus in 2013 and 2014: (1) Building Foundational Changes for Better Health Outcomes; (2) Promoting Independence through Community-Based Care; and (3) Managing Smarter for Better Performance. While these transformative initiatives don’t represent the full book of business of the Department, the goal within this business plan is to present the Department’s top priorities. Other initiatives are expected to emerge throughout the year, and DHH leadership encourages residents and stakeholders to respond with their own big ideas and priorities for health care in Louisiana today.

♦ **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.

Performance Based Budgeting activities (including, but not limited to, strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the DHH Division of Planning and Budget. This section reviews (and sometime develops) objectives, performance indicators and strategies for the Office of the

Secretary, as well as each DHH agency. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed. Also, at the close of a fiscal year, agencies 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.)

There are no significant department management or operations problems to note.

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

A. Problem/Issue Description

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

B. Corrective Actions

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

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

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

No. If not, please explain.

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

Please discuss the following:

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

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

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

Internal audit

The Office of the Secretary ensures ongoing monitoring of programmatic and

administrative functions. The internal audit function within DHH appraises activities within the department to safeguard the department against fraud, waste & abuse. This function also 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.

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

The Louisiana Office of the Legislative Auditor 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. In the coming fiscal years, the DHH Internal Audit Division plans to contract with an external audit firm if/when the audit needs of the Department require additional resources.

- 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)

Performance Based Budgeting activities (including, but not limited to strategic planning, operational planning, and the Louisiana Performance Accountability System) are coordinated by the DHH Division of Planning and Budget. This section reviews all objectives, performance indicators and strategies for each DHH agency. Recommendations are made directly to the Assistant Secretaries or Secretary, if modifications or additions are needed. Data is collected and reported into LaPAS on a quarterly basis. Any variances that are above 5% (+ or -) are explained in the Notes section of LaPAS.

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

Benchmarking for Best Management Practices

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

 Performance-based contracting (including contract monitoring)

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

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

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

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

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

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

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
09-309 South Central La. Human Services Authority

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Executive Director: Lisa Schilling

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

For each accomplishment, please discuss and explain:

A. What was achieved?

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

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

B. Why is this success significant?

This accreditation decision represents the highest level of accreditation that can be awarded to an organization and shows the organization's substantial conformance to the

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

C. Who benefits and how?

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

D. How was the accomplishment achieved?

Achieving accreditation requires a service provider to commit to quality improvement, focus on the unique needs of each person the provider serves, and monitor the results of services. SCLHSA began its accreditation process with an internal examination of its program and business practices. The examination consisted of the SCLHSA staff conducting an in-depth self-evaluation review of agency policies, procedures and documents over a nine month period. The administrative team conducted numerous site visits and mock surveys at all eight behavioral health clinics, which consistently in compliance with all CARF standards. Consequently, SCLHSA requested an on-site survey that was conducted by a team of expert practitioners selected by CARF. During the three-day survey, SCLHSA had to demonstrate that it conformed to a series of rigorous and internationally recognized CARF standards. The survey team visited all aspects of the agency to include administration, pharmacy and all eight behavioral clinic sites under SCLHSA purview. Interviews were conducted with staff, clients, contractors, stakeholders, board members and representatives from DHH. Based on the results of the survey, CARF prepared a written report of the SCLHSA's strengths and areas for improvement. Since SCLHSA demonstrated exemplary conformance to the standards, the agency earned a three year CARF accreditation which is the highest level of accreditation that can be achieved. The SCLHSA has submitted a Quality Improvement Plan (QIP) to CARF to show how it is addressing any areas cited for

improvement. Each year during the term of accreditation, the SCLHSA must submit a report to CARF documenting additional improvements it has made to its service array.

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

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

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

Payers - whether a third-party funder, referral agency, insurance company, or governmental regulator looks for CARF-accredited service providers to lessen risk and provide greater accountability. Behavioral health payers prefer CARF International as an independent accrediting body of health and human service providers. Accredited providers have proven they have applied a comprehensive set of standards for quality to their business and service delivery practices. Because CARF accreditation signals a provider's demonstrated conformance to internationally accepted standards, it can significantly reduce governmental monitoring and help to streamline regulation processes. The value of CARF Accreditation is more than a certificate hanging on the wall. CARF Accreditation is evidence that an organization strives to improve efficiency, fiscal health, and service delivery -- creating a foundation for consumer satisfaction. With the addition of the Integrated Care/Primary Care Program this year, SCLHSA is now considered a one stop shop for patients with its holistic approach to care. This designation is not only desired by patients, but by health insurance agents as well.

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment? To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

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

Overall, South Central Louisiana Human Services Authority remained on target with Progress toward achieving our 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 policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)
 - Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department’s contribution to the joint success?
 - Other? Please specify.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace?

During FY 2014-2015, South Central Louisiana Human Services Authority has made huge strides in demonstrating compliance with its Strategic Goals which were created with input from the SCLHSA Board of Directors, Local Providers and SCLHSA staff. The four following goals represent the community’s perspective on where our agency needs to continue to concentrate its efforts:

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 committing to quality improvement, focusing on the unique needs of each person we serve, and monitoring the results of services we provide.

The South Central Louisiana Human Services Authority will continue to utilize all Strategic Plan strategies with a concentrated focus on utilization management, monitoring and related follow-up activities, client engagement, and positive outcomes to achieve the Authorities goals and objectives. The South Central Louisiana Human Services Authority strives for continued progress toward achieving Strategic Goals and Objectives in support of its Mission: To increase public awareness of and to provide access for individuals with behavioral health and developmental disabilities to integrated community based services while promoting wellness, recovery and independence through education and the choice of a broad range of programmatic and community resources.

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

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; 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 support. The Authority also honed performance Indicators, retaining some trending

data with the bulk of the attention focused on the development of true and meaningful outcome measures.

No. If not, why not?

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

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

As an organization that has adopted and actively practices both Accountable Care and Performance and Performance Improvement models/philosophies, South Central Louisiana Human Services Authority continuously communicates, monitors, reports, and implements corrective action/process improvement activities with regard to Strategic Plan Goals, Objectives, and Performance Indicators via a broad range of Venues (from individual supervision to performance reporting available to staff).

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

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

The Executive Director schedules quarterly All-Staff Videoconference meetings each year with the entire agency. Performance improvement is a routine part of the agenda. Further, the Executive Director bases a significant portion of the Division Directors'

annual performance reviews on their contributions to the South Central Louisiana Human Services Authority Strategic Plan and Performance Improvement Initiatives as well as on their degree of success in accomplishing organizational goals and objectives.

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

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

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

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

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

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

A. Problem/Issue Description

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

During FY 2014-2015, South Central Louisiana Human Services Authority experienced no increase in State General Funds (SGF). Vacant positions in service areas such as clinical services are a priority to fill.

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 community.
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) 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 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.
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 2014-2015 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 been battling large budget deficits over the last couple of years which have been addressed through utilizing "rainy day funds". This past year the State realized a \$1.6 Billion dollar deficit heading into the 2015 Legislative Session because of oil prices dropping, healthcare costs sky rocketing, etc. The budget gaps are handed 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 then to find ways to minimize cuts without affecting patient care if possible.

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 must utilize effective and flexible strategies/tactics to continuously improve performance, service quality and to identify and capture alternative revenue streams.

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?

South Central Louisiana Human Services Authority (SCLHSA) will:

- 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 DHH and the Bayou Health Plans (Statewide Management Organizations) 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 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.

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

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

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?

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 Statewide Management Organization (SMO) and the ongoing implementation of National Healthcare Reform.

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?

Corrective 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 Executive Director; primary responsibility for execution of corrective actions rests with members of the Executive Administrative Team. Resources needed to successfully carry out these processes are through the Human Resources component; related duties and responsibilities are included in each Executive Administrative Team member's position description and in employees performance planning and rating documents.

Executive Administrative Team members are expected to manage priorities with flexibility and their respective 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. Add comments to explain each methodology utilized.

- Internal audit
South Central Louisiana Human Services Authority's Administrative Services Division provides ongoing monitoring of clinical and administrative functions. Audit tools, with identified criteria and targets are utilized; results are reported; and, appropriate process improvement and/or corrective actions are executed. Further, South Central Louisiana Human Services Authority developed process improvement and fiscal functions to audit Authority performance using benchmarks set forth in the Council on Accreditation of Rehabilitation Facilities (CARF) standards and to implement process improvement and/or corrective action as needed. A member of the Administrative Services Division oversees each of these areas to assure there is no duplication of effort.
- External audits (Example: audits by the Office of the Legislative Auditor)
South Central Louisiana Human Services Authority is audited on an annual basis through the Office of the Legislative Auditor as well as by the Department of Health & Hospitals Office of Behavioral Health Licensing Standards and the Louisiana Department of State Civil Service.
- Policy, research, planning, and/or quality assurance functions in-house
The South Central Louisiana Human Services Authority's Executive Administrative Team provides these functions with oversight from the SCLHSA Deputy Director.
- Policy, research, planning, and/or quality assurance functions by contract
The South Central Louisiana Human Services Authority Adult, Child and Prevention Services Contract Monitors meet monthly with all contracted services for review of contract objectives and to gather service data information. The contract agency or individual has the opportunity to share any issues with service provision or funding at that time.
- Program evaluation by in-house staff
Performance is monitored on an ongoing basis utilizing the South Central Louisiana Human Services Authority's Strategic Plan, Operational Plan, Performance Improvement Plan, Risk Management Plan, and position-specific performance expectations. All have clearly stated expectations and performance targets. The Executive Director, Executive Administrative Team,

and the Supervisory Staff share responsibility for oversight of these functions. Outcomes are reported on no less than a quarterly basis.

- Program evaluation by contract
The South Central Louisiana Human Services Authority Administrative Team 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 South Central Louisiana Human Services Authority meets with its contracted services on a quarterly basis for review of contract objectives and service data information. The contract agency has the opportunity to share any issues with service provision or funding at that time. Additionally, each contractor with SCLHSA is required to fill out a survey on the previous service year and offer comments on ways to improve the contractual relationship which is reviewed and changes may be implemented to the contract process for performance improvement.
- In-house performance accountability system or process
South Central Louisiana Human Services Authority utilizes: the Department of Health & Hospitals Accountability and Implementation Plan, the Commission on Accreditation of Rehabilitation Facilities (CARF), and Performance Improvement model, Staff Development and Supervision Guidelines in conjunction with the Louisiana Department of Civil Service Performance Planning and Review system; ongoing internal monitoring and auditing mechanisms including corrective action and/or process improvement action plans with assigned accountability.
- Benchmarking for Best Management Practices
South Central Louisiana Human Services Authority has an active and robust decision-support function supported by the availability of live data from state and other internal data warehouses. Data analysis includes comparative studies to benchmark against national statistics and internally set goals/targets. Studies range from individual service provider productivity to billing denial rates. South Central Louisiana Human Services Authority also utilizes benchmarks set forth in the Accountability Implementation Plan and Council on Accreditation of Rehabilitation Facilities (CARF) for ongoing performance and quality improvement initiatives

- Performance-based contracting (including contract monitoring)
All South Central Louisiana Human Services Authority contracts have explicit performance requirements and include mandatory reporting and development of corrective action and/or process improvement plans if the need is indicated.
- Peer review
South Central Louisiana Human Services Authority's Performance Improvement Program uses peer review as part of the ongoing performance and quality improvement initiative. The Authority's Medical Director leads comprehensive multi-disciplinary peer review in cases. The Authority has initiated an ongoing peer review process to be conducted annually as part of the compliance standards implemented for the CARF accreditation process.
- Accreditation review
South Central Louisiana Human Services Authority is implementing an Authority-wide plan for re-accreditation readiness with the Commission on Accreditation of Rehabilitation Facilities (CARF). Communication between the Authority and Commission on Accreditation of Rehabilitation Facilities (CARF) is ongoing and formal application was filed. As stated previously, South Central Louisiana Human Services Authority has active process improvement functions that focus on meeting and/or exceeding requirements set forth in the Commission on Accreditation of Rehabilitation Facilities (CARF) Standards, the Statewide Management Organization and the Department of Health and Hospitals.
- Customer/stakeholder feedback
South Central Louisiana Human Services Authority participates in satisfaction surveys sponsored by the Office of Behavioral Health and the Office of Citizens with Developmental Disabilities. Additionally, South Central Louisiana Human Services Authority fields a proprietary survey within its Behavioral Health Clinics on a quarterly basis to gain additional information for the identification of opportunities for improvement. The Authority has initiated satisfaction surveys for all contractors as part of standard contractual requirements. South Central Louisiana Human Services Authority also partners with the Office of Behavioral Health to hold an annual community forum for the residents of our seven parishes. The members of the Board of Directors, per the Carver Policy Governance Model, actively engage in "community linkages" and report the results of these interactions with community stakeholders during monthly Board meetings.
- Other (please specify):

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

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

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

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

The South Central Louisiana Human Services Authority monitors and evaluates its operations and programs on an ongoing basis as described throughout this report and has a well-developed decision-support function in place. Data is analyzed (including trending and projecting future performance) and discussions are held during Executive Administrative 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 Administrative 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)
 985-858-2931
lisa.schilling@la.gov

Kristin Bonner
 Deputy Director
 South Central Louisiana Human Services Authority (SCLHSA)
 985-858-2931
kristin.bonner@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
09-310 Northeast Delta Human Services Authority

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Executive Director: Dr. Monteic Sizer

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

For each accomplishment, please discuss and explain:

A. What was achieved?

- The Human Resources Department effectively achieved 100% timely turn-in rate of Performance Evaluation for FY 14-15.
- NE Delta HSA hosted three working Summits that focused on improving coordinated care for people in crises situations who suffer from mental health issues and addictive disorders.
- Provided Support Coordination and Family Support funding for services for 190 recipients and an additional 163 children through the Flexible Family Fund Program; Developed and implemented a competency based training program for the Family Support Program providing training and certification to direct support staff providing in-home supports; Certified 100 new recipients into the waiver programs in addition to over 1000 Waiver recipients that received annual certifications through the agency
- NE Delta HSA has exceeded performance standards for patients who would recommend our clinic to family and friends.

A. What was achieved?

The Human Resources Department effectively achieved 100% timely turn-in rate of Performance Evaluation for FY 14-15.

- B. Why is this success significant?
HR Department established a 95% rate of submission as a target to ensure that our PES evaluations are conducted and submitted in a timely manner. Our agency/department not only met the goal, but exceeded the target rate.
- C. Who benefits and how?
This achievement benefits the agency, supervisors and employees, by displaying a sense of accountability and responsibility from supervisors to their subordinates regarding annual performance duties.
- D. How was the accomplishment achieved?
The HR Department mandated all supervisors to complete the CPTP PES Evaluation training to ensure that they are aware of the requirements and responsibilities related to employee planning and evaluation. Also, the HR Department set up a suspense date of 2 weeks prior from the Civil Service submission date and sent out weekly reminders to supervisors to ensure that evaluations were completed as required.
- E. Does this accomplishment contribute to the success of your strategic plan?
NEDHSA's strategic plan was approved beginning fiscal year 15-16
- 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. What was achieved?
NE Delta HSA hosted three working Summits that focused on improving coordinated care for people in crises situations who suffer from mental health issues and addictive disorders.
- B. Why is this success significant?
Catalyzing the coordination of care for citizens experiencing a crisis, particularly those who may suffer from co-occurring mental health, substance issues and developmental disabilities, helps address the need for increased psychiatric inpatient care and the protocol for people in crisis who come in contact with police. These sessions helped find innovative ways to use existing resources and further improve coordination of care, which in turn improves services and fills service gaps for some of the highest-need citizens in the region. More than 25 regional sheriffs, police chiefs, coroners, and hospital administrators attended each of these sessions.
- C. Who benefits and how?
Behavioral healthcare clients as well as law enforcement first responders and entities that treat clients may all benefit from this work, because all parties will either receive increased levels of care or enhance their ability to provide better care. Clients may realize shorter waiting times for care, better transportation and improved interactions with law enforcement. Improved safety may also be realized for clients, communities and law enforcement personnel.

- D. How was the accomplishment achieved?
At these sessions, NE Delta HSA gathered input and feedback from law enforcement, including those who serve outlying rural parishes, coroner's offices, hospital groups and behavioral health experts. Current processes were discussed, then needs for increased, coordinated care were defined. Recommendations were made, using existing resources, to improve regional health outcomes.
- E. Does this accomplishment contribute to the success of your strategic plan? (See Section II below.)
NEDHSA's strategic plan was approved beginning fiscal year 15-16
- 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. What was achieved?
Provided Support Coordination and Family Support funding for services for 190 recipients and an additional 163 children through the Flexible Family Fund Program; Developed and implemented a competency based training program for the Family Support Program providing training and certification to direct support staff providing in-home supports; Certified 100 new recipients into the waiver programs in addition to over 1000 Waiver recipients that received annual certifications through the agency
- B. Why is this success significant?
These successes are significant in illustrating the ongoing actions taken by our agency to meet the needs of people with developmental disabilities in northeast Louisiana by providing assistance to both new customers and to those receiving ongoing services. The accomplishments also represent NE Delta HSA's commitment to improving the quality of services provided in this region of the state.
- C. Who benefits and how?
The recipients\customers of services benefit from these accomplishments through access to the service system, receipt of services, and in the quality of services provided. Recipients of services benefit overall in having the ability to remain in their homes and communities with services rather than having to seek services in an institutional setting or away from their natural home.
- D. How was the accomplishment achieved?
NE Delta HSA has established three tenets that guide our work. These tenets include excellent customer service, greater access to services, and competent, quality care. The staff advocates on behalf of those requesting services and strive to coordinate individualized plans to meet the needs identified by the recipients seeking services. Efforts have been continually made to be present throughout communities all over northeast Louisiana including health fairs, school fairs, community forums and various

other gatherings in order to make people aware of the services available through the agency. We have partnered with agencies within the region to accomplish new initiatives and to provide services to those who need the support of DD services.

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

NEDHSA's strategic plan was approved beginning fiscal year 15-16

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

Yes, our 3 tenets should be considered for any agency serving the public. Also, partnerships with agencies that have a common interest in seeing people served and communities thriving should always be promoted.

- A. What was achieved?

NE Delta HSA has exceeded performance standard for patients who would recommend our clinic to family and friends. (Performance Standard: 85%/Actual 90%).

- B. Why is this success significant?

This rating demonstrates the consumers' perception of the level and quality of services and care being provided in the clinics. It further demonstrates the capacity of our clinicians to assess, evaluate, and manage complicated healthcare issues of BH/AD clients and to integrate services that meet the complex needs of this consumer population.

- C. Who benefits and how?

Healthcare consumers with co-occurring BH and AD and the healthcare providers responsible for managing their care. Patients of the agency benefit from effective care provision.

- D. How was the accomplishment achieved?

Staff education and collaboration have contributed to the increased quality of services being provided. Customer service training, evidence-based practices, and patient centered care planning, individualized care planning, collaborative planning, and translating a healthcare integration model of care into future healthcare realities.

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

NEDHSA's strategic plan was approved beginning fiscal year 15-16

- 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 success of our organization is based on coordinated care and a training and education model. This model could benefit other agencies who struggle with achieving

a standard of quality care.

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

NE Delta HSA strategic plan is set for implementation for fiscal year 15-16

- ♦ **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?
- ♦ **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?

NE Delta HSA strategic plan is set for implementation for fiscal year 15-16

- ♦ **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?

Attracting and retaining adequate and competent psychiatric service providers, especially in rural areas, has been a significant issue for our agency. We contract with a tele-psychiatric provider for our rural clinics; however, limited time is granted to each clinic based on the demanding schedule of the agency with other

contractual obligations.

It is a challenge to attract specialized/licensed professionals in the parishes served by NEDHSA. In addition, NEDHSA is economically challenged in its ability to be competitive with salary level needed to attract these professionals. We have launched our loan forgiveness program to assist in recruiting staff.

Lack of stable housing and transitional housing options have indirectly impacted clients' services as well. Although this is not a core function of our agency, we have seen an increased need for housing services. Funds used to support our agency has historically been used in part to support housing, however, with increased demand for core services, more housing associated funds are in high demand.

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

Our strategic plan can potentially be impacted for fiscal year 15-16 if a solution is not realized.

3. What organizational unit in the department is experiencing the problem or issue?
Rural behavioral health clinics are mostly impacted by the shortage of professionals. Housing is a district wide concern for our agency and consumers. We have more people requesting housing services than there are available options to accommodate them.

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

The behavior health community as a whole is impacted by these problems.

5. How long has the problem or issue existed?

Ongoing

6. What are the causes of the problem or issue?

The challenge with recruiting specialized licensed professionals can be attributed to two distinct factors. The rural nature of the parishes served by NEDHSA contribute to the area being served is considered as less desirable. The rural setting provides less amenities than are typically available in larger, more populated cities. In addition, the ability to be competitive related to salary is a huge deterrent in the rural area in which NEDHSA is situated. Limited options for stable transitional housing for those with behavioral health challenges can be tied to the proper diagnosis of management of behavioral health issues. The notion as a whole is seeing an increase in homelessness. If behavioral health issues are not identified and treated appropriately, the unfortunate result is that individuals often times do not qualify for traditional housing opportunities.

How do you know?

NEDHSA has completed a strategic recruitment plan to identify, recruit, and train competent staff. This plan highlights the strengths and weaknesses of retaining specialized staff. Homeless and housing demands are requested regularly by consumers which place a demand on clinicians to help assist them in accessing housing services.

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

If qualified, licensed professionals are unable to be recruited fewer clients/patients

will receive adequate psychiatric services and access to care will be impacted. If additional transitional housing is not available, the result will be an increased homeless population related to those with unmanaged mental illness.

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?

A primary issue for ongoing success of providing services is having the ability to acquire more staff to meet the growing needs of our area. As we are successful in reaching more people and identifying needs we also need qualified staff to manage the services requested from our customers. Staff has a caseload of 183 people each at this time. The need for qualified staff to continue the work needed has become critical. As we continue to move toward increases in people receiving services and expectations of improved quality of those services we must not allow current staff to burn out or become so overwhelmed with responsibilities that we become unproductive.

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

Our strategic plan can potentially be impacted for fiscal year 15-16 if a solution is not realized.

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

The Local Waiver Support Unit is experiencing this problem..

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

Internal customers and staff are affected. Consistent increases in job responsibilities to the Waiver Program require staff to take on a heavier workload. Adequate staffing is needed in order to provide services to external customers. If not resolved, this will ultimately impact clients served.

5. How long has the problem or issue existed?

The waiver program has grown significantly in the last 3 years. The waiver staff to recipient ratio has not been revisited in over 5 years despite growth in waiver certifications and additional duties.

6. What are the causes of the problem or issue?

Lack of additional resources allocated to us from our state level DD funders to secure more staff

How do you know?

Budget allocation

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

Please see explanations above

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

Corporate Compliance performs audits of each department within NEDHSA

External audits (Example: audits by the Office of the Legislative Auditor)
Audits by SMO, ORM, Office of Legislative Auditor, etc.

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

Corporate Compliance manages policy issuance and ensure adherence to policy for any procedures initiated within NDHSA

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

Program evaluation by in-house staff

Evaluations of clinical services by Corporate Compliance staff using Treatment Record Review, Review of Consumer Complaints, Critical Incident Analysis, and TeleSage Outcomes Measurement System (TOMS)

Program evaluation by contract

Substance abuse block grant report, mental health block grant report, Accountability Implementation Plan (AIP) for Behavioral Health and Developmental Disabilities

Performance Progress Reports (Louisiana Performance Accountability System)

Corporate Compliance reports performance data in LaPAS

In-house performance accountability system or process

Performance Improvement Committee

Benchmarking for Best Management Practices

Performance-based contracting (including contract monitoring)

Contract monitoring of the technical direction of contracts

Peer review

SAPT Block Grant Annual Peer Reviews

Accreditation review

CARF

Customer/stakeholder feedback

Consumer Satisfaction Surveys/C'est Bon

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 2014-2015

Department: Office of Aging and Adult Services
09-320 Office of Aging and Adult Services

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Assistant Secretary: Tara LeBlanc

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

#1. Completion of Request for Proposal and preparation of federal waiver amendments for the implementation of fully integrated Managed Medicaid for individuals receiving or at risk for long term supports and services that would produce substantial SFG savings if implemented.

With input from multiple public forums and a comprehensive group of stakeholders who served on a public advisory group, the Office of Aging and Adult Services (OAAS) **completed a Request for Proposals and prepared for submission all necessary federal amendments to implement Bayou Choices as the comprehensive managed Medicaid delivery system** for individuals receiving and at risk for needing long term supports and services. OAAS would operate Bayou Choices through contracts with 2-3 managed care organizations that would be responsible for managing all Medicaid services for this population and achieving benchmarks for improved health outcomes. The goal of MLTSS is to improve health outcomes for this population by coordinating all health care; acute, behavioral, pharmacy, as well as long term care. OAAS stands ready to join the majority of states that have either implemented or are in the process of implementing MLTSS.

Managed care for this population – often referred to as Managed Long Term Supports and Services (MLTSS) – has been shown to reduce costs and improve outcomes for older adults and people with disabilities. Projections prepared by OAAS and Medicaid show over \$10.5-million in savings and revenue generation through additional Federal Financial Participation (FFP) in year one rising to \$78-million in year three. These projections are based on initial implementation in the middle of a fiscal year;

implementation at the start of a fiscal year would increase year one savings and FFP.

Individuals receiving and at risk for needing long term supports and services as well as their families and caregivers would benefit from increased coordination of care and increased opportunity to be served in their homes and communities. Goals for Bayou Choices include reduced inpatient and emergent admissions for the chronic conditions so common in the target population, i.e., diabetes, COPD, and hypertension; and reduced admissions for preventable conditions such as dehydration, bacterial pneumonia, and urinary tract infections. Improvements in preventive and palliative care, for instance, pain reduction, are also sought through implementation of MLTSS. Reduction in the waitlist for home and community-based services, which exceeded 37,000 individuals at the end of SFY 15, is another significant goal. The existing Fee For Service approach has shown no improvements in any of these areas.

The completion of these documents was achieved through a highly public process involving a 31 member advisory group and statewide public forums and webinars. Consulting services were also used including use of actuary services to develop actuarially sound rates for MLTSS contracts. OAAS staff were lead in completing both preliminary and final documents necessary to implement MLTSS but had considerable collaboration with DHH Offices of Behavioral Health and Bureau of Health Services Financing. The Office of State Procurement approved the RFP with the sign off of the Legislative Fiscal Office.

This accomplishment is entirely consistent with the OAAS strategic plan and is the single most significant strategy to achieve the goals of the strategic plan.

Managed Medicaid and MLTSS are national best practices which the majority of states have either adopted or are in the process of adopting. Development of Bayou Choices was done according to Guiding Principles published by the Centers for Medicare and Medicaid Services (CMS) using a transparent stakeholder process that had the support of the vast majority of participants and members of the Advisory Group.

#2. Program Enhancements to the Unified Protective Services Structure

In FY2013, Elderly Protective Services (EPS) and Adult Protective Services (APS) were placed under a single management structure. The complete unification of protective services was completed in FY2015 with the cancellation of the last EPS contract office.

Protective Services has worked to enhance the unified structure by using data to support administrative decisions, assessing program quality, and improving program standards and training. The enhancements include the following initiatives:

- The Protective Services data team has developed critical reports to assist with management decisions and to improve productivity and quality.
- Protective Services has restructured its quality assurance process. A comprehensive review of all aspects of case activity from intake to closure was performed. The process established a performance baseline which is being used to set future performance goals.
- Protective Services has revised its training curriculum by using material developed by the National Adult Protection Services Association and Project Master at San Diego State University's Academy for Professional Excellence. Built around practice issues in Adult Protective Services, the training program designed to provide a competency-based, multidisciplinary training to Adult Protective Services investigators.

- Louisiana is participating on the National Adult Protective Services Association Education Committee. The Education Committee focuses on developing educational content for APS workers, improving subject matter expertise, and working with other allied professionals.

The most important benefit created by the improvements to the APS Program is that vulnerable adults and their families receive better and timelier service. Local communities have experienced greater access to services and improved communications at both the local and state level. The State of Louisiana benefits by having a quality program that meets the needs of its citizens.

#3. Continuation of the Nursing Home Quality Innovations Grants

The Nursing Home Quality Innovations Grants Program offers a limited number of small grants of up to \$19,500 each to fund quality improvement projects that will make nursing homes better places to live, work and visit. The grants are funded using civil money penalties collected from nursing homes for regulatory infractions and held in a restricted use fund. Federal law requires that the funds be used for activities that benefit nursing home residents.

In FY15, OAAS awarded Nursing Home Quality Innovations Grants – small grants of up to \$19,500 to fund quality improvement projects that will make nursing homes better places to live, work and visit to nine (9) facilities. The grants are funded using civil money penalties collected from nursing homes for regulatory infractions and held in a restricted use fund.

Five (5) of the grants were for interactive computer systems that were designed to improve therapy outcomes and social engagement. Another facility brought in community volunteers to teach residents computer skills, especially around email and internet use. Two facilities were funded to create “spa” bathing, efforts which relied on improved equipment and atmosphere and on staff training to make the bathing experience less institutional. The final grant was to create a “café” intended to improve social engagement and combat unintended weight loss.

While some staff expressed increased job satisfaction, the clearest beneficiaries of the grants are the nursing home residents. The benefits realized for residents by the grants include:

- Improved participation in activities
- Increased tolerance for therapy and improved therapeutic outcomes
- Increased resident satisfaction

Only one facility failed to meet or exceed established goals, and even that facility managed some improvement as reported by the residents.

#4. Compliance and Audit Team (CAT)

In FY2015, the OAAS Compliance and Audit Team (CAT) continued to conduct audits and targeted assessments designed to assure the quality and accuracy of the LTPCS assessment, eligibility, and resource allocation processes. In this role, the team is also well positioned to discover potential fraud and abuse. CAT partners with Program Integrity and the Attorney General, and findings have led to several referrals to both Medicaid Program Integrity and the Attorney General. The result of these various efforts reduced program cost by 16% (\$37 million) from FY 14 to FY 15.

CAT is aided by strategic data-mining and analysis performed by the OAAS statistical team which discovers patterns that are used to focus CAT efforts and provides data for more complete profiling of

participant and provider performance and behavior. These efforts have led to major improvements in the accuracy of LTPCS eligibility and resource level determinations. Data and audit findings pointing to issues in the assessment contractor's performance were reported and used in the contractor's quality improvement efforts. CAT also affords the State the opportunity to monitor service delivery, therefore adding another resource to the oversight and delivery of LTPCS.

Louisiana taxpayers and citizens in need of long-term care services are the primary beneficiaries of this effort. OAAS' goal in this effort is to make community-based services available to additional citizens and to ensure that those citizens most in need receive those services.

#5. Opened Third PACE Program

OAAS worked with the Franciscan Missionaries of Our Lady Health System (FMOLHS) to develop and open a Program of All-Inclusive Care (PACE) program in Lafayette. PACE Lafayette is the third PACE program in the state. PACE programs coordinate and provide all needed preventive, primary, acute and long term care services so that older individuals can continue living in the community. PACE Lafayette has a capacity of 200 participants. PACE is a viable alternative to institutionalization at 64% of the cost of nursing facilities.

A recent study found that the top diagnoses nationwide among PACE participants are vascular disease, diabetes with chronic complications, congestive heart failure, and chronic obstructive pulmonary disease, and major depressive, bipolar and paranoid disorders. Nearly 47% of PACE enrollees have dementia. PACE participants can remain enrolled in the program if they need to go to a nursing facility. In Louisiana, 94% of all PACE participants live in their community, as compared to the national average of 90%.

Characteristics of PACE programs:

- PACE utilizes interdisciplinary teams including physicians, nurse practitioners, nurses, social workers, therapists, van drivers and aides. The team exchanges information and solves problems as the conditions and needs of each participant changes.
- PACE provides participants regular access to doctors and other primary care professionals who know them and who specialize in caring for older people. This care results in fewer health crises and emergency department visits.
- PACE participants have improved health status and quality of life, lower mortality rates, increased choice in how time is spent, and greater confidence in dealing with life's problems, according to a recent Abt Associates study.
- The PACE financing model combines payments from Medicare and Medicaid or private pay sources into one flat-rate payment to provide the entire range of health care and services, including paying for hospital care, in response to individual needs.
- PACE utilizes transportation systems to enable participants to live as independently as possible in the community while having access to the supportive services, medical specialists, therapies and other medical care they need.

PACE provides an additional opportunity for individuals to be served in the community rather than in an institution.

#6. Monitored In-Home Caregiving (MIHC) Services

The first Monitored In-Home Caregiving (MIHC) provider began offering services to Community Choices Waiver (CCW) participants in 2015. MIHC services allow Community Choices Waiver (CCW) participants to receive care at home from a live-in caregiver. The caregiver receives a daily stipend and is supported by a care team, including a nurse and a care manager. Caregivers are required to submit daily progress notes, which allow the professional MIHC staff to closely monitor the delivery and outcomes of service and provide targeted technical assistance and training to the caregiver.

MIHC providers are responsible for the following:

- Employing professional nursing staff and other professionals to train and support caregivers to perform direct care activities in the home
- Assessing and approving the participant's home
- Having contractual agreements with caregivers who have been approved and trained
- Paying a stipend to the caregiver
- Capturing daily notes electronically to monitor the participant's health and the caregiver's performance

MIHC provides an additional service option to CCW participants wishing to receive necessary care in the home and is the first 24/7 option available under CCW. It benefits those who would otherwise be at high risk of nursing facility placement, and benefits taxpayers by avoiding the higher cost of nursing facility care.

#7. Transition of Permanent Supportive House to a more stable funding source

By the end of State Fiscal Year 2014-2015, sixty-four percent (64%) of Permanent Supportive Housing (PSH) households were transitioned from the temporary revenue source of Community Development Block Grant (CDBG) funded services to a more sustainable revenue source of Medicaid funded services. This is an increase of 23% from State Fiscal Year 2012-2013. Initially, PSH services were funded through a CDBG award. This CDBG funding was a non-renewable source that required a sustainability plan to ensure services would continue for PSH participants. Medicaid services were identified as the sustainable source and have proved to be a cost-effective and efficient way to continue these vital services for PSH participants.

The PSH program strives to house households with disabilities who without support services are not likely to maintain housing. This sustainable funding significantly increases the chances of participants maintaining safe and affordable housing. For many, these services also aid in avoiding institutional settings for their long-term housing solution. PSH has proven to be cost effective for Medicaid. These services coupled with housing reduce both long and short-term hospitalizations, emergency room visits, and long-term institutionalization.

This accomplishment was achieved through the efforts of many partners in the PSH program. OAAS and OCDD both rewrote waivers to include PSH services and facilitated transition of PSH recipients from CDBG funding to waiver participation. For households eligible for behavioral health services under 1915(i), PSH service providers conducted assessments and worked with the State Management Organization (SMO) to transition households to these services.

DHH-OAAS transition to Medicaid funded PSH services is a nationally recognized model and has been the basis for federal legislation seeking to improve housing options for people with disabilities.

#8. Improvements to the Quality Assurance Process and the Environment of Care at Villa Feliciano Medical Center (VFMC)

During FY15, Villa Feliciano Medical Center (VFMC) made significant improvements to the physical plant and continued to use the Quality Assurance/ Performance Improvement (QAPI) to improve practices that directly affect resident quality of life and care.

The major physical plant improvements were:

- Renovations in two of the three buildings that house residents, including a new HVAC, improved lighting and new ceilings
- Improved computer capacity including a move to a wireless internet system and the use of tablets that allow more staff to timely report resident care information
- The development of a training lab for the nursing department
- New furniture for residents

The continued use of the QAPI process, introduced last year, led to a revamp of the record-keeping processes for the hospital and nursing facility and a new system for inventorying and tracking resident clothing.

These changes came about because the leadership remains vigilant to opportunities for improvement and has set in place a process for implementing change that involves staff participation and feedback. Their implementation meant that VFMC not only successfully passed the annual Health Standards survey and the tri-annual hospital inspection, but more importantly they have improved the quality of life for residents.

Do these accomplishments contribute to the success of your strategic plan?

Accomplishments #1, #4-8 and #10 noted above contribute to the OAAS strategic goal, “To expand existing and develop additional community-based services as an alternative to institutional care.” As the State seeks to advance better health through increased reliance on community-based services, there is a corresponding increased need for oversight and protection for those residing in settings that lack the degree of regulation associated with an institutional setting.

Accomplishment #2 APS also contributes to the OAAS Strategic goal, “To timely complete investigations of adult abuse, neglect, exploitation, and extortion in the community” by utilizing best practices and available resources, through the consolidation of Protective Services, OAAS is better able to fulfill its mission to serve adjust with disabilities and to enable them to live free form harm due to abuse, neglect, exploitation or extortion.

Accomplishments #3 and #9 Villa contribute to the OAAS Strategic goal, “To administer and manage patient care programs at Villa Feliciano Medical Complex in a manner that ensures compliance with applicable standards of care; and to promote policies that improve the quality and cost-effectiveness of privately-owned nursing facilities.

Do these accomplishments or their methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?

MLTSS, PACE, and PSH are all nationally recognized best or promising practices. Development of MLTSS was done according to best-practice guidelines for transparent and inclusive policy development. DHH-OAAS transition to Medicaid funded PSH services is a nationally recognized model and has been the basis for federal legislation seeking to improve housing options for people with disabilities. The operation of a single adult protective services program under one agency is far and away the preferred practice nationally.

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

OAAS continues to make steady progress on all strategic goals and objectives.

◆ Please provide a brief analysis of the overall status of your strategic progress.

OAAS is serving more people, and higher percentage of people, in the community than ever before, and at an average cost per person of less than 50% of nursing home cost. OAAS has also increased program efficiency, reduced administrative costs, and improved timely access in several areas including statewide single point of access to community-based services and nursing home facility admissions and reduction of waiting lists for state-funded programs. This is consonant with our major strategic goal to expand access to existing home and community-based services as an alternative to nursing home care, and to develop new alternatives in community-based services.

◆ Where are you making significant progress?

Significant progress is being made in the areas of transitioning individuals from institutions to community-based settings, improving efficiency and quality assurance in HCBS waiver operations, addressing quality in institutional settings, and rationalizing program operations to assure that the Office is providing effective services to as many individuals as possible within available funding.

Money Follows the Person Demonstration (MFP) continues to exceed benchmarks for transitioning individuals from nursing homes to the community. MFP is piloting the use of assessment data to target individuals with greatest potential for success post-transition. The Permanent Supportive Housing program and its pending statewide expansion through the HUD 811 Project Based Rental Assistance Demonstration have become the keystone to a multi-faceted housing strategy. OAAS continues to work closely with the Office of Behavioral Health and contractors to improve timely access to community-based behavioral health services for individuals with mental illness seeking to return to the community from nursing homes.

A new Quality Improvement Strategy was implemented for Medicaid-funded HCBS waiver programs in January 2012 and was reported in last two year's AMPAR report. The approach is more data-driven and outcome focused and shifts OAAS field operations towards training, technical assistance, sampling-based oversight, and performance management. The office has completed four rounds of data-collection using the implemented monitoring protocols and is able to see and report measurable improvements on all federally-reported performance measures. This work has allowed the office to develop provider profiles

from multiple data sources that provide a snapshot of individual provider business patterns and performance. Additional data for program management will become available with complete implementation of the OPTs participant tracking and plan of care system; a system that will also improve the efficiency of OAAS business processes.

OAAS continues to ensure that recipients receive the appropriate services based on their assessed level of need, so that each recipient receives what they need, no more or no less. This resource allocation has proven to be effective and consistent with the level of care needed to meet recipient's needs.

In SFY 14, OAAS hired staff with expert skills and knowledge to create a Compliance and Audit Team (CAT). CAT focused efforts on conducting audit and targeted assessments to control quality and conduct monitoring of the Long-Term Personal Care Services program (LTPCS). CAT has proven to be effective by identifying persons who were incorrectly receiving services through LTCPS and persons who should have been receiving LTPCS services as well as identified potential fraud and abuse of billing of LTPCS Medicaid services. OAAS has also focused efforts on nursing facility level of care reviews to insure that persons meet nursing facility level of care and are appropriate for continued services in a nursing facility. This level of care review process benefits the residents by ensuring that they do not become institutionalized beyond need.

Overall, OAAS continues to meet internal objectives of operating and providing access to Medicaid long term care programs that provide over a billion dollars in direct services to people. In SFY 15, OAAS costs for administering and operating these programs constituted less than 3% of the cost of services delivered.

These successes are due to good program design and policy developed by OAAS staff, and to solid, data-driven decision making by OAAS leadership and staff. State funds available for outside consultation and technical assistance, though limited, have also been important.

Though average per person cost of community-based services may stabilize, cost-avoidance will continue and improve the state's ability to respond to ever growing demand for services to the older adult population.

♦ **Where are you experiencing a significant lack of progress?**

Though OAAS continues to increase the percentage of people services in the community versus those served in nursing facilities, this rebalancing is not reflected in percentage spending. Though the number of person receiving care in nursing facilities is not increasing, Medicaid spending for nursing facility care continues to rise.

Furthermore, delivery of long term services and supports alone is not sufficient to address the significant chronic care needs of the population served by OAAS. Delay in implementing MLTSS means that these conditions remain unaddressed and unmanaged, to the detriment of both quality of life of recipients and cost to the taxpayer.

There is less than expected progress with respect to information technology issues that impact the program goal of "improving access and quality in long-term care programs". OAAS has been working to develop a web-based assessment and care planning system which would make the process of accessing and enrolling in community-based services more efficient and improving the ability to conduct real-time monitoring of participant plans of care.

- ♦ **Has your department revised its strategic plan/business 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?

Our successes are consistent with our current plan.

While the problem issues do impact progress, they are not at the level of strategic or 15 operational planning. Nor are they so critical that they require us to modify our plan.

- ♦ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**

The vision that OAAS maintains on 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 obtain office objectives. Because OAAS administers Medicaid funded programs, OAAS works very closely with that agency and with other offices in DHH to assure strategies and goals are aligned, even going as far as to share and report joint performance indicators with the Medicaid program.

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

There is no significant department management or operational problems or issues that exist.

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

A. Problem/Issue Description

1. What is the nature of the problem or issue?
2. Is the problem or issue affecting the progress of your strategic plan? (See Section

II above.)

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

B. Corrective Actions

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

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

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

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

No. If not, please explain.

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

Please discuss the following:

- a. What are the costs of implementing the corrective actions? Be specific regarding types and amounts of costs.
- b. How much has been expended so far?
- c. Can this investment be managed within your existing budget? If so, does this require reallocation of existing resources? If so, how will this reallocation affect other department efforts?

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

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

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

- Internal audit
- External audits (Example: audits by the Office of the Legislative Auditor)
- 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)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

1. Title of Report or Program Evaluation
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: Tara LeBlanc
 - Title: Deputy Assistant Secretary
 - Agency & Program: Office of Aging and Adult Services
 - Telephone: (225) 219-0223
 - E-mail: tara.leblanc@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
09-324 Louisiana Emergency Response Network

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Executive Director: Paige Hargrove

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

For each accomplishment, please discuss and explain:

A. What was achieved?

1. LERN Board developed and adopted requirements for Level 2 and Level 3 Trauma Programs. Louisiana's statewide trauma system is focused on serving severely injured patients – making sure those patients have timely access to the level of care they require. Often times distance to an ACS verified trauma center prevents injured patients from receiving care within an adequate timeframe. As hospitals work to build trauma programs, LERN recognizes the opportunity to reduce the morbidity and mortality of trauma patients in Louisiana through a process which recognizes the achievement of specific benchmarks in hospitals who are actively pursuing trauma center verification through the American College of Surgeons. To this end, the LERN Board approved a process whereby the CEO of hospitals pursuing Trauma Center verification can sign an affidavit detailing hospital compliance with core components of a trauma program. As of October 2015, three hospitals have signed such affidavits: North Oaks Medical Center, Lafayette General Medical Center, and Lakeview Regional Medical Center.
2. Continue to expand trauma training opportunities across the state in line with the strategic plan. CY to date, LERN has conducted 25 classes (TNCC, ENPC, RTTDC, PHTLS) and 434 students across the state have completed the courses. LERN also provided Trauma Care after Resuscitation (TCAR) to

nurses at the state Trauma Centers/Programs. According to a report titled, The Facts Hurt: A State by State Injury Prevention Policy Report – LA improved from the 8th highest for injury related deaths (80.0/100,000) to 11th highest (75.2/100,000). This was a statistically significant decrease. It is believed by the trauma leaders in the state that this improvement is due to expansion of the trauma system and education efforts across the state.

3. Collaborated with State Police and the Crime lab to educate hospital emergency departments on proper blood specimen collection for DWI sampling.
4. LERN Communication Center assisted in routing 15,602 patients. This is the highest volume since the LCC was established.
5. Developed two stroke education videos: Stroke Education Video (for public) and Stroke Assessment Video (for Hospital and EMS).
6. Developed 12 Lead EKG Assessment Course – 8 hour course for clinical providers (hospital personnel and EMS).

B. Why is this success significant?

1. This is significant because more injured patients are receiving trauma level care from trauma surgeons and staff trained in the care of the severely injured.
2. The primary goal of this workgroup Share ideas, don't re-invent the wheel and seek/share solutions to common problems. This was identified as a goal in our 2014-2015 strategic plan.
3. In Level I, II, and III trauma centers, the hospital must provide a mechanism to offer trauma-related education to nurses involved in trauma care. As the lead agency for the state, LERN is fulfilling this role, removing some of the burden from the trauma centers. This education is required by the ACS for a successful verification visit.
4. Promulgating the structure of the stroke and STEMI system solidifies the state program.
5. An EMS registry is a necessary step towards the development of a trauma system for the state.
6. Without proper sampling cases cannot be prosecuted.
7. The mission of LERN is to defend the public health, safety, and welfare by protecting the people of the state of Louisiana from unnecessary deaths and morbidity due to trauma and time-sensitive illness. Directing critically ill patients to the right hospital, at the right time, for the right care is one mechanism of accomplishing our mission.
8. The state stroke work group identified public education and process for stroke transfer as a gap in the system. These videos address these gaps.
9. Building a STEMI system of care is part of our legislative responsibility. 12 Lead EKG interpretation is necessary to build a successful system. Pre-hospital and ED personnel must be proficient in recognizing the deadly rhythm.
10. This allowed an opportunity for the regional stakeholders to ask questions of the state medical directors and for the networks to fully understand the progress over the last few years.

11. Integration of LERN with ESF-8 is outlined in our enabling Legislation. As the 24 hour a day/365 day a year communications center resource, LERN serves as the “early warning” receptor of mass casualty events. When the LERN Communications Center is notified of a mass casualty that reaches ESF-8 trigger, LERN notifies the region(s) stakeholders and DHH leadership, allowing for mass casualty preparations. LERN participated in multiple table top exercises that proved effective when faced with live events – specifically the theatre shooting in Lafayette, LA.

C. Who benefits and how?

1. The injured patients and their families benefit. Patients are able to get quality trauma care close to home. Their families don't have to travel to other regions to assist in the care or visit them. The EMS providers also benefit by being able to keep their units local and provide better coverage for the communities they serve.
2. The trauma centers and the communities they serve benefit by leveraging the expertise of each trauma program manager across the state to address internal issues.
3. The nurses, paramedics and physicians providing the care benefit by expanding their knowledge base in the care of injured patients. The injured patients receiving the care also benefit.
4. The citizens of the state and anyone visiting the state benefits from a stroke and STEMI system of care. It also benefits the providers (hospital and EMS) by identifying hospitals capable of treating these time sensitive illnesses.
5. The citizens of the State of Louisiana and any visitors to the State benefit because the registry is the mechanism used to evaluate care provided and improve performance.
6. The public/citizens of Louisiana benefit when drunk drivers are taken off the road. Major Saizon reports a 50% reduction in insufficient samples being submitted to the crime lab.
7. The LERN Call Center assists in routing severely injured trauma patients, stroke and STEMI patients. These are all time-sensitive illnesses. The patients benefit by getting to the right hospital as quickly as possible.
8. The public benefits by learning the signs of symptoms of stroke. The education video targets the importance of seeking care immediately and utilizing 911 to ensure the most rapid response and delivery to the right hospital. Patients, EMS and hospital providers benefit from the assessment video. It was noted on several joint commission surveys that there was no consistent assessment process in place for stroke patients being transferred to a higher level of care - specifically monitoring and assessment of stroke patients who received tPA. The assessment video addressed that gap.
9. Nurses and pre-hospital providers benefit by expanding their knowledge base. Most importantly, the patient benefits by early recognition of this deadly heart rhythm. The longer the rhythm goes undiagnosed, the more heart muscle dies and the risk of death.
10. Regional stakeholders benefit by being informed of how the systems of care

are intended to operate. This allows them to communicate effectively to the communities where they live and work. It also allows for networking with other regions.

11. The citizens of the state that benefit. Early notification in relation to disaster preparedness or in response to a mass causality event results in a coordinated response and better outcomes. Hospitals benefit from a coordinated response whereby patients are distributed evenly as not to overload facilities.

D. How was the accomplishment achieved?

1. This was achieved by establishing relationships and securing commitments from community hospitals to pursue trauma center designation. Once the relationships were built, the LERN Trauma Medical Director worked individually with each hospital until they achieved the benchmarks required by the LERN Board. The leadership on the LERN Board was instrumental in developing the Trauma Program requirements and the process for attestation. Each center MUST apply for either a consultation or full review from the American College of Surgeons within 1 year of signing the affidavit. As of October 2015, here is the status of such reviews:
 - i. North Oaks Medical Center – Requested full ACS Level 2 Trauma Center verification review for February 2016
 - ii. Lafayette General Medical Center – Requested full ACS Level 2 Trauma Center verification review for July 2016.
 - iii. Lakeview Regional Medical Center – Requested full ACS Level 3 Trauma Center consultation review for April 2016.
2. This was achieved through the LERN network and through the LA Chapter of the American College of Surgeons Committee on Trauma.
3. The need for LERN to focus on Trauma Education was identified three years and incorporated into the strategic plan. LERN's two tri-regional coordinators lead the effort. The tri-regional model works well in developing relationships with regional partners, identifying gaps in education, and scheduling education programs to fulfill those gaps. Emergency Nursing Pediatric Course was an identified gap. The LERN tri-regional coordinators partnered with the LA Bureau of EMS (EMS- for Children) and became course directors in order to fill that gap.
4. Achieved by working with the state stroke and STEMI workgroups to develop the language for the rule. Obtaining stakeholder buy in was vital to moving the rule through the promulgation process without any public push back.
5. Achieved by including data sharing as a stipulation for EHRIT grant participants. Obtained a grant from the Traffic Records Coordinating Committee (TRCC) for a data assistant. This position has been instrumental in the growth of the registry because he meets one on one with each provider to work through issues or set up needed templates.
6. The need for education was identified at the DOTD Impaired Driving Meeting. LERN is a part of that meeting and invited State Police and the crime lab to present the education at each of the 9 LERN Regional Commission meetings. Each commission has hospital representation. The commission members

- brought the education back to their respective hospitals.
7. We added stroke and STEMI in addition to continuing to route trauma patients. We routed 602 stroke patients in CY 2014.
 8. Achieved by validating the Joint Commission observation with the EMS/hospital providers across the state. This was done via the EMS Stroke workgroup. All agreed that since Tissue Plasminogen Activator (tPA) use and the number of transfers to higher levels of care were increasing that an assessment guideline was needed. The guideline was developed by the workgroup and adopted by the EMS Commission. It was noted that the guideline alone was not sufficient without providing education on the specific content. Therefore, the assessment video was developed. We garnered support from the Bureau of EMS to provide 1 hour of continuing education for any EMT or paramedic completing the post test.
 9. Accomplished by identifying the need via the State STEMI workgroup and via the expertise of our State STEMI Medical Director. The tri-regional coordinators identified regional resources to assist in teach the 6 module course. All of the 8 courses conducted in 2014 have been taught by regional volunteers. 252 students thus far in CY 2014.
 10. Identified need at the regional commission level and was carried out by the LERN Team.
 11. Support for disaster planning activities has been achieved via coordination between ESF-8 leadership and LERN leadership. We have also added disaster preparedness as a strategic priority. The tri-regional coordinators also worked closely with the Governor's Office of Homeland Security and Emergency Preparedness (GHOSEP) rep on their commissions to embed LERN in more table top drills. LERN has also provided on sight training at hospitals and EMS agencies across the state.

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?

1. Yes – leverage the expertise of the Board to establish processes that improve access to specialized care.
2. Yes – working with the LA- ACS/COT has provided many networking opportunities and access to many leading trauma surgeons in the state.
3. Yes- Partnering with EMS for Children (via the LA Bureau of EMS) has been an outstanding collaboration. LERN and EMS-C identified a common goal of providing ENPC across the state. We pooled resources and the result is a broader outreach than if we each tackled the issue alone.
4. Common practice.
5. Yes – engaging stakeholders builds commitment to the system.
6. Yes – Identifying and securing grant opportunities where appropriate.

7. Yes
8. Yes
9. Yes – Utilizing regional resources improves participation and collaboration.
10. Yes
11. 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.

Yes, we are progressing towards meeting the goals and objectives as set forth by our strategic priorities.

- ◆ **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?

1. LERN Mission Sustainability

Strengthen the sustainability of LERN’s mission, including state office operations and the development of an ideal statewide network of designated trauma centers

- Lessen or eliminate LERN’s reliance on state general fund dollars
- Maximize LERN funding from recurring, dedicated sources

Status: Comparative research has been conducted for funding alternatives. 8 options identified. The Executive Committee determined that the best option is to add LERN to an Existing Statutory Dedication and Enhance the Revenue stream. Strategy: Possible legislation in 2016. LERN operations could be added into the intended purpose of the Traumatic Head and Spinal Cord Injury Trust Fund. Penalties in current law for various serious motor vehicle violations could be doubled with half the revenue funding LERN. We continue the Low Income Needy Care Collaborative Agreement (LINCCA) for the Communication Center Staffing contract in order to leverage state general fund dollars.

2. Statewide Trauma Center Network

Build a consensus among key stakeholders for the development of an ideal statewide network of designated trauma centers in Louisiana.

- Develop priority prospects for new Level II or Level III trauma center designations in regions without a trauma center. Secure at least two new commitments from hospitals to pursue ACS Level II or Level III trauma center verification.
- Develop a trauma Program Managers work group.
- Provide trauma training opportunities to all Level providers statewide.
- Fully assess, evaluate and determine the value of adding Level IV trauma designation to the system.

Status:

- Tremendous progress has been made. We have 4 ACS Verified/State Designated Trauma centers in the state. In 2016, two hospitals are scheduled for a verification visit by the ACS for Level 2 trauma center status (Lafayette General and North Oaks Medical Center). Lakeview Regional Medical Center is pursuing Level 3 trauma center designation. We anticipate that by 2017 we will have 6 verified trauma centers in the state. In the 2015 legislative session Senate Concurrent Resolution 42 was passed. This directs LERN to organize and facilitate a working group of healthcare providers who deal with victims of trauma to develop recommendations for a Level III Trauma Center in Northeast Louisiana. A report will be presented in January of 2016.
- Education and outreach for trauma continues via multiple classes for TNCC, RTTDC, PHTLS and ENPC. The LERN Communication Center routed 15,602 patients in 2014.
- The Trauma Program Manager work group was developed (met x2).
- The board evaluated the benefits of adding Level IV trauma centers to the state and adopted the motion to move forward with this in the 2016 legislative session.

3. STEMI Network

Develop a statewide system of STEMI care to improve outcomes for Louisiana citizens regardless of where they live in the state.

- Continue to map geographic distribution of STEMI resources statewide.
- Educate and inform stakeholders of their role in the STEMI System.
- Provide 12 Lead EKG Interpretation education in each region of the state
- Establish ACTION regional report to drive performance

Status: Map of geographic distribution of STEMI resources updated based on new 2015 attestations. Education provided via the tri-regional coordinators at the regional commissions and at the 3 tri-regional meetings conducted statewide. The ESF-8 portal was updated with statewide STEMI resources and the LCC continues to route patients to definitive STEMI care as needed. Rule promulgation for the STEMI system and the STEMI pre-hospital destination protocol completed. 12 Lead EKG education has been provided in Regions 1, 6, and 7. We should have a state ACTION regional report by the end of the year. The LERN Executive Director and the LERN STEMI Medical Director met with 13 of the hospitals that subscribe to the ACTION Registry. 11 of the 13 agreed to participate in the regional report.

4. Stroke Network

Develop a statewide system of stroke care to improve outcomes for Louisiana citizens regardless of where they live in the state.

- Establish stroke physician champions in each region
- Develop education plan for public and providers.
- Refine process to monitor compliance with LERN Stroke Hospital requirements

- In regions w/o an existing PSC or CSC, develop priority prospects & secure commitments from at least one Level III hospital to pursue PSC and one Level IV to pursue Level III status.

Status:

- Stroke champions identified in all regions except for regions 3, 5, and 8.
- Education plan developed. In addition to the education videos, Level 3 stroke tool kit, Stroke Reference Cards, and the Mini NIHSS Cards, we have outlined a webinar series for 2016.
- Monitoring is a work in progress. The Stroke Medical Director reviews the data submitted by level 3 centers and provides feedback.
- LSU Health Shreveport and Willis-Knighton Medical Center are working on becoming a PSC. This will fill the void in Region 7. Eight hospitals advanced to Level III from a level IV. North Oaks Medical Center and St. Tammany Parish Hospital achieved PSC this year.

5. MCI/Disaster Preparedness

Promote LERN as the “information coordinator” for unfolding events in Louisiana on a 24/7 basis.

- Participation in regional activities to integrate LERN into region specific protocols for even management and support.
- Serve as the primary coordinating entity for messaging and notifications regarding events and incidents as they occur
- Maximize regional assets by coordinating patient flow/transport

Status: Provided a LERN update at each of the tri-regional meetings across the state. So far in 2015 we have participated in the following:

2015 Exercises

- State Hurricane Exercise
- Gonzales small scale active shooter drill
- Waterford 3 Plane Crash Drill, June 2015
- Gonzales full scale active shooter drill November 2015
- Acadian MCI Boot Camp, December 2015

2015 Live Events

- Region 4 active shooter, movie theatre
- HL Bourgeois school bomb threat, March 2015

2015 Education/Outreach

- R2 funded LERN training at Emergency Management Institute in Maryland
- St. Tammy District 4, MCI training
- Scheduling education with Motiva
- All Hazard Incident Commander training, Oklahoma (BEMS funded)

- ♦ **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 continues in part due to external factors. Contracting with subject matter experts continues to augment the effectiveness of the LERN staff. LERN continues to collaborate with local, regional and state level stakeholders to continue to build the statewide trauma & time sensitive illness network. Subject matter experts in Trauma Data Systems and the development of the Trauma Registry were instrumental in making progress. The same results would not have been achieved without specific departmental action.

- **Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)**

Yes – Progress is directly related to specific department actions. The tri-regional coordinators work collaboratively with the 9 LERN Regional Commissions to further the trauma network and to build the networks for Stroke and STEMI. The trauma registry and the EMS registry would not exist without LERN leading these efforts. The timely notification processes implemented to ensure key stakeholders are aware and responsive to regional events would not happen without the coordinated efforts of the LERN Communication Center and ESF-8 working together. Policies have been implemented and processes have been embedded into the LCC standard operating procedures. LERN has initiated, supported and implemented every aspect of the Stroke and STEMI system to date. We have reallocated resources to have a more direct focus on outreach and education for the four tiers of LERNs mission: Trauma, Stroke, STEMI, and All Disasters-Response.

- **Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department’s contribution to the joint success?**

Specific department actions have directly related to the success of LERN. Examples include: DHH Health Standards Department has been integral in assisting with the development of rules and regulations for

STEMI/Stroke. They are also an integral part of designating trauma centers in a timely manner. They are also working collaboratively with LERN in the Level IV trauma center development. Kolynda Parker has assisted in running LaHidd data as well as the office of Vital Records. Obtaining LaHidd data has been helpful identifying progress with the stroke network. Data indicates that since 2010 the tPA administration rate has doubled.

- **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?
Building and maintaining systems of care takes time and is a long term commitment. Progress will continue at a steady pace.
- ♦ **Where are you experiencing a significant lack of progress?** If you are experiencing no significant lack of progress, state “None.” However, if you are experiencing a significant lack of progress, identify and discuss goals and objectives that may fall significantly short of the targeted outcome; identify and discuss strategies that are not working well. Be specific; discuss the following for each:

1. **To what do you attribute this lack of progress? For example:**

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

We have made little progress lessening or eliminating LERN’s reliance on state general fund dollars. While we have searched for grant opportunities we have not been successful in identifying available grant dollars that fit LERN’s mission and strategy. Despite budget cuts, 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. It is not the right time politically to pursue those funding sources.

Data collection/registry development for STEMI and Trauma has been difficult. LERN does not have the authority to mandate data collection. Hospitals have a hard time collecting data due to competing priorities. It cost money to hire a data entry person. To deal with STEMI data collection, LERN has had success getting hospitals that already use ACTION Registry to agree to submit their data to a state report. This does not cost them any money. For trauma, we are focusing our efforts on

those facilities working to become trauma centers.

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

The problem will continue until we are in a position where we can successfully pursue passing legislation to fund the system. Most trauma systems are funded via fees or fines associated with DUI, traffic violations or vehicle registration.

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

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

We did not adjust the priorities, but made adjustments to the action plans to achieve each of the priorities.

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 Nurses and the LERN Administrative & Medical Directors.

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

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

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

A. Problem/Issue Description

1. What is the nature of the problem or issue?
LERN operates on 100% State General Fund. This is problematic due to the fiscal condition of the state.
2. Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)
To date, we have adjusted operations to absorb state funding cuts while still meeting our strategic priorities. We are reaching the point where this will no longer be possible. The strategic priority that will be most impacted by future cuts are outreach and education efforts related to trauma.
3. What organizational unit in the department is experiencing the problem or issue?
Louisiana Emergency Response Network in the unit within the Department of Health and Hospitals. DHH has been very supportive and has worked with us in order to best prepare for budget adjustments.
4. Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)
Fortunately, we have adjusted operations to prevent any cuts to the Communication Center and therefore continue to provide assistance to EMS and the ESF-8 network 24/7/365. Going forward, public, hospital and EMS providers will be impacted by reductions in education and support provided.
5. How long has the problem or issue existed?
The state budget has been lean for the past 6 years.
6. What are the causes of the problem or issue? How do you know?
Economic factors such as dropping oil prices and a big decrease in the Medicaid match. This is widely reported by the media and DHH.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue?
Future cuts or changes to LINCCA will result in an inability to operate the communication center 24/7/365.

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)
 - Policy, research, planning, and/or quality assurance functions in-house
 - Policy, research, planning, and/or quality assurance functions by contract
- Review of literature, other best practices, review of other state trauma programs, is performed by LERN staff and consultants, used to guide the implementation

and continued development of the LERN Trauma and Time Sensitive Illness Network

- Program evaluation by in-house staff – Bi-monthly case reviews
- Program evaluation by contract
 - Communications Center staffing provided by contract with AMR. Data is input to the Louisiana State owned ImageTrend system. This system software provides data on calls, time to definitive care, mechanism of injury and transport time. LaHidd data used to evaluate the stroke program.
- Performance Progress Reports (Louisiana Performance Accountability System)
 - LERN reports Performance Indicators quarterly through the LaPAS system
- In-house performance accountability system or process
 - Monthly audits on Communications Center calls. Error statistics on data base with follow-up with each communicator. % secondary transfer log.
- Benchmarking for Best Management Practices
 - Compare state trauma registry data with NTDB data.
- Performance-based contracting (including contract monitoring)
- Peer review
 - The LERN Communicators are required to perform peer review audits on two calls per shift.
- Accreditation review
- Customer/stakeholder feedback
 - Case review process. Tri-regional meetings with 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 Annual Report 2013-2014
2. Date completed February 2015
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 and from the trauma registry.
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) Hard copy and LERN Website www.LERN.la.gov

10. Contact person for more information, including

Name: Paige Hargrove

Title: Executive Director

Agency & Program: Louisiana Emergency Response Network

Telephone: (225)756-3440

E-mail: Paige.Hargrove@la.gov

- a) LERN Annual Report to the Louisiana Legislature and the House and Senate Health and Welfare Committees – submitted in March in compliance with the 2004 LERN Enabling Legislation
- b) Monthly Fiscal Reports submitted to LERN Treasurer, Chairman of the Board and discussed at LERN Board meetings.

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
325 Acadiana Area Human Services District

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Executive Director: Brad Farmer

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

For each accomplishment, please discuss and explain:

- A. **What was achieved?** Acadiana Area Human Services District (AAHSD) pharmacy generated over \$5.32M in Patient Assistance Program (PAP) medication for clients last fiscal year (up from \$5.21M in FY14). AAHSD's SGF expenditures for pharmacy were 3.04% of total pharmacy expenditures for FY15.
- B. **Why is this success significant?** The PAP program is designed to assist clients in obtaining their medications at little to no cost to the client or AAHSD.
- C. **Who benefits and how?** Clients benefit from this as they receive needed medications they otherwise may not be able to afford/obtain. AAHSD is able to utilize resources to provide medications to other clients who otherwise may not be able to afford/obtain medications and may not qualify for PAP medications.
- D. **How was the accomplishment achieved?** PAP staff works under the supervision of the AAHSD Pharmacy Director. The Pharmacy Director and Medical Director maintain close communication to ensure the success of this program.
- E. **Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) Yes
- F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes

- A. **What was achieved?** AAHSD fully implemented contract with Department of Corrections to provide L-SART services as directed by Act 389.
- B. **Why is this success significant?** This process allows AAHSD to participate in prison sentencing reforms directed by Act 389 and to divert persons needing treatment services from being incarcerated.
- C. **Who benefits and how?** The individuals referred benefit via reception of needed services and the state budget is relieved of the cost of incarcerating these persons.
- D. **How was the accomplishment achieved?** This was achieved via contract with Department of Corrections, along with establishment of programming guidelines/protocols within the AAHSD treatment system.
- 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
-
- A. **What was achieved?** AAHSD implemented use of standardized admissions and medical record documentation.
- B. **Why is this success significant?** This allows for greater accuracy in monitoring quality of treatment services, provides for universal template to house client's treatment records – making transfer to another clinic a smooth process if the client moves.
- C. **Who benefits and how?** Clients benefit from an organized system of care documentation by being exposed to reduced repetition of information collection. The system of care benefits by gathering the required information in a timelier manner, allowing for allocation of remaining time/resources to treatment of additional clients.
- D. **How was the accomplishment achieved?** This process was driven from the Quality Improvement Team and involved a representative sample of staff from all clinics across the District. Once the documents were developed into working drafts, all staff was given an opportunity to give feedback to the Team prior to implementation.
- E. **Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) Yes.
- F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes

II. Is your department Five-year Strategic Plan/Business Plan on time and on target for accomplishment? To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

AAHSD submitted our initial five-year Strategic Plan in June 2013. Thus far, our goals and objectives are being met and the plan is on target for successful completion.

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

AAHSD is progressing towards accomplishing goals and objectives, such as: developing clear policy objectives; providing behavioral health treatment services as part of the State's continuum of care; improving accessibility; increasing stakeholders' involvement; and, providing quality services and supports. These strategies are effective in ensuring persons served receive the highest quality care.

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

1. To what do you attribute this success? For example:

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

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

- a. 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.
- b. 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/business plan to build on your successes and address shortfalls?**
 - Yes. If so, what adjustments have been made and how will they address the situation?
 - No. If not, why not?
The AAHSD five-year Strategic Plan gave a clear overview of goals and objectives to accomplish. The plan fully encompasses administrative and programmatic issues for ongoing review/improvement.
- ♦ **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?** Use as much space as needed to explain fully.

All senior managers gave input into the development of the strategic plan and received a copy of the final version. Senior managers shared this with their departments and staff. This strategic plan, along with the annual management report, is made available to all staff and is included as public information on our website so the community at large and other interested stakeholders can be fully informed as to these plans. The Strategic Plan was also shared with our Governing Board.

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

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

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

A. Problem/Issue Description

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

B. Corrective Actions

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

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

2. What corrective actions do you recommend to alleviate or resolve the problem or issue?
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?
4. Are corrective actions underway?
 - a. If so:
 - What is the expected time frame for corrective actions to be implemented and improvements to occur?
 - How much progress has been made and how much additional

progress is needed?

b. If not:

- Why has no action been taken regarding this recommendation?
- What are the obstacles preventing or delaying corrective actions?
- If those obstacles are removed, how soon could you implement corrective actions and generate improvements?

5. Do corrective actions carry a cost?

No. If not, please explain.

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

Please discuss the following:

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

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)
- 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)
 - Contract Monitoring
- Peer review
 - Medical Doctors and OCDD peer review process
- Accreditation review
 - CARF Accreditation—AAHSD received a 3-year accreditation and is seeking reaccreditation.
- Customer/stakeholder feedback
 - Stakeholder Survey
- Other (please specify):
 - Human Services Accountability and Implementation Plan (AIP) 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 2015
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's 2014/2015 budget has been developed and submitted per Division of Administration (DOA) requirements (*at the time of this report, the 2015/2016 budget has also been submitted*).
 - New AAHSD policies have been approved by State Civil Service.
 - Employees have completed Civil Service PES as required.

- The AAHSD Human Resource office has successfully completed a Civil Service audit.
- AAHSD is moving to a new EHR, CareLogic.
- AAHSD has conducted and/or participated in numerous public events, health fairs, community forums, and other professional forums.
- AAHSD has supported other organizations in their efforts to provide crisis services to the community – either through education/training opportunities, funding and/or referrals.

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 DHH officials as well as the entire ‘Acadiana Delegation’. Additionally, this report is posted on our website for public view.

7. Major Recommendations None
8. Action taken in response to the report or evaluation None
9. Availability (hard copy, electronic file, website)
Located in the policy and procedure manual and website
10. Contact person for more information, including
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 2014-2015

Department: Department of Health and Hospitals
09-326 Office of Public Health

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Assistant Secretary: J.T. Lane

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

For each accomplishment, please discuss and explain:

CENTER FOR POPULATION HEALTH INFORMATICS • Improvements to Technology

Accomplishment #1:

A. What was achieved?

Implementation of Electronic Health Records in Parish Health Units (PHU)

For many years the 68 parish health units and 3 specialty clinics throughout the State used an assortment of applications cobbled together to accommodate various needs of the programs that provide clinic services. These applications were completely standalone and primarily accommodated billing requirements for the various clinics. In collaboration with the Louisiana Health Care Quality Forum (LHCQF), OPH has implemented an Electronic Health Records system in all PHUs. Integration with the Louisiana Health Information Exchange (LaHIE) in the near future will allow patient data sharing where appropriate to all participants in the Exchange, contributing to a more integrated system of care as well as strengthening OPH's billing abilities.

B. Why is this success significant?

Having a more robust software program in the health units provides a more functional

health record for a patient, regardless of which location they may visit. It allows for enhanced billing capabilities, which will enable OPH to more fully recoup costs associated with providing many of the services that can be reimbursed, both through Medicaid Managed Care Organizations, and through private payers which OPH has largely been unable to bill in the past. Clinical management capabilities will allow OPH to make informed decisions about the array of services and the staffing conducting them, leading to more efficient and targeted provision of services in the PHU.

C. Who benefits and how?

Both the patients and staff of the health units will benefit if the cost to operate can become more manageable through the use of proven technology. Many program areas that fund services in the health units will also be able to provide more services to more individuals when the costs are reimbursed properly and fully. Patients who present at more than one location will not have duplicate tests and/or treatment. The practice management modules will allow more informed decisions to be made about efficacy of each unit, appropriate staffing levels, and will allow OPH to evaluate how adding or decreasing services can affect workload, clinical care and revenue.

D. How was the accomplishment achieved?

This project was completed with collaboration with the LHCQF, the contractor managing LaHIE, and administration and project management staff from the OPH/CPHI, along with the Medicaid office.

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

Yes. This project directly contributes to Health Information Technology and Infrastructure by allowing consolidation of several disparate systems, and providing a robust tool for clinic management. This was a collaboration between multiple Centers within OPH, with Medicaid under DHH, and with the LHCQF. This project helps us address disparities by providing a standardized clinic management and workflow system and providing detailed encounter data. The revenue generation improvements will directly affect financial stability.

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 project demonstrates a wide range of collaboration between multiple Programs and Offices, bringing an improvement to all of them.

Accomplishment #2:

A. What was achieved?

Restoration of Louisiana Inpatient Discharge Data (LaHIDD), Health Report Card and other Legislatively Mandated Reports

As part of the process to construct the Center for Population Health Informatics (CPHI), a number of positions that had not been permanently anchored in DHH were moved to CPHI, along with the functions that had been assigned to those job titles. LaHIDD had been non-functional for two years as the institutional knowledge required to manage the data in Oracle had been lost; the Health Report Card had last been published using 2010 data. CPHI staff rebuilt the process to receive the LaHIDD data within the subsequent quarter to the report dates, instead of within a year of report as had been the process. These data feed the also-neglected Consumer Right to Know website, which is also in process of being restored. CPHI staff also created a Health Report Card, revamped the website to publish it, and has contracted to build a self-service open data portal for multiple DHH datasets. CPHI also successfully promoted legislation to allow expansion of the LaHIDD data to also include Emergency Department and Ambulatory Care data, allowing OPH to access a much finer view into population health issues. With the convening of the Health Data Panel, CPHI expects to promulgate the Rule to allow the collection of data to begin.

B. Why is this success significant?

These various reports are mandated by legislative acts to provide transparency of healthcare costs to the public, and to provide data to guide DHH about health concerns throughout the state. The accomplishments made have streamlined and simplified the processes to present these data in a much more timely way, and in turn this leads to sustainability for the programs and useful data for the public.

C. Who benefits and how?

DHH benefits from being compliant with the legislation; the public benefits from timely and complete access to important data about health care costs; the OPH benefits from access to a more complete picture of population health, leading to better assessments and interventions.

D. How was the accomplishment achieved?

This project was completed by cooperation between several branches of CPHI, with guidance provided by the DHH Secretary's Office.

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

Yes. This project is an improvement in process and cost in a Health Information Technology; addresses integration with multiple program areas that use these data for

analyses; and allows utilization of the data internally and externally. The Health Data Panel will be part of the external collaborations with medical providers in the state of LA by increased access to population level data. The data will be used, among other purposes, to provide a clearer picture of health disparities that exist in LA.

- 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 project is an example of how to find cost effective and sustainable solutions to problems that were formerly considered too expensive or resource-intensive to manage.

CENTER FOR COMMUNITY AND PREVENTIVE HEALTH • BUREAU OF FAMILY HEALTH PROGRAM • STD HIV PROGRAM • IMMUNIZATION PROGRAM • LABORATORY SERVICES • NUTRITION PROGRAM • TUBERCULOSIS

Accomplishment #3:

- A. What was achieved?

Bureau of Family Health

The DHH-OPH Bureau of Family Health has successfully contributed to the state increasing access to critical reproductive health services by: 1) elevating the quality of reproductive health services in parish health units by implementing new evidence based clinical protocols, including increasing competencies in contraceptive counseling and insertion of long acting reversible contraceptives. 2) elevated the quality and availability of best-practice reproductive health services in primary care settings through a targeted reproductive health quality collaborative; 3) actively contributed to enrollment of patients into the state's new Take Charge Plus Program, as well as worked in partnership with Medicaid to develop marketing strategies for the program 4) worked to implement an electronic health record system for reproductive health services in PHUs, which will contribute to an improved patient care experience as well as the financial sustainability and productivity of the program.

- B. Why is this success significant?

Maximizing access to high quality reproductive health services in Louisiana is essential to improve the state's birth outcomes, prevent unintended pregnancy, and address the high rate of sexually transmitted infections. In addition, efforts to increase the efficiency, quality, and utilization of OPH reproductive health services is essential to ensure that OPH is viable as the state's go-to clinical provider of choice.

- C. Who benefits and how?

The citizens of Louisiana will benefit by increased access to high quality reproductive health services. OPH will benefit by ensuring that services are state-of-the-art, efficient,

and better supported by self-generated revenue.

D. How was the accomplishment achieved?

The accomplishments achieved to date set the stage for impact on priority reproductive health outcomes. This was achieved through staff who have aggressively sought to understand and prepare the state for the changing healthcare landscape of coverage and quality. However, the actualization of the intended health outcomes will depend on continued successful implementation of the established work plans.

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

Yes. Reproductive Health is one of OPH's current agency "Big Bets."

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

The collaboration between DHH-OPH and DHH-Medicaid to develop the plans for expanded services has been a productive and valuable model of synergy between programs. In addition, the BFH RHP plan demonstrates the strength of aligning of public health programs with national standards for clinical quality (HEDIS, CHIPRA, Healthy People 2020). Practice changes in PHUs realized through clinical quality improvement should certainly, when fully realized, represent a best management practice.

Accomplishment #4:

A. What was achieved?

STD/HIV

In order to address the high rates of syphilis in the Shreveport area, the STD/HIV Program formed a Shreveport Syphilis Response Task Force, which includes community leaders, key stakeholders, OPH staff and CDC federal assignees. The Task Force developed a syphilis action plan, and five Task Force subcommittees (Media/Communications, Outreach, Evaluation, Provider Education, and Youth Advisory) carried out activities outlined in the plan. Successes include increased ability of the parish health unit to effectively serve more clients; reached over 200 medical providers through educational outreach activities; established public/private partnerships to address structural barriers that affected testing and treatment; and encouraged providers to offer services to clients during non-traditional hours. From 2014 through June 2015, early infectious syphilis decreased by 19% in Shreveport.

B. Why is this success significant?

In 2013, Shreveport had both the highest syphilis rate and the highest number of cases in the state. Activities conducted by the Task Force have increased the number of persons

tested and treated for syphilis in a timely manner and has led to a decrease in new infections in Shreveport.

C. Who benefits and how?

Individuals living with syphilis and partners at risk have benefited from the Shreveport Task Force activities by getting tested and treated earlier. Untreated syphilis can cause significant long-term complications and can also be passed from mothers to their children, greatly increasing the risk of stillbirth, miscarriage and health issues for the infant.

D. How was the accomplishment achieved?

The project has been successful due to Louisiana's strong and mature HIV surveillance program and a philosophy of using those data for informed public health action. Staff examines surveillance data to identify persons with HIV who are not in medical care and reach out to them in a confidential and compassionate manner, assisting them with a variety of challenges in order to get them established in care.

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

Yes. These activities are directly related to the Program's key indicators to: 1) increase the proportion of persons living with HIV, who are linked to HIV medical care, and who are virally suppressed, and 2) ensure persons with syphilis are treated in a timely manner.

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

Yes. These activities are directly related to the Program's key indicators to: 1) increase the proportion of persons living with HIV who are linked to HIV medical care and who are virally suppressed, and 2) ensure persons with syphilis are treated in a timely manner.

Accomplishment #5:

A. What was achieved?

Immunization

In keeping with our programmatic goals of increasing immunization rates statewide, the Louisiana OPH Immunization Program has markedly increased our Reminder Recall efforts during the previous year. Reminder Recall is a tool used to "remind" parents when a child is due or overdue for a vaccination. By reminding parents, we can better keep children on-track to complete vaccination series. The OPH Immunization Program has partnered with several immunization advocates in the State, and are now doing monthly reminder recall for all children under age 2. We are currently researching expansion of this program to all children under age 18.

B. Why is this success significant?

Reminder Recall lets parents know when a vaccination is due, prompting them to make an appointment with their healthcare provider. National guidance recommends client reminder and recall interventions based on strong evidence of effectiveness in improving vaccination rates. Given how complex the vaccination schedule is, this tool makes it so parents and providers don't have to remember, they get a postcard and then a phone call reminder to make the next appointment. Reminder Recall helps keep children on track to complete the vaccination series, an area where Louisiana falls behind.

C. Who benefits and how?

Parents, providers, and communities as a whole benefit from Reminder Recall. Immunizations are seen as a "cornerstone" of pediatric and childhood health. By seeing a physician regularly for vaccinations, all aspects of health and development can be assessed.

D. How was the accomplishment achieved?

OPH has achieved success with the Reminder Recall effort by partnering with other immunization advocates who have a vested interest in immunizing children on time. In addition, by partnering with advocates with resources, we now do our monthly reminder recall at no cost to the State, which is a huge achievement.

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

Monthly Reminder Recall will certainly contribute to higher immunization rates and on-time vaccination. This is directly in line with our strategic goal of having 75% of our <35months of age be vaccinated against 4:3:3:3:1:1.

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

Yes, we have partnered with our community to share the task of ensuring children are vaccinated. We use the Immunization Registry (LINKS) to provide data about who is lacking a vaccination, and our partners provide financial resources to pay for the postcards and telephone calls.

Accomplishment #6:

A. What was achieved?

Laboratory Services

The OPH Laboratory was relocated from Metairie to Baton Rouge as of January 23, 2015. The lab also began a Lean Six Sigma performance improvement project which is

aimed at improving the efficiency of processes and aligning staffing with the amount of testing that needs to be accomplished within the timelines required.

B. Why is this success significant?

The relocation of the laboratory will allow more timely completion of existing testing due to a more reliable physical location and it will allow the lab to bring testing back in house that was outsourced after hurricane Katrina in 2005.

C. Who benefits and how?

Each of the over thirty programs and their clients that use OPH laboratory services will benefit from more timely and reliable testing.

D. How was the accomplishment achieved?

This is was a long term agency project that included coordination with the Office of Facilities Planning and Control and the Office of State Buildings.

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

This contributes to the OPH Laboratories business plan by having allowed the consolidation of the services provided by the Lake Charles, Metairie and Shreveport Laboratories. This has lowered the lab building overhead cost and has allowed the laboratory to move into an up to date facility that meets all current laboratory safety and security standards.

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

This will allow the OPH Laboratory to move towards best management practices that would not have been possible in the temporary post Katrina facility due to facilities and space limitations.

Accomplishment #7:

A. What was achieved?

Nutrition Services Reorganization

Historically, Nutrition Services State Office relied on nutrition educators to conduct vendor monitoring visits for over 700 retail vendors annually. This procedure proved to be massive and State Office fell behind with the enforcement of vendor violations for retail vendor as a result. It was determined that Nutrition Services State Office must regain indirect supervision of vendor monitoring to ensure federal compliance. As a part of the Nutrition Services Reorganization Plan, Nutrition Services collaborated with

Sanitarian Services to integrate WIC vendor monitoring into the routine sanitarian inspections where sanitarians conduct WIC vendor monitor visits and report all results directly to WIC State Office. Sanitarians were oriented and trained by Nutrition Services and the new vendor monitor process commenced in 2014. Sanitarians were able to absorb these new duties without disruption of their routine duties. Nutrition Services is now able to immediately enforce requisite actions to ensure policy and procedure compliance as a result of this new process for vendor monitoring.

B. Why is this success significant?

The successful reorganization is significant as it provides an opportunity to recruit more highly skilled talent to manage WIC's Vendor Operations Unit, which must implement a complex cost containment strategy in order to comply with USDA regulations. In addition, the newly created position of Program Monitor to act as the Vendor Relations / Communications Liaison is a position consistent with other state WIC programs and will serve to engage the WIC vendor stakeholders as the program prepares to implement *eWIC*, an Electronic Benefits Transfer (EBT) solution, which USDA mandates by 2020.

C. Who benefits and how?

The benefits realized from the reorganization will be felt by the agency, the program, the vendor stakeholders and the public. In that, this opportunity will allow Nutrition Services to recruit more highly skilled talent to manage WIC's Vendor Operations Unit, which must implement a complex cost containment strategy in order to comply with USDA regulations.

D. How was the accomplishment achieved?

Nutrition Services engaged nationally-renown experts from the Altarum Institute to provide professional consultation to overhaul the Program, which included a comprehensive assessment of the Program's structure and staffing. In addition to Altarum's recommendations, successful completion was largely due to a high level of OPH Administration support. This effort took a great deal of communication and coordination with Civil Service, DHH and OPH Human Resources.

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

Through the reorganization of personnel and their respective activities, it is expected that Nutrition Services will increase its efficiencies and compliance of WIC Vendor Operations in order to provide the highest level of service to ensure robust cost containment and effective vendor management. By improving the program's level of capability to serve the needs of the industry and the public, this reorganization supports the goals of the OPH 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, interdepartmental collaboration has proven to be of benefit to the organization to streamline the WIC Vendor inspection process while simultaneously inspecting the overall sanitary compliance of the store. The OPH Sanitarians possess the requisite skill-set to objectively appraise stores, report findings and conduct follow-ups. The leveraging of resources between “sister” Programs (Nutrition Services and Sanitarian Services) is efficient from a personnel, work product, and cost perspective.

Accomplishment #8:

A. What was achieved?

Tuberculosis

The Tuberculosis Program was able to reduce the TB case rate (cases/100,000 population) to 12% below the National case rate and reduce the TB cases rate by 41% over the last five years. In addition the HIV+/TB Cases were reduced by 59% over the last five years.

IMPACT: OUTCOMES AND PERFORMANCE INDICATORS			
Year**	Measure: Cases	State Case Rate*	National Case Rate*
2014	121	2.6	3.0
2013	139	3.0	3.0
2012	149	3.3	3.1
2011	167	3.7	3.4
2010	200	4.4	3.6
2009	194	4.3	3.8
2008	227	5.4	4.2

*Cases/100,000 population

**Calendar Year

This rate reduction decreases the risk of TB exposure in Louisiana. In addition, the Louisiana TB Control Program is using all the modern tools (GenXpert, T-SPOT.TB and INH/Rifapentine 12 dose prevention) that have been developed since 2009 to diagnose and treat more contacts and High Risk individuals. Resources that were saved treating fewer cases were used to increase screening and prevention to reduce case rates further.

B. Why is this success significant?

This is a significant because no other state has reduced the TB Case rate by 41% over the last five years.

C. Who benefits and how?

The reduction of cases/case rate in Louisiana reduces the risk of exposure for individuals, especially high risk individuals (children and immune compromised individuals).

D. How was the accomplishment achieved?

The Louisiana TB Control Program applied three new tools (GenXpert, T-SPOT.TB and INH/Rifapentine 12 dose prevention) to reduce the case rate.

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

Yes, this accomplishment exceeds the goal for case rate reduction in the Louisiana TB Control 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, but only to the extent that new tools should be identified for other disease control programs to reduce morbidity.

CENTER FOR ENVIRONMENTAL HEALTH • Engineering Services

Accomplishment #9:

A. What was achieved?

Amoeba Surveillance and Response Activities

In August of 2014, as part of the amoeba response activities, DHH launched the Amoeba Surveillance Program (ASP). Under this program DHH conducts strategic amoeba sampling of public water systems and drinking water sources for *Naegleria fowleri*. DHH has collected 431 water samples from 54 public water systems. *Naegleria fowleri* has been detected in 21 water samples from 7 public water systems in the state. At the direction of DHH, the affected public water systems take corrective action to eliminate the amoeba from the water system. DHH conducts follow-up sampling to determine if *Naegleria fowleri* has been eliminated from the system.

B. Why is this success significant?

Under this program DHH now has the ability to detect and eliminate *Naegleria fowleri* from public water systems. In addition, the water quality data which has been collected is providing important scientific data to develop rules and regulations in order to reduce risk of infection of Louisiana resident and visitors from *Naegleria fowleri* in drinking water.

C. Who benefits and how?

Safe drinking water benefits all Louisiana residents and visitors.

D. How was the accomplishment achieved?

By employing multidisciplinary strategies combining agency resources and expertise with private sector assistance, and increasing staff overtime over an extended period of time, DHH was able to collect and analyze water samples, determine corrective actions, and effectively monitor public water systems.

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

Yes. Engineering Services, through its Public Health Engineering activities, provides a regulatory framework which will reduce the risk of public exposure to contaminated drinking water, which can cause illness or deaths.

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 effort took coordination and cooperation between the local officials, water systems, both Engineering Services and Laboratory Services and the private sector.

CENTER FOR VITAL RECORDS AND STATISTICS • LEERS

Accomplishment #10:

A. What was achieved?

PORTAL/RESTRUCTURED VITAL RECORDS/QUALITY MANAGEMENT UNIT

The LEERS portal was launched for use by DCFS Child Support Enforcement to view paternity information. This allows credentialed case workers real-time access to Vital Records database information to ensure instant and accurate identification of paternity information for child support enforcement purposes.

Vital Records restructured from paper record management to a modern, quality-based approach through the establishment of a Quality Management Unit. This unit is tasked with the communication, training, and improvement of registration processes with stakeholders statewide in an effort to improve the quality and timeliness of data. By improving the timeliness and quality of data, Louisiana Vital Records is able to receive higher rates of compensation for providing this data to national organizations such as the Centers for Disease Control and Prevention, and Social Security Administration. In addition, by improving data, researchers are better able to use the information collected on vital records to apply to research aimed at improving health outcomes.

Under the newly-formed Quality Management Unit and its predecessor transition staff, Vital Records continued to manage a grant awarded from the National Center for Health Statistics to reduce registration times for death certificates and increase the number of death records signed electronically. At the one-year halfway point of the contract period, all target marks continue to be exceeded.

B. Why is this success significant?

This allows credentialed DCFS Support Enforcement case workers real-time access to Vital Records birth information to ensure instant and accurate identification of paternity information for child support enforcement purposes.

The Quality Management Unit is tasked with the communication, training, and improvement of registration processes with stakeholders statewide in an effort to improve the quality and timeliness of data.

C. Who benefits and how?

The LEERS DCFS Support Enforcement portal benefits Louisiana families by providing accurate child support information more quickly and streamline processes between the two programs that were previously manual.

By improving the timeliness and quality of data, Louisiana Vital Records is able to receive higher rates of compensation for providing this data to national organizations such as the Centers for Disease Control and Prevention, and Social Security Administration. In addition, by improving data, researchers are better able to use the information collected on vital records to apply to research aimed at improving health outcomes.

D. How was the accomplishment achieved?

The LEERS DCFS portal was created in a joint effort by Vital Records and the DCFS Support Enforcement.

Vital Records restructuring took place through strategic planning and organizational needs. This was guided by a shift to become more efficient in the electronic record registration process.

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

Using existing LEERS infrastructure to benefit other state agencies such as DCFS is one of the planned and ongoing benefits of an electronic registration system, and supports Vital Records' strategic plan of fully utilizing LEERS to maximize its benefit to Louisiana residents and other programs.

By focusing efforts on improving the quality and timeliness of Vital Records data, the Quality Management Unit directly contributes to the success of Vital Records' strategic

plan.

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

Yes. The creation of the LEERS DCFS Support Enforcement portal represents an example of state agencies working across silos to share technology in an effort to better serve Louisiana residents. Rather than relying on the previous manual system, modifications to LEERS allowed an existing solution to be used to support the needs of another agency.

The establishment of a Quality Management Unit allowed Vital Records as an organization to better align its structure with its current operations and goals. After undergoing such a radical shift in operations from a pen and paper based system to nearly completely electronic, it was necessary to adapt the structure and focus of the organization to improve the quality and timeliness of vital record data. Reorganization allowed the efficiencies realized from electronic registration to be used to draw down additional grant funding and maximize contract payments by improving the data that Vital Records provides.

Accomplishment #11:

- A. What was achieved?

Health Promotion • Well-Ahead

Well-Ahead Louisiana is a statewide initiative focused on creating healthy environments where Louisiana residents live, work, learn and play. Launched in April 2014, the program is the State's first initiative to coordinate evidence based strategies for health promotion across multiple sectors. To date, over 1,000 organizations in communities across Louisiana have adopted tobacco free policies and met other wellness benchmarks. This initiative benefits all Louisiana residents by ensuring they have the opportunity to make healthy choices. Well-Ahead Louisiana has increased Health Promotion productivity, specifically in the area of worksite wellness. The effort to coordinate work across programs and agencies within DHH is a management best practice.

- B. Why is this success significant?

This is the first time in DHH history a statewide initiative with government, private sector, and community support has been created to address Louisiana's enormous burden of chronic disease. Over 1,200 organizations in all 64 parishes have voluntarily adopted Well-Ahead Louisiana benchmarks. In response to the overwhelming support for the initiative, DHH staff streamlined their organizational structure and process for providing technical assistance on the development of these benchmarks. Furthermore, the initiative is grounded in national best practice for population health improvement and will be evaluated by Pennington Biomedical Research Center to ensure the financial investment

in Well-Ahead Louisiana is truly tied to an improvement in the state's health outcomes.

C. Who benefits and how?

This initiative benefits all Louisiana residents by ensuring they have the opportunity to make healthy choices.

D. How was the accomplishment achieved?

This accomplishment was achieved by the Well-Ahead Louisiana staff.

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

Yes. The Health Promotion Team is on track and aligned to meet its strategic plan goals.

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

Yes. The effort to coordinate work across programs and agencies within DHH is a best management practice.

Accomplishment #12:

A. What was achieved?

BUREAU OF PRIMARY CARE AND RURAL HEALTH • Community and Rural Health Clinic Development • School Based Health Clinics

The Bureau of Primary Care and Rural Health (BPCRHR) provided hands-on technical assistance to 20 rural providers working towards development of 20 rural health clinics (RHCs). Nine of those providers opened RHCs in 2014-2015. Since July 1, 2011 BPCRHR provided technical assistance resulting in the opening of 28 RHCs.

The Adolescent School Health Program completed 17 Quality Assurance reviews with one site having 17 clinics.

62 school based health clinics are all connected to the Louisiana Health Information Exchange, with plans to flow data through their electronic health records.

Based Health Centers continue to provide primary medical and behavioral health to students on site. A total of 119,008 students visited these centers last fiscal year.

B. Why is this success significant?

Additional RHCs provide increased access to primary care services for Louisiana's rural and underserved residents and helps to assure a safety net of preventive health services.

Quality Assurance reviews are important because they verify compliance with the OPH/LCS contract and the *Principles, Standards and Guidelines for School- Based Health Centers (SBHCs) in Louisiana* as well as identify best practices in SBHC quality of care, identify barriers to continuous quality improvements in SBHC care, assess the quality of clinical services and data management by examining the SBHCs progress toward achieving goals set for identified core sentinel conditions, recommend improvements to better serve the students in LA SBHCs and certify that the SBHC qualifies to continue operating under the auspices of OPH.

LAHIE will allow data to be readily available from all of our school based health centers.

The success of SBHCs is significant because it improves health care outcomes for students and families and aids in eliminating barriers to learning by providing healthcare to those who otherwise would have no access.

C. Who benefits and how?

All residents living in rural and underserved areas of Louisiana benefit from rural health clinics by increasing access to quality health care services. The students receiving service in the SBHCs benefit from the provision of quality care in the school based health centers. The Quality Assurance (QA) reviews assure that these services will be provided. Readily available SBHC data provides necessary information for all stakeholders and substantiate the need for SBHCs. Healthy children encourage healthy families. Louisiana benefits if our students are healthier, test scores improve. The overall health of all of our citizens improves as healthy life style choices are introduced in the homes via the SBHCs.

D. How was the accomplishment achieved?

Hands on technical assistance. This was accomplished through many visits, phone calls, data support, emails, etc. Funding for this was accomplished through a combination of federal Funds and state funding.

The adolescent school health program has two program monitors, a QA consultant and two Behavioral health consultants, as well as peer reviewers to provide the QA services. LAHIE services are provided through a partnership with the Louisiana Healthcare Quality Forum.

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

Yes, School based health centers continuously provide quality health care services to students on the school campuses which contributes to the elimination of health disparities by providing services to those that would otherwise have no healthcare. This is accomplished through collaborative efforts statewide. The development of rural health clinics increases local access to primary health care for residents living in rural 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. Our school-based health centers strive to provide for healthier students, thus effecting educational and local economic outcomes. Students stay in school while receiving preventative health care services thus limiting the student's time away from school and the need for parents to miss work.

Accomplishment #13:

- A. What was achieved?

Bureau of Emergency Medical Services

Full Integration of eLicense Portal: BEMS modernized its technology infrastructure in order to simplify and strengthen the licensure/credentialing process. The result is a complete migration to an e-License Portal system that provides robust audit, tracking, and credentialing features, as well as a simultaneous migration to electronic payments in the form of credit and debit cards. EMS practitioners are now credentialed using state-of-the-art technology that integrates seamlessly with the National Registry of Emergency Medical Technicians (NREMT) certification verification processes. In doing so, the state achieves 100% audit throughout on every license application received. EMS practitioners, employers and the citizens of Louisiana benefit from this in a variety of ways. Time to licensure has been reduced from over 30 days to a mere hours (4 hours or less). The applicant audit trail is more robust, resulting in the development of a stronger, credentialed workforce. This in turn provides better value to Louisiana taxpayers and improves the health of the public. After careful consideration of all readily available and viable platforms, the Louisiana Bureau of EMS teamed with a nationally recognized vendor who services nearly 30 states nationwide. This is a proven credentialing resource with the history, background and infrastructure to handle the 20,000 plus EMS professionals licensed in Louisiana alone. This accomplishment directly contributes to the success of the BEMS' strategic plan by addressing a critical component of the Bureau's Title 40:1133.1 mandate, which is to "provide the issuance of license, renewal of licenses, and requirements for emergency medical practitioners." This accomplishment and its methodology clearly represent a Best Management Practice that should be shared with other executive branch departments or agencies. The cost savings to EMS practitioners in the forms of reduced payment processing fees, the lack of any need for certified and overnight mailing of paper applications, non-reliance upon securing money order, reduced opportunities for human error and the expediency with which licenses can be processed are all key components of implementing a sound and sustainable credentialing infrastructure in any agency that issues licenses.

- B. Why is this success significant?

With this accomplishment, the state achieves 100% audit on every license application received.

C. Who benefits and how?

EMS practitioners, employers and the citizens of Louisiana benefit from this in a variety of ways. Time to licensure has been reduced from over 30 days to a mere 4 hours or less. The applicant audit trail is more robust, resulting in the development of a stronger, credentialed workforce. This in turn provides better value to Louisiana taxpayers and improves the health of the public.

D. How was the accomplishment achieved?

After careful consideration of all readily available and viable platforms, the Louisiana Bureau of EMS teamed with a nationally recognized vendor who services nearly 30 states nationwide. This is a proven credentialing resource with the history, background and infrastructure to handle the 20,000 plus EMS professionals licensed in Louisiana alone.

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

This accomplishment directly contributes to the success of the BEMS' strategic plan by addressing a critical component of the Bureau's Title 40:1133.1 mandate, which is to "provide the issuance of license, renewal of licenses, and requirements for emergency medical practitioners."

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

This accomplishment and its methodology clearly represent a Best Management Practice that should be shared with other executive branch departments or agencies. The cost savings to EMS practitioners in the forms of reduced payment processing fees, the lack of any need for certified and overnight mailing of paper applications, non-reliance upon securing money order, reduced opportunities for human error and the expediency with which licenses can be processed are all key components of implementing a sound and sustainable credentialing infrastructure in any agency that issues licenses.

Accomplishment #14:

A. What was achieved?

Bureau Of Emergency Medical Services•Integrated BEMS with GOHSEP, WebEOC and the LWIN Interoperability Platforms:

BEMS moved the Bureau substantially forward with respect to its operational preparedness during a disaster declaration by forging a strong partnership with the Governor's Office of Homeland Security & Emergency Preparedness. This in turn lead to BEMS obtaining its very own 16-channel talk group within the construct of the

Louisiana Wireless Information Network¹, BEMS becoming fully integrated into WebEOC², and obtaining a seat at the ESF-8 branch within the State EOC at GOHSEP.

B. Why is this success significant?

This accomplishment lead to BEMS obtaining its very own 16-channel talk group within the construct of the Louisiana Wireless Information Network³, BEMS becoming fully integrated into WebEOC⁴, and obtaining a seat at the ESF-8 branch within the State EOC at GOHSEP.

C. Who benefits and how?

The agency and the citizens of Louisiana benefit from these advances innumerable. From the agency standpoint, these three measures are tools, used by response agencies in 64 parishes that heretofore were left simply untapped. Integration into the state EOC, LWIN and WebEOC bring BEMS into alignment with statewide disaster planning, and provides the record keeping and request tracking required to assure proper levels of financial reimbursement from FEMA. To the public, this means their disaster response agencies at tribal, local, parish and state levels are communicating in real-time, over approved platforms endorsed by state and federal partners. This improves the time intervals of assets requests through deployment by truncating the time it takes to move patients, the sick and infirmed out of the way of harm.

D. How was the accomplishment achieved?

Over the course of 2014, BEMS completed the hiring of its professional team of program managers, with subject matter expertise in EMS operations, training, education, state government administration, law enforcement, grants management and disaster preparedness. The result has been acceptance, buy-in and inclusion in state and local planning initiatives. Additionally, BEMS embarked upon and completed initial drafts of disaster plans with a focus on being swift, operational, NIMS compliant and defensible.

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

This accomplishment contributes to the success of the BEMS strategic plan, particularly with respect to Strategic Initiative 1.1—*Promote Collaborative Approaches*, 1.2—*Coordinate responses to emergencies both natural and man-made*, and 3.3—*Upgrade technology and communication*. These strategic goals call for BEMS to interface with EMS agencies, hospitals and other organizations to derive at meaningful collaboration;

¹ The Louisiana Wireless Information Network (LWIN) is the largest statewide radio system in the country. It provides daily voice communications to more than 79,000 users at the Federal, State, local and nongovernmental levels.

² WebEOC is the State's official emergency management software system. All 64 Parishes, as well as State and Federal agencies and approved non-governmental emergency management partners (NGOs) use it to monitor and manage activities before, during and after an emergency or disaster.

³ The Louisiana Wireless Information Network (LWIN) is the largest statewide radio system in the country. It provides daily voice communications to more than 79,000 users at the Federal, State, local and nongovernmental levels.

⁴ WebEOC is the State's official emergency management software system. All 64 Parishes, as well as State and Federal agencies and approved non-governmental emergency management partners (NGOs) use it to monitor and manage activities before, during and after an emergency or disaster.

support, coordination and maintenance of deployable emergency response resources. BEMS accomplishes this by incorporating strategies to develop emergency response plans that address the four phases of an emergency (preparedness, mitigation, response, and recovery) exercising the plan, and leveraging technology to foster efficiency and derive at cost savings for Louisiana’s citizens.

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

These accomplishments and their methodologies represent Best Management Practices that should be shared with other executive branch departments or agencies. Mitigating interagency disconnects, working together and avoiding plan stagnation are significant outgrowths of the various post-Katarina, Rita, Gustav and Ike after action reports (AARs).

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?

BUREAU OF FAMILY HEALTH

Three main elements to the OPH-Bureau of Family Health Reproductive Health Program plan: 1) Maximize the quality, efficiency, and use of OPH clinical reproductive health services; 2) Lead a fruitful Reproductive Health Quality Collaborative to increase the capacity of community primary care settings (e.g. FQHCs) to implement quality reproductive health services; 3) Maximize enrollment in the state’s coverage options for family planning services.

IMMUNIZATION

Yes, the LOPH Immunization Program is on target to achieve program goals and objectives. Strategies include vaccine provision, assessment of both vaccination rates and practices, quality assurance, and technology to ensure providers and parents can participate in the “on time” vaccination of children. We expect by investing in these strategies, we will see an overall increase in our vaccination rates within 3-5 years.

LABORATORY

Yes, construction was completed as was the move into the new Baton Rouge

Laboratory. We are currently using a LEAN/Six Sigma project to improve laboratory operations efficiency in the new facility and to detect issues with customer/client services and organizational effectiveness. Some efficiencies related to better facilities with more reliable HVAC and electric service have been noted.

NUTRITION

Nutrition Services is working to reorganize internal operations.

VITAL RECORDS AND STATISTICS

Vital Records' achievements during the previous fiscal year align with anticipated goals of reducing registration times while improving the quality of data collected. The creation of the DCFS Support Enforcement Portal in LEERS is a practical application of the utility of a fully-electronic birth registration system, and serves to reduce manual oversight of a process that can now be done more quickly and with more responsive results as an automated process.

The establishment of the Quality Management Unit is an important step in the strategic plan for Vital Records as its overall mission shifts from time-consuming manual processes to automation and analysis. This analysis of data will be followed by regular communication with stakeholders to continue to improve the quality and timeliness of data collected from them.

ENGINEERING

Of the 4 performance indicators in the Business Plan, one target was exceeded for all four quarters and one target exceeded for three of the quarters. Two targets were not met for the four quarters.

HEALTH PROMOTION • Well-Ahead

The Health Promotion Team is on track to meet its strategic plan goals. In order to measure progress toward these goals, the team renewed and enhanced an evaluation contract with Pennington Biomedical Research Center (PBRC). PBRC will implement a coordinated evaluation of all the team's activities and progress toward performance measures. During quarterly meetings with PBRC, the team will identify areas of progress and impediment and actively work to resolve problems in real time. This is a marked improvement from past practice, where problems were typically not noticed or identified until the end of a grant year or grant cycle.

CENTER FOR COMMUNITY PREPAREDNESS

Louisiana's emergency preparedness efforts contribute to the overall success of the agency's core function of emergency preparedness. Louisiana's efforts in emergency preparedness are considered best practices and have been spotlighted in CDC's *Public Health Preparedness: Strengthening the Nation's Emergency Response State by State and Trust for America's: Ready or Not? Protecting the Public from Diseases, Disasters and Bioterrorism Report*. The department's all-hazards preparedness approach to disasters has been tested through many exercises and real-world events.

Once tested, the agency reviews, reevaluates and updates plans according to those lessons learned and national standards. This process has proven effective in moving the state towards being a leader in emergency preparedness planning and response.

It should be noted that the American College of Emergency Physicians report released in January 2014 ranked Louisiana 3rd in Disaster Preparedness. Louisiana was seen as having strong plans and protocols to serve medical fragile patients as well as above average rates of nurses who received emergency training. Further in the Preparedness Report Released in January 2015 Louisiana met all indicators in the following:

- ▶ Laboratories: Biological and Chemical
- ▶ Response Readiness: Emergency Operations Coordination
- ▶ Administrative Preparedness

BUREAU OF PRIMARY CARE AND RURAL HEALTH • Community and Rural Health Clinic Development • School-based Health Clinics

The BPCRH provides a great deal of hands-on technical assistance from the beginning thoughts of practice development in rural areas to sustainability support for RHCs after they are developed. Typically RHC development takes one to one and a half years to develop in Louisiana. The BPCRH provides regulatory knowledge, connections to needed programs, and other services required during RHC development. Timeliness of these services depends on many factors including health standards staffing, CMS regulations, and follow through of providers.

BUREAU OF EMERGENCY MEDICAL SERVICES

Yes. The BEMS strategic plan is on target. Recent review of the initial plan, as it has transitioned to being comprehensive 5-year plan, reveals that the anticipated outcomes—goals and objectives—are being attained as expected (even better in some cases) and that the BEMS’ strategies are working as expected and proceeding on schedule.

♦ **Where are you making significant progress?**

LABORATORY

Replacement of staff lost due to laboratory relocation and consolidation is occurring at an accelerated rate.

ENGINEERING

Significant improvement was made in *Plans Review* with meeting the required review time frames.

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?**
- **Education**

BEMS has seen an uptick of first-time passing rates for EMT level candidates of approximately 14% over 2013 pass rates. This is due to placing emphasis on site visits, conducting more frequent instructor updates, furnishing instructors with visualized data and candidly discussing methods and expectations with instructors face-to-face. Also, the implementation of a program manager for education and training with a certified teaching background has paid dividends to the strategic goals of supplying quality education and certification of EMS personnel. Louisiana was openly recognized by NASEMSO in early 2015 for being the first state on record to hire a certified teacher as an education program manager. Not implementing these approaches would likely have resulted in little to no positive movement with passing trends.

Using the eLicense Portal as both a licensing and training clearing house has greatly attributed to increasing the oversight and efficiency of training audits and review. For the foreseeable future, this does not represent a one-time gain, but rather a sustainable ascension toward even greater outcomes across all EMS certification/license levels

BEMS has done away with paper applications, processing money orders for payment and issuing paper licenses that were devoid of bar codes, magnetic strips, QR codes, holograms, or photos. The result has been a drastic decrease in applicant cost, and rapid turnaround of license applications reviewed and issued. This is due to modernizing technology, increasing efficiency in the application process and introducing a robust quality improvement program in Louisiana. Switching to an electronic application system has reduced costs for EMS professionals seeking to practice in Louisiana, saving approximately \$185,000 in the first year of implementation in the form of money order fees, certified mail and expedited shipping costs associated with hard copy applications. Not implementing these approaches would have resulted in no improvements to the processing cycle, which previously took anywhere from 30 to 40 days to complete. Opportunity for error was also significant as form could be lost, destroyed in transit and processing money order payments cost taxpayers more. Investments made in information technology have allowed BEMS to streamline processes, refocus on compliance and expand education efforts, thus improving the quality of care provided by EMS professionals and creating a better, stronger EMS industry in Louisiana

IMMUNIZATION

No, this is directly a result of committed hard work on the part of the immunization community.

LABORATORY

Increase speed of staff replacement if due to LSS Program and engagement of all parties in the process.

Is progress directly related to specific department actions? (For example: Have you reallocated resources to emphasize excellence in particular areas? Have you initiated new policies or activities to address particular issues or needs? Have you utilized technology or other methodologies to achieve economies or improve service delivery?)

IMMUNIZATION

Using technology and community partnerships, the Louisiana OPH Immunization Program has increased reminder recall efforts from one or twice a year in the past three years to now monthly.

LABORATORY

Department supporting both LSS program and staff recruitment.

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.

IMMUNIZATION

This is a partnership between the State, the Immunization Registry, and community advocates who all bring resources to the table to make our Reminder Recall effort successful.

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

IMMUNIZATION

No, this is not a one-time gain. Monthly Reminder Recall will continue to improve Louisiana vaccination rates in the future. The OPH Immunization Program also plans to expand the program to other age groups to achieve overall high vaccination rates.

LABORATORY

This is in response to a onetime event but, the progress made will be applied to recruitment and retention efforts in the future.

BUREAU OF FAMILY HEALTH

BFH RHP is making significant progress in setting standards for quality clinical care. Updating clinical protocols according to national guidelines for evidence based care has modernized the array of services available through PHUs. BFH RHP has tapped into a variety of national expertise and brought technical assistance and training opportunities to Louisiana, including technical assistance from UCSF to hold LARC

Trainings with PHUs on September 16 – 18. This was an evidence-based training, provided by the UCSF Bixby Center, that has had great results and been proven to reduce unintended pregnancies. It covered all LARC methods, medical eligibility

criteria for each, how to reduce barriers to access in your clinic, counseling best practices, and insertion.

Significant progress has been realized with the establishment and depth of key partnerships external to OPH in regard to statewide reproductive health champions and other potential provider types, such as FQHCs and Rural Health Centers.

The Louisiana RHP is nationally recognized as a leader in the delivery and management of reproductive health services.

OPH-BFH allocated resources to hire and grow a lean strategic team who have been traveling extensively to work directly with the experts in the field (clinic staff) and get their assistance to refine, improve, and implement the work plan.

HIV/STD

The STD/HIV Program is making substantial progress toward goals related to HIV and syphilis testing, linkage to HIV medical care and timely syphilis treatment, and viral suppression among persons living with HIV. The success of linkage-to-care efforts has been a result of successful competition for federal grant funds, the strong data collection and management practices regarding surveillance data, and careful, compassionate engagement of persons with HIV and syphilis.

IMMUNIZATION

No, this is not a one-time gain. Monthly Reminder Recall will continue to improve Louisiana vaccination rates in the future. The OPH Immunization Program also plans to expand the program to other age groups to achieve overall high vaccination rates.

ENGINEERING

No, other Targets require improvement, so priority will shift to those Targets.

- ♦ **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:

ENGINEERING

The *Sanitary Survey* target was not met due to staff turnover, difficulty in recruiting and position vacancies. It was also due to staff having to devote so much time toward the amoeba surveillance/response activities and expedited plans review times. The amoeba surveillance/response while new and an emergency, have been incorporated into the Engineering Services normal duties. Staff turnover is unpredictable and dependent on DHH offering competitive salaries in order to retain competent qualified staff.

The *Water Safe to Drink* target was not met due to the implementation of new EPA drinking water regulations such as the Stage 2 Disinfection By-products Rule. This

performance indicator is a direct measure of the water system compliance with drinking water regulations. Public water systems normally need time and assistance to learn how to balance between existing regulations and new drinking water regulations. DHH provides technical assistance and training workshops for all new regulations and issues administrative orders to ensure compliance with the drinking water regulations. However, additional funding is needed for these water systems to comply with regulations.

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?

ENGINEERING

Yes, priority was shifted to the *Plans Review* target.

- 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.

ENGINEERING

Yes, lack of progress was also due to staffing issues. Corrective action is to be fully staffed and train new staff quickly as possible to meet all targets.

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?

BUREAU OF FAMILY HEALTH

Progress towards realizing productivity and efficiency goals has been slower than anticipated.

Expertise related to practice management is not fully and cohesively integrated into the OPH organizational structure

Efforts to improve quality and productivity related to OPH clinical services is not operating from a common plan

Limited investment in staff to manage clinical revenue processes, though a new department recently established in OPH as well as having an EHR will hopefully go a long way towards building this capacity

The current PHU staffing mix (type, number, and location) and their skills may require changes in order to optimize the quality and efficiency of the OPH clinical

care system

Other public health priorities, such as emergency response, may be a competing priority with clinical services or clinical quality improvement activities

With regard to increasing access to reproductive health services in other settings (FQHCs and RHCs), barriers inherent in existing payment models and financing mechanisms have proved challenging and complicated to work through.

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

ENGINEERING

No. If not, why not?

OPH did not revise its strategic plan in FY 2015, but is laying the groundwork for the development of the new five-year strategic plan that is due on June 30, 2016.

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

The formulation of the OPH strategic plan adheres to management strategies implemented by the Executive Management Team. These strategies, at a minimum, include:

- ♦ **Training:** Ongoing training is provided to ensure staff develops the necessary skills to understand and apply the concepts of the OPH strategic plan.
- ♦ **Input:** Gathering input from all levels of the agency's functional areas. Discussions are conducted with Team Leaders and participants representing functional areas essential to support agency priorities.
- ♦ **Communication:** Receiving and sending information at the central office.
- ♦ **Performance measurement:** Formulation of objectives that are specific, measurable, attainable, results oriented and time-bound. Performance indicators are formulated to ensure monitoring of progress in goal/objective attainment.
- ♦ **Evaluation:** The Strategic Plan will be revised, as warranted, to reflect fiscal, managerial and programmatic changes. These revisions will be conducted using the same strategies as the original plan, as warranted. Plan revisions will utilize strategies that are pertinent to the task at hand.

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

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question.

A. Problem/Issue Description

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

NUTRITION

WIC Vendor Management has been sighted to have significant issues as a result of the SFY 2014 Legislative Auditor’s Report.

ENGINEERING

There has been high staff turnover in Engineering Services, which can be attributed to the laboratory move.

Is the problem or issue affecting the progress of your strategic plan?

No.

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

ENGINEERING

Staff turnover has affected all areas of Engineering Services including Central Office and Regional offices and the OPH Laboratory.

ENGINEERING

Stakeholders are affected when there is staff turnover because there are delays in permitting plans reviews, performing sanitary surveys and complications with sample collection and analysis.

3. How long has the problem or issue existed?

ENGINEERING

Over 2 years

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

ENGINEERING

There are multiple factors associated with the staff turnover.

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

NUTRITION

Grant funding may be jeopardized

ENGINEERING

There is a large learning curve for new employees that start a career with Engineering Services. A new employee must be trained in federal and state regulations, design standards, compliance data entry, field work, plan review, technical assistance activities, and enforcement actions. Senior personnel invest a lot of time in training, mentoring, and assisting a new employee. Therefore, a senior level or more experienced staff member losses impacts productivity and time spent training the new person. When the new person vacates a position for an opportunity elsewhere, all of the time and energy vested is lost and the process must start over.

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

Staff turnover.

B. Corrective Actions

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

NUTRITION

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

2. **What corrective actions do you recommend to alleviate or resolve the problem or issue?** Corrective action recommendations were made by LLA and therefore the Nutrition Services Reorganization is underway.
3. **Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?** Yes
4. **Are corrective actions underway?** Yes
 - a. If so:
 - What is the expected time frame for corrective actions to be implemented and improvements to occur? 1-3 years
 - How much progress has been made and how much additional progress is needed? Progress is at about 25% with 75% 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.)

Contract Personnel-\$69,350

Re-allocation of current organizational structure and salaries-\$50,000

Contracting Professional Services-\$49,885

Please discuss the following:

- a. What are the costs of implementing the corrective actions? See above
Be specific regarding types and amounts of costs. Personnel
- b. How much has been expended so far? Undetermined
- c. Can this investment be managed within your existing budget? Yes
If so, does this require reallocation of existing resources? Yes
If so, how will this reallocation affect other department efforts? No affect
- 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. Please see above
 - Have these resources been requested in your budget request for the upcoming fiscal year or in previous department budget requests? Yes

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)
- 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)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

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

BUREAU OF FAMILY HEALTH

1. Targeted Chart Review
2. Monthly audits with quarterly central office review
3. Chart reviews are a standard quality assurance practice in direct service
4. Review tool designed by program which is commensurate with industry standards
5. Staff costs – RN Nurse Consultant time and field staff time. No cost for the specific report
6. Top Opportunities for Improvement Noted:
 1. All documents which required signature and dates completed
 2. Visit Type documented
 3. Any required referral & follow-up documented
 4. Most current forms used
 5. Medicaid eligibility verification document available from date of visit (if appropriate)
7. Major Recommendations - All areas have implemented corrective actions to correct and monitor these activities. All indicators have demonstrated steady improvement each quarter.
8. Action taken in response to the report or evaluation - Nurse Consultant provided

regional technical assistance to all regions regarding results and corrective action plan.

9. Availability – hard copy and electronic version
10. Contact person for more information, including
 - Name: Gail Gibson
 - Title: OPH BFH Nurse Consultant
 - Agency & Program: OPH
 - Telephone: 504-568-3504
 - E-mail: gail.gibson@la.gov

1. Clinic Flow Analysis
2. Quarterly reports submitted to OPH BFH
3. Clinic flow analysis are a standard quality assurance practice in direct service and are a cornerstone of the program's goal to improve productivity
4. Review tool designed by program which is commensurate with industry standards
5. Staff costs – RN Nurse Consultant time and field staff time. No cost for the specific report
6. Top Opportunities for Improvement Noted: The data collected in the spring clinic analysis showed a crucial need to continue monitoring and improving our clinic flow. As demonstrated by the data collected in the spring our clients:
 1. Experience increased overall time within the clinic (120 - 160 minutes)
 2. Experience increased wait time (45 - 60 minutes)
7. Major Recommendations - The bottlenecks and opportunities for improvement included:
 1. Registration process
 2. Scheduling
 3. Staff utilization (esp. RN & support staff)
 4. Space utilization (includes both use and availability of space for clinic)
8. Action taken in response to the report or evaluation - Nurse Consultant provided regional technical assistance to all regions regarding results and corrective action plan.
9. Availability – hard copy and electronic version
10. Contact person for more information, including
 - Name: Gail Gibson
 - Title: BFH Nurse Consultant
 - Agency & Program: OPH
 - Telephone: 504-568-3504
 - E-mail: gail.gibson@la.gov

In addition to the reports above, an annual comprehensive site assessment is completed in the fall according to the federal Title X quality assurance tool.

HIV/STD

1. Title of Report or Program Evaluation: Semi-Annual Evaluation Report: Addressing Louisiana Inequities in HIV and AIDS, CARE and Prevention in the United States (CAPUS) Demonstration Project
2. Date completed: November 2014 and May 2015
3. Subject or purpose and reason for initiation of the analysis or evaluation: The STD/HIV Program contracted with Policy and Research Group (PRG) to complete an evaluation of SHP's CAPUS project on a semi-annual basis. The reports provide formative feedback on the implementation of each of the six CAPUS strategies and progress towards meeting project objectives. CAPUS strategies aim to significantly impact HIV inequities and health disparities among racial and ethnic minorities in Louisiana, particularly African Americans and men who have sex with men who bear the greatest HIV burden in the state.
4. Methodology used for analysis or evaluation: PRG's semi-annual evaluation plan specifies program implementation and outcome objectives and their empirical measures. On a semi-annual basis, aggregate and client-level data collected by SHP are de-identified and submitted to PRG using a secure VPN protocol. PRG produces a report that presents descriptive information in tabular and graphic form on each of the indicators and describes progress made towards meeting the objectives of each of the six strategies. The six strategies are 1) implementation of a new Laboratory Information Management System (LIMS); 2) LA Links, which is a linkage/re-engagement to care and patient navigation intervention; 3) expanded routine opt-out HIV testing in emergency rooms and clinics; 4) Health Models; which is a pay-for-performance-based linkage/re-engagement to care and treatment adherence intervention in three community-based HIV specialty clinics; 5) social marketing campaigns to reduce HIV testing-related stigma and ensure people know where to access HIV testing services; and 6) capacity building strategy to increase awareness of and undo institutional racism and structural homophobia.
5. Cost (allocation of in-house resources or purchase price): \$14,000
6. Major Findings and Conclusions: The report highlighted several findings: 1) Although the LA Links intervention was not on target to meet the enrollment objectives, a high proportion of LA Links clients linked to medical care (83%) and received referrals to support services (94%). 2) Health Model enrollment numbers and the number of incentives distributed exceeded the targets; 84% of clients were retained in care, and 67% maintained viral suppression. 3) The expanded testing objectives were on track to be met. 4) Social marketing objectives were met. Two social marketing campaigns were implemented and members of target communities were involved in the planning and implementation of the campaigns. 5) The report highlighted the success of the Undoing Racism and Deconstructing Homophobia workshops. Participant satisfaction scores were very high, and participant's knowledge of health disparities and self-efficacy to address institutional racism and homophobia increased from pre to post-workshop assessments.
7. Major Recommendations: The report did not list recommendations.
8. Action taken in response to the report or evaluation: Based on the success of LA

Links, continued funding has been obtained and the program is currently being expanded to additional regions of the state. A work group (SHP Design Team) has been established to continue to work on the priority issues identified during the workshops.

9. Availability (hard copy, electronic file, website): hard copy or electronic file
10. Contact person for more information, including
 - Name: DeAnn Gruber
 - Title: STD/HIV Program Director
 - Agency & Program: Department of Health and Hospital's Office of Public Health, STD/HIV Program
 - Telephone: (504) 568-7474
 - E-mail: deann.gruber@la.gov

THE OPH IMMUNIZATION PROGRAM

1. Title of Report or Program Evaluation: 2014 Financial Audit Services Management Letter
2. Date completed: December 3, 2014
3. Subject or purpose and reason for initiation of the analysis or evaluation: Internal control and compliance testing of Immunization Cooperative Agreements Program (CDFA 93.268).
4. Methodology used for analysis or evaluation: Legislative audit
5. Cost (allocation of in-house resources or purchase price): No cost to OPH
6. Major Findings and Conclusions: Lack of controls over immunization vaccine
7. Major Recommendations: OPH does not have procedures in place for overseeing program-enrolled immunization providers to ensure proper recording of the receipt, transfer, and usage of vaccines.
8. Action taken in response to the report or evaluation: Refinement of the controlling and verifying the input of vaccine, review of provider editing capabilities and improved inventory counts at immunization provider locations.
9. Availability (hard copy, electronic file, website): Electronic file
10. Contact person for more information:

Name: Stacy Hall
 Title: OPH Immunization Program Director
 Agency & Program: Louisiana Office of Public Health
 Telephone: 504-838-5300
 E-mail: stacy.hall@la.gov

1. Title of Report or Program Evaluation: 2014 CDC Immunization Services Division Technical Assistance Site Visit Report for Louisiana
2. Date completed: March 19, 2014
3. Subject or purpose and reason for initiation of the analysis or evaluation: The

purpose of the annual CDC site visit is to follow-up on past issues and recommendations, confirm continued progress and fulfillment of the cooperative agreement objectives, and to provide consultation and assistance concerning programmatic and technical matters.

4. Methodology used for analysis or evaluation: Site Visit
5. Cost (allocation of in-house resources or purchase price): No cost to OPH
6. Major Findings and Conclusions: Four recommendations were made within the Vaccines for Children topic area.
7. Major Recommendations: Major Recommendations were in the sub-topic areas of training, staffing and program planning.
8. Action taken in response to the report or evaluation: The OPH Immunization Program responded to these recommendations by improving training through monthly conference calls and adjusting staffing assignments as detailed in the VFC/AFIX Site-Visit Restructuring 2015 document.
9. Availability (hard copy, electronic file, website): Electronic file
10. Contact person for more information:
 Name: Stacy Hall
 Title: Immunization Program Director
 Agency & Program: Louisiana Office of Public Health
 Telephone: 504-838-5300
 E-mail: stacy.hall@la.gov

NUTRITION

1. Title of Report or Program Evaluation: Louisiana Legislative Auditor's Report
2. Date completed October 9, 2013
3. Subject or purpose and reason for initiation of the analysis or evaluation:
Performance Audit
4. Methodology used for analysis or evaluation
5. Cost (allocation of in-house resources or purchase price)- No cost
6. Major Findings and Conclusions-Majors flaws in vendor operations
7. Major Recommendations-Vendor overhaul
8. Action taken in response to the report or evaluation: Nutrition Services Reorganization Plan
9. Availability (hard copy, electronic file, website) all 3
10. Contact person for more information, including
 Name: Karen Chustz
 Title: Program Manager 3/Nutrition Services Director
 Agency & Program: DHH/OPH/Nutrition Services/WIC Program
 Telephone:504-568-8258
 E-mail: Karen.Chustz@la.gov

ENGINEERING

1. Title of Report or Program Evaluation: EPA End-of-Year Review and EPA

Data Audit

2. Date completed
October 30, 2015
3. Subject or purpose and reason for initiation of the analysis or evaluation
Required by primacy and federal grant funding.
4. Methodology used for analysis or evaluation
Onsite interview and audit by EPA
5. Cost (allocation of in-house resources or purchase price) NA
6. Major Findings and Conclusions
Program has met the EPA primacy requirements
7. Major Recommendations
EPA recommended that DHH continue to dedicate resources to ensure State adoption of the last promulgated drinking water rules, Ground Water Rule and Revised Total Coliform Rule.
8. Action taken in response to the report or evaluation
Program will continue to devote time to work on adopting and implementing new drinking water regulations
9. Availability (hard copy, electronic file, website) Hard copy
10. Contact person for more information, including
Name: Amanda Laughlin
Title: Chief Engineer
Agency & Program: DHH OPH Engineering Services
Telephone: 225-342-7499
E-mail: Amanda.Laughlin@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: **Department of Health and Hospitals**
09-330 Office of Behavioral Health

Department Head: **Kathy Kliebert, Secretary**

Undersecretary: **Jeff Reynolds**

Assistant Secretary: **Rochelle Head-Dunham**

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

The Office of Behavioral Health (OBH) achieved eight major accomplishments during the fiscal year under review: (1) new onboarding and offboarding programs; (2) development of Behavioral Health Crisis Support Cadre; (3) implementation of ICD-10 in hospitals; (4) opioid antagonist/naloxone legislation; (5) general Coordinated System of Care (CSoC) accomplishments; (6) implementation of new evidence-based practices for first episode psychosis; (7) implementation of new evidence-based practices for transition-aged youth; and (8) Network for the Improvement of Addiction Treatment (NIATx) Strategic Provider Partnerships Collaborative.

Accomplishment #1: Employee Onboarding and Offboarding

A. What was achieved?

OBH developed an onboarding program for new employees, which is a supported process through which new employees gain knowledge and build relationships with the goal of quickly and successfully integrating into OBH. Offboarding is an administrative process surrounding an employee's exit from an organization once there has been the decision to separate from the agency, and includes managing payments, exit interviews, health insurance, and transfer of work and property. Offboarding is a natural expansion of an onboarding program in that it completes the lifecycle of an employee, and allows the employee to leave the agency on good terms, regardless of the situation.

B. Why is this success significant?

An initial survey was deployed for existing staff that was designed to explore the various onboarding activities (if any) that they experienced upon their arrival. While some employees reported that they felt well-oriented and were provided relevant information timely, the majority indicated that information received was spotty, and the process for finding information hard to decipher. The Onboarding Program attempts to remedy this confusion and dissatisfaction for new employees.

C. Who benefits and how?

Research has demonstrated that onboarding techniques lead to positive outcomes for new employees such as higher job satisfaction, better job performance, greater organizational commitment, and reduction in occupational stress and intent to quit. While the program has only been recently launched, new employees have responded favorably to the program and indicated that they felt supported and were provided with very useful information about the agency and its operations. Existing employees, including the new employee's supervisor, have stated that the resources and processes developed for the program help them to impart important information in more structured way.

D. How was the accomplishment achieved?

The OBH Executive Management Team (EMT) recognized that the existing orientation/onboarding program at OBH was inconsistent and lacking; new employees had a wide range of experiences upon joining OBH ranging from detailed orientation processes to arriving without having adequate workspace available. They wanted to obtain the advantages of increased retention and increased engagement that onboarding programs provide to organizations, and contacted the Louisiana Civil Service Comprehensive Public Training Program (CPTP) to help develop a structured onboarding program to help achieve these goals for the agency.

The development of the onboarding program at OBH took shape over the course of one year and included the following steps:

1. Assignment of OBH liaison
2. Initial office-wide survey created and deployed
3. OBH Onboarding Task Force created
4. Definitions of onboarding and orientation clarified
5. Information and resources gathered
6. Identification and development of missing pieces
7. Organization of relevant information and material into a time-based program
8. Development of roles

9. Development of supporting checklists
10. Role assignment and training
11. Deployment of test run
12. Office-wide rollout and full implementation
13. Evaluation

Based on materials and resources developed for the program, specific roles were created in order to communicate information in the most logical way:

Ambassador – partners with a new employee during his/her first two months of employment. While primarily responsible for offering advice and guidance regarding the day-to-day aspects of working at OBH, the ambassador may also offer encouragement, knowledge, and resources as they help introduce the new employee to the OBH culture.

Human Resources Liaison – provides an essential link between the department's human resources and hiring functions and the OBH Onboarding Program. The DHH Human Resources liaison provides guidance and technical assistance to help new hires navigate the human resources processes.

Logistics Coordinator – ensures that all new employees have the necessary resources and equipment to begin work right away, and to provide guidance regarding the operational aspects of working at OBH.

Onboarding Coordinator – facilitates the design and delivery of the Onboarding Program, assists all Onboarding Coordinators in their roles, provides technical assistance, and troubleshoots problems.

Safety and Emergency Preparedness Coordinator – ensures that all new employees understand their role in department emergency preparedness and response, and have the resources necessary for maintaining a safe and productive workplace.

Supervisor – in addition to traditional supervisory responsibilities, helps the new employee acclimate to the culture and values of the agency, clearly explains expectations to ensure a smooth transition, and ultimately offers resources for the new employee to succeed in their new position.

Training Coordinator – assists all new employees with their understanding of the mandatory agency training requirements, how to access training, and where to obtain help.

- E. Does this accomplishment contribute to the success of your strategic plan/Business Plan?

Yes. OBH supports the personal and professional development of agency staff,

which ultimately helps to contribute to the success of the agency strategic plan.

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

Yes. Onboarding is widely supported as a best management practice in the private sector but less so in government agencies. Since the contents and structure of onboarding initiatives tend to vary depending on the agency mission and culture, the OBH Onboarding Program was developed based on needs identification and is continually modified as internal best practices are identified. The commitment to onboarding itself as a best management practice could benefit other executive branch departments or agencies.

Accomplishment #2: Behavioral Health Crisis Support Cadre

- A. What was achieved?

OBH Emergency Preparedness' efforts resulted in the development and implementation of a Behavioral Health Crisis Support Cadre to offer assistance/support to individuals in need of crisis/grief and loss assistance in traumatic events beyond the capability of state/local response systems. OBH identified a core behavioral health crisis support cadre in 2014 and developed a peer training model to respond to crisis situations as required statewide. Training was conducted between January and May 2015 using four modules covering crisis intervention, grief and loss, trauma informed approaches in crisis intervention, and suicide post-vention strategies to increase the capacity of behavioral health staff to provide needed support to survivors and staff in special crisis situations.

- B. Why is this success significant?

OBH is the pre-identified and pre-positioned resource within the state that provides ad hoc deployment of the behavioral health crisis counseling/support resource when there is a layoff, death or suicide, or unexpected loss involving staff (e.g. specific incidents occurred over past few years within other state agencies include: employee deaths, employee suicide at the workplace, hospital layoffs, incident with domestic violence involving clients, death of insurance agents, death involving domestic violence within our own parent agency).

The loss of federal resources has resulted in a gap in the capacity of the office to fulfill requests to provide grief and loss counseling and specialized crisis support by experienced and trained staff. The number of agency requests for staff support has continued to increase as employees are more overwhelmed in their professional and personal lives, and more often than not find themselves in

stressful situations where they lack sufficient coping skills to deal with additional challenges.

C. Who benefits and how?

Internal and external state partners and the DHH/ESF-8 responder community at large during a catastrophic event will benefit from support offered by the cadre. The impact of the services provided by the OBH Louisiana Spirit Crisis Counseling Program post Hurricanes in 2005, 2008, and 2012, and the 2010 Deepwater Horizon Oil Spill is that agencies continue to look to OBH for ongoing crisis support. The absence of an Employee Assistance Program also increases the need for some level of support when an employee is in crisis (also a past request to OBH). OBH has provided crisis support to DHH employees and other external state partners and stakeholders when requested. OBH staff works with the agency leadership and staff in a supportive role to conduct groups, meet with individuals requesting a “one-on-one” brief employee assistance session, provide self-help/awareness resources, and recommend referral to local behavioral health providers for treatment when indicated.

D. How was the accomplishment achieved?

The Emergency Preparedness section developed a strategy and proposed training curriculum to improve capability of the office to respond to the multiple requests for employee crisis support. A select number of clinical and other professional staff was recommended to be assigned this role in addition to their current OBH roles. With EMT approval and further consultation, the specific modules were developed and Behavioral Health Crisis Support/Incident Response trainings commenced in January 2015 for 26 appointees.

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

The required trainings and function of the cadre are based on modules created by members of their peers. The initial concept for this cadre is based on the modified SAMHSA Crisis Counseling and Training Program model (OBH Louisiana Spirit). This practice would be of most benefit to other states with similar behavioral health structures. This practice would also complement the Crisis Counseling Program (CCP) in a presidentially-declared event and the modules added to the required CCP training model by all States implementing the program. Other executive branch departments and agencies could benefit from some of the trainings to help them raise awareness, identify potential risk factors, and provide an understanding of how to better support their employees and improve overall safety of the workplace.

The effectiveness of this cadre and the application of the skills-based training are evident as most of the requests for support come from agencies that are repeat recipients of the services offered.

Accomplishment #3: Implementation of ICD-10 in State-run Hospitals

A. What was achieved?

In accordance with 45 CFR Part 162, providers began using the International Classification of Diseases, version 10 (ICD-10) for diagnoses October 1, 2015. This covers any provider who is considered a covered entity under HIPAA. While this applies to all Office of Behavioral Health (OBH) contractors that submit Medicare or Medicaid claims, it also applies to the OBH state psychiatric hospitals, which use the Patient Information Portal Electronic Medical Record (PIP) system to bill for Medicaid/Medicare.

B. Why is this success significant?

The success of ICD-10 implementation for the state psychiatric hospitals indicates continued compliance with Centers for Medicare/Medicaid (CMS) directives utilizing the current PIP system.

C. Who benefits and how?

The state psychiatric hospitals benefit as they will be using ICD-10 coding for billing Medicaid and Medicare claims. This will ensure continuity in reimbursement through the ICD-10 change.

D. How was the accomplishment achieved?

The OBH Health Informatics team created a small workgroup to determine how the new codes would be implemented in the PIP systems. Because coders enter diagnostic information into the system, Health Informatics determined the best course of action would be to include all ICD-10 codes in the PIP system and allow coders to convert DSM5 coding into the corresponding ICD-10 codes. The PIP system houses both ICD-10 codes and descriptors. Historical information will be both Diagnostic and Statistical Manual of Mental Disorders, version 4 (DSM-IV) and ICD-9 codes for diagnoses pre-dating October 1, 2015.

In addition, a certified coder at the Central Louisiana State Hospital was provided AHIMA training and given the responsibility of monitoring ongoing ICD-10 activities for both hospitals and reporting to OBH Health Informatics. OBH and the hospitals expect issues to arise, but a plan of action is in place to address these issues.

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

Yes, OBH continues to support the refinement and enhancement of the system of care for the state hospitals. The successful use of ICD-10 coding ensures the availability of detailed diagnostic data in the future.

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

Yes, from a team and resource perspective, the success of this project represents best management practices in utilizing available resources. From an achievement perspective, ICD-10 compliance is mandatory for HIPAA-covered entities and all departments outside of OBH should be compliant.

Accomplishment #4: Opioid Antagonist/Naloxone Legislation

A. What was achieved?

Each year, about 17,000 people die as a result of an opioid overdose. Naloxone is a drug that reverses the effects of respiratory depression following heavy opioid use, resulting in a significantly decreased likelihood of death following an overdose. Administration of naloxone in a medical setting is standard practice for hospital medical staff and first responders caring for a patient who has overdosed on opioids. Research has demonstrated naloxone to be safe, successful, non-addictive, and cost-effective. During the 2015 Regular Legislative Session, OBH worked with the bill author of Act 192 (of the 2015 R.L.S.) to pass legislation allowing Licensed Healthcare Providers to prescribe take-home naloxone to individuals who are at risk of overdose, such as persons taking prescription opioid painkillers and heroin users, and to third parties who may need to administer the opiate antagonist in suspected overdose situations. The legislation also created criminal and civil immunity protections for laypersons to administer naloxone or other opioid antagonists.

B. Why is this success significant?

Immunity provided via this legislation will encourage opiate users and their families and friends to maintain and administer naloxone in cases of overdose without fear of legal repercussions, thereby saving lives. According to the CDC, there are currently 118 prescriptions per 100 people in Louisiana and Louisiana has the 8th highest ratio of prescription painkillers per person. Accidental overdose deaths are now the leading cause of accidental death in the United States, exceeding even motor vehicle accidents among people ages 25 to 64. Many of these deaths are preventable if emergency medical assistance is summoned, but people using drugs or alcohol illegally often fear arrest if they

call 911, even in cases where they need emergency medical assistance for a friend or family member at the scene of a suspected overdose. The best way to encourage overdose witnesses to seek medical help is to exempt them from arrest and prosecution.

C. Who benefits and how?

Persons at risk of opiate overdose and their friends and families are anticipated to benefit from this legislation in terms of the number of lives saved.

D. How was the accomplishment achieved?

During the 2015 Regular Legislative Session, OBH worked with the legislature to provide subject matter expertise, research, information, and testimony to encourage legislators to pass Good Samaritan provisions for victims of overdose and third party administrators that utilize naloxone or other opioid antagonists in overdose situations.

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

As per the strategic plan, OBH's mission is to lead the effort to build and provide a comprehensive, integrated, person-centered system of prevention and treatment services that promote recovery and resilience for all citizens of Louisiana. OBH assures public behavioral health services are accessible, have a positive impact, are culturally and clinically competent and are delivered in partnership with all stakeholders. This legislation supports OBH's mission promoting recovery by requiring victims of overdose to be connected with treatment after administration of emergency care, and working to prevent future relapses and overdose situations.

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

Whenever there is an issue of importance to an executive department or agency, it is an effective strategy to find a legislator that shares the same goals to champion the cause. Subsequently, like OBH, the agency can provide the necessary support and expertise to create a positive outcome.

Accomplishment #5: Coordinated System of Care (CSoC) Implementation

A. What was achieved?

During FY 2015, the Coordinated System of Care (CSoC) expanded operations

from five Phase I wraparound regions to statewide implementation in November 2014 after CMS approval of a waiver amendment in September 2014. Throughout the course of the fiscal year, enrollment numbers continued to increase. As of June 26, 2015, 1,641 children and youth out of 2,400 available slots were enrolled in CSoC.

B. Why is this success significant?

The CSoC implementation results from a multi-year collaborative planning effort between DHH, the Department of Children and Family Services (DCFS), the Office of Juvenile Justice (OJJ) and the Department of Education (DOE). CSoC uses an evidence-informed approach to support young people with significant behavioral health challenges who are in or at risk of out-of-home placement to remain with their families, in the community, which research demonstrates results in more positive outcomes over time. It also makes better use of state resources, by leveraging additional Medicaid funding, to enhance available services for high-risk children and youth within the State of Louisiana. The successful implementation of CSoC is particularly significant because it represents true partnership across the child-serving state agencies to ensure that youth who are at highest risk and in greatest need, and their families, receive timely access to appropriate services and supports.

C. Who benefits and how?

CSoC serves children and youth aged 0 through 21 with significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out-of-home placement. Children and youth with complex behavioral health challenges and their families benefit from a coordinated approach to care. New behavioral health services that were previously not part of the service array in Louisiana are now available as part of the Medicaid State Plan Amendments and Waivers that support CSoC and the broader LBHP. These new services include an organized planning process for young people with significant emotional and behavioral challenges, called Wraparound, which helps to ensure that individual and family needs are identified and addressed with an array of specialized services and natural supports. These efforts are proven to result in a reduced need for more costly out-of-home placement options. Families and young people also benefit from other specialized services which include: Parent Support and Training, Youth Support and Training, Crisis Stabilization, Independent Living/Skills Building and Short-term Respite.

D. How was the accomplishment achieved?

During 2009, DHH, DCFS, OJJ and DOE began collaboration on a multi-year planning process to develop a common vision and goals to improve behavioral health outcomes and reduce out-of-home placements among children and youth with significant mental health and/or substance use disorders. During the

planning phase, 18 stakeholder workgroups participated in designing the initial coordinated system of care. Subsequently, Governor Bobby Jindal issued Executive Order BJ-2001-5 on March 3, 2011, to formally established a policy-level Governance Board with members including leadership of DHH, DCFS, OJJ and DOE, a representative of the Governor's office, two family representatives, an advocate representative, and a youth representative. This board is charged with providing oversight to the development and implementation of CSoC. Each of the four collaborating agencies (DHH, DCFS, OJJ and DOE) also assigned staff to form a unified CSoC team, housed at OBH headquarters, to participate in development of the Medicaid State Plan Amendments and Waivers necessary to support service development, enhancement, and support and guidance for CSoC implementation. OBH used a community driven process to select initial regions for statewide implementation.

To support the availability of CSoC in each region, a community process selected a WAA that would serve as the locus for treatment and care coordination for every enrolled youth.

During FY2015:

- During November 2014, CSoC was implemented in four additional regions providing statewide availability. This expansion increased the potential enrollment from 1,200 to 2,400.
- As of June 26, 2015 CSoC has served 5,172 youth and children, with the fiscal year end enrollment of 1,641 children/youth. Fiscal year end enrollment ranges from 69 to 310 per region as follows: Greater New Orleans (310), Baton Rouge (268) Covington (136), Thibodaux (118), Lafayette (69), Alexandria (180), Shreveport (221), and Monroe (254).
- WAAs in each region ensured that youth with complex needs benefited from a coordinated care planning process that produced a single plan of care that was created with the youth, their family, natural supports and all agencies and providers involved with the youth and family.
- OBH collaborated with the University of Maryland and the Wraparound Evaluation and Research Team at the University of Washington to monitor initial fidelity to national wraparound practice standards. According to the University of Washington's research team, results show that Louisiana's fidelity to practice scores were almost identical to that of the national means. The researchers stated that this was a remarkable achievement given the ambitious nature of the CSoC initiative, going statewide in three years. The researchers reported that many states that were included in the national means score had small 'boutique' wraparound programs. In addition to reporting on fidelity to practice in Louisiana, the research also indicated very high satisfaction from families and caregivers enrolled in CSoC.
- The Family Support Organization (FSO) operated with a statewide organizational structure with local supervision and service provision established in FY 2013. The centralized administrative functions reduced overhead costs,

and resulted in standardization of policies and procedures across all regions.

- The FSO service delivery increased steadily over the year.
- The CSoC team is composed of a CSoC Director with over eleven years of experience leading system of care efforts, a Family Lead and team members detailed from DCFS, DOE, OJJ, and OBH. The team provided guidance and technical assistance to the WAAs and FSO in each region in order to ensure that the appropriate certification and training requirements were completed.
- The University of Maryland, Institute for Innovation and Implementation provided training and technical assistance on the implementation of the wraparound process, in accordance with standards established by the National Wraparound Initiative (NWI) through a contractual agreement with OBH.
- The CSoC Team provided training and technical assistance for the FSO in order to ensure members of the FSO had the knowledge and skills needed to support effective implementation of wraparound process.
- Quarterly meetings of the CSoC Governance Board were held to review progress, provide guidance, and establish policy as needed.
- The Statewide Coordinating Council (SCC) provided community level input to the CSoC Governance Board.

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

Yes. The CSoC initiative was included in the OBH business and strategic plans as a top priority.

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

Yes. There are several aspects of the CSoC initiative that represent best practices from a national perspective:

The formation of the Governance Board through Executive Order No. BJ 2011-5 represents a significant accomplishment. Across the country, there are very few states that have a Governor endorsed and supported CSoC initiative and policy-making Board. This collaboration and breaking down of historic silos between agencies has resulted in improved services for children and families and for enhanced collaboration across multiple efforts and initiatives.

Detailing of staff from across child-serving agencies to a unified CSoC Team represents a true innovation in the system of care field. Sharing staff from other departments under an integrated team design breeds increased understanding and familiarity of the mandates and requirements of each state agency and helps all members develop a deeper understanding and appreciation for the work of each child-serving agency.

Developing Medicaid state plan amendments and waivers and leveraging braided

funding across child-serving state agencies to support service development and expansion is an example of best practices in the system of care field. This also represents a higher level of coordination across agencies which results in less fragmentation, duplication and redundancy.

Accomplishment #6: Implementation of New Evidence-Based Practices (EBP) - First Episode Psychosis (FEP)

A. What was achieved?

As a part of the Mental Health Block Grant, the Substance Abuse and Mental Health Services Administration (SAMHSA) requires states to use a portion of their allocated funding toward the implementation of a program to support “evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.” To address this need, Louisiana has established a multi-pronged approach which includes completion of a needs assessment, training, and funding for Peer Support Specialists (PSS) within each of the 10 Local Governing Entities (LGEs) of the state. Through this process, Louisiana was able to identify those areas of the state with the capacity to implement a full-fidelity first episode psychosis (FEP) program while providing training and support to staff within the system increasing capacity to serve this population.

Needs Assessment - Louisiana began the process of conducting the needs assessment in conjunction with a consultant through Rutgers University. Through this process, LGEs were surveyed regarding their existing services systems. In particular, the consultant explored staffing, services, and collaborations with community partners to better identify those areas of the state that have the existing capacity to implement the RAISE program, which is an evidence-based practice through which wrap-around, multi-disciplinary supports are provided to individuals experiencing FEP.

Training – A training series was developed and implemented through which participants were provided information about FEP, tenants of the RAISE model were explored, and best practices regarding the provision of services were reviewed. The trainings included a face to face training held in 3 areas of the state as well as a series of webinars. Participants included PSS, LGE staff, and Assertive Community Treatment (ACT) providers. Through this process, 164 individuals were trained. The topics the trainings are as follows:

- Understanding RAISE: Services for Young People Experiencing FEP
- FEP - Engaging Youth
- FEP - Understanding Change
- FEP - Goal Setting
- FEP - Facilitating Change

Peer Support - Funding has been provided to the LGEs through which they can hire PSS to work with this population. In this capacity, Peers can aid in the identification of individuals experiencing FEP, helping to link them with services within the clinics. While in services, PSS can provide a bridge between the service recipient, their family and the treatment team.

B. Why is this success significant?

Through this plan, the state has been successful in providing the foundation for FEP implementation to LGEs throughout the state. LGEs were identified who were interested in implementing a true to fidelity RAISE program while others will be implementing a public health initiative through which their capacity to identify and treat individuals experiencing FEP will be increased though they will not be utilizing RAISE.

C. Who benefits and how?

Research on FEP programs have shown that that treating people with first episode psychosis with a team-based, coordinated specialty care approach produces better clinical and functional outcomes than typical community care. These outcomes include higher retention in treatment and length of service, improvement in symptoms, interpersonal relationships, quality of life, and involvement in work and school. These outcomes are most effective for people who receive care soon after psychotic symptoms begin.

D. How was the accomplishment achieved?

This accomplishment was achieved through the training of staff throughout the system of care and inclusion of LGEs in the development of the program.

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

Yes, the implementation of FEP programming supports the OBH Business Plan through the continued refinement and improvement of the system of care.

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

Yes, for the purpose of further collaboration with those entities who serve the same population.

Accomplishment #7: Implementation of New Evidence-Based Practices (EBP) – SAT-ED

A. What was achieved?

The SAMHSA funded Louisiana Statewide Adolescent Treatment Enhancement and Dissemination grant program (LA SAT-ED) has identified and implemented evidence based practices (EBPs) through a learning collaborative model. The purpose of the grant is to provide improved service delivery mechanisms to youth ages 12-18 with substance use and/or co-occurring disorders. The evidence-based practices selected are the Global Assessment of Individual Need (GAIN), Adolescent Community Reinforcement Approach (A-CRA), and Assertive Continuing Care (ACC). Two local community provider sites were included in the learning collaborative and served 274 youth. LA SAT-ED has also further disseminated the use of the identified EBPs in various areas of Louisiana in subsequent years. Four additional sites were selected in October, 2014 and received training in EBP's in April, 2015. These four sites are currently in various phases of certification in these EBPs and technical support from LA SAT-ED continues to be provided to them.

As a result of technical assistance provided by LA SAT-ED, the Louisiana Behavioral Health Advisory Council appointed a Standing Committee for Youth with Substance Use, Co-occurring, and Addictive Disorders. The Committee has established ongoing and specific duties by quarter and will establish goals and priorities for next year in the final quarter of this year. Additional efforts continue to identify and recruit representatives of the youth voice to serve on this Committee and the Council.

Louisiana SAT-ED has developed a workforce training implementation plan that has provided workforce development activities to partners and providers that serve adolescents aged 12 through 18. LA SAT-ED collaborated with other child-serving state agencies to provide cross-agency training for staff and develop and make accessible continuing education events throughout Louisiana. The LA SAT-ED Project Director met with staff from the Office of Juvenile Justice (OJJ), the Department of Children and Family Services (DCFS), and the Department of Education (DOE) to assess workforce development needs and develop the workforce training implementation plan. Training needs were identified and LA SAT-ED completed contracts with presenters in Motivational Interviewing (Alan Lyme) and Trauma Informed Care (Laura Riddle) in order to provide training for OJJ and DCFS staff. DCFS staff and partners completed a 2 day basic Motivational Interviewing training. OJJ trained 25 staff persons to the advanced level and 8 completed training to the trainer level in Motivational Interviewing. OJJ intends to establish a learning community in various facilities in order to improve implementation of this evidence based practice and improve sustainability of these practices in the agency. Information on trauma informed care was provided to all OJJ staff in Louisiana through a series of trainings

provided around the state.

OBH has been awarded the SAMHSA Statewide Youth Treatment Implementation grant (SYT-I) which began on 9/30/15. This grant opportunity will enable additional provider sites to be trained in GAIN and A-CRA to serve youth ages 16 through 25. This grant will also continue to provide workforce development activities for substance use disorder providers and fellow child serving state agencies.

B. Why is this success significant?

Training in evidence-based practices is costly and time consuming and this grant allowed for the provision of these services. However, implementation of EBPs is challenging following training. LA SAT-ED has succeeded in support of the implementation of EBPs for substance use and co-occurring disorders and supported the development of a feedback loop to enable Louisiana and the provider sites to identify barriers and test solutions through a services component operating in real time.

C. Who benefits and how?

Workforce and staff development needs of providers and staff of other child serving state agencies have benefitted from the provision of training opportunities. Following training, providers have utilized these effective approaches with the youth and families in their respective programs.

D. How was the accomplishment achieved?

OBH has committed to increase the use of evidence-based practices to improve service delivery and recovery rates for youth with substance use and co-occurring disorders. This commitment has resulted in additional grant funding awarded to Louisiana to accomplish this goal.

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

The accomplishments achieved through the LA SAT-ED grant support the DHH and OBH initiative to improve health outcomes by the provision of treatment services that promote recovery and resilience for citizens 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, for the purpose of further collaboration with those entities who serve the same population.

Accomplishment #8: Network for the Improvement of Addiction Treatment (NIATx) Strategic Provider Partnerships Collaborative

A. What was achieved?

Louisiana's Office of Behavioral Health participated in the Strategic Provider Partnerships Collaborative, which is part of SAMHSA's Business Plus initiative conducted by the National Council for Behavioral Health and the Network for the Improvement of Addiction Treatment (NIATx). This initiative assisted the state with conducting a statewide survey to assess substance use disorder (SUD) provider service benefit array and identify business processes and their capacity to integrate/partner/collaborate with primary care providers within each local governing entity (LGE).

B. Why is this success significant?

Results of the data will allow the ability to conduct a gap analysis of all behavioral health providers that are publicly funded through each respective LGE.

C. Who benefits and how?

This analysis will provide information at the state and LGE level on gaps in services, ineffective business processes/practices and whether organizations have the capacity to leverage partnerships/collaborations. Survey results can assist organizations with enhancing their business operations, practices, policies and protocols.

D. How was the accomplishment achieved?

SUD providers within each LGE completed a survey. Survey results were compiled and analyzed by NIATx. Each LGE received results of the survey and technical assistance was provided by NIATx and OBH to review outcomes.

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

Yes. OBH's mission is to enhance quality services through integration of behavioral health and primary care.

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

Yes. It's imperative that organizations continue to assess their programmatic operations in order to identify efficient and effective practices that produce quality of care.

II. Is your department five-year Strategic Plan/Department Business Plan on time and target for accomplishment?

Significant progress has been experienced in five distinct areas: the transition of Magellan to Bayou Health and the preparation for integration; laying the groundwork for the development of administrative management of the non-Medicaid population; Peer Support Services; and the Innovative Accelerator Program for Substance Use Disorders (IAP-SUD).

Significant Progress #1: Transition of Magellan Medicaid Specialized Behavioral Health Services to Bayou Health / Preparation for Integration

- **Where are you making significant progress?**

DHH-OBH currently contracts with Magellan of Louisiana which operates as the single statewide managing entity for provision of specialized behavioral health services. In November 2014, the Louisiana Department of Health and Hospitals announced a plan to integrate all behavioral health care services into its existing Medicaid managed care system called Bayou Health. Magellan's contract for provision of those services will expire on November 30, 2015.

Starting in November 2014, DHH began researching and coordinating efforts toward integrated care to begin December 1, 2015. In approximately April 2015, OBH began working with Magellan to have a successful close out of the Magellan contract and hand off to the Bayou Health Plans. This plan is on target to be completed by December 1, 2015 as originally planned.

DHH worked to develop the current Bayou Health contract amendment authorizing integrated care starting in the spring of 2015 throughout the summer of 2015. DHH also reviewed in detail the relevant federal authorities, including waivers and the state plan, and drafted appropriate amendments as needed to CMS in order to support the integrated contract. DHH will be completing readiness reviews of the Bayou Health Plans in the fall of 2015 to ensure sufficient progress.

A. To what do you attribute this success?

Magellan Transition. OBH and Magellan have organized a very structured transition process to close out the current Magellan contract with avenues for bi-directional and frequent communication. OBH facilitates multiple meetings per week, most solely focused on transition issues and milestones. An extremely detailed transition plan notes action items, tracks due dates and documents agreements. Transition meetings involve input from other state agencies and multiple sections within DHH.

Public and Stakeholder Input. OBH began informing the public of the decision to integrate management of services in the annual block grant public forums that occur in all DHH regions of the state in early 2015. OBH also hosted two integration summits, the last in a three-year series of integration focused summits across the state. DHH formed and hosted four “advisory group” meetings in early 2015 to collect information and guidance from the stakeholders and advocates, which included providers, state agencies and peers. DHH developed an integration website containing information on research and support for integration, important contact numbers, FAQs and an avenue to submit questions directly to DHH for response.

Provider Readiness. DHH, in addition to the above mentioned avenues for collecting information, engaged a consultant to conduct a provider readiness survey, conduct provider webinars and advise on next steps as it relates to providers. DHH also implemented planning for hosting provider calls three times per week to allow providers to ask questions in an unstructured way and travel the state to address providers and their concerns in “roadshows” in the fall of 2015. DHH Medicaid, with OBH’s content expertise, also published written topic specific guidance in the form of Informational Bulletins.

DHH Internal Collaboration. DHH initiated cross-agency communications on policy decisions related to integration, contract development and future planning. This forum allows all affected DHH agencies to participate in development of the program and recognition of OBH as behavioral health subject matter experts. Cross DHH agency calls and in person bi-weekly meetings allow DHH to come together in joint decision making.

Member Involvement and Education. DHH engaged members (people receiving services or who have previously experienced mental illness and/or addiction) in order to learn about concerns and problems with the current system, with integrated care and inform policy decisions going forward. While invited to all public and stakeholder forums mentioned above, there was specific outreach to this group of people. OBH hosted a focus group to hear concerns and recommendations prior to the final advisory group meeting. DHH also engaged a consultant to travel the state and conduct small roundtable discussions with members currently receiving services. Information gathered from these forums was used in subsequent member’s communications.

Health Plan Training. DHH hosted trainings conducted by OBH, OAAS, Medicaid, and Magellan to inform and encourage open communication about intent, processes and requirements under the integrated contract. OBH and Medicaid have weekly calls with the health plans answering questions about integration. Medicaid hosts monthly in person meeting with the health plans with OBH attendance to respond to questions.

B. Is progress directly related to specific department actions?

Yes, OBH, La Medicaid, OAAS and OCDD have collaborated in policy making decisions related to integration. OBH has facilitated Magellan transitions meeting with the participation of La Medicaid as well as our sister agencies involved with the LBHP – DCFS, OJJ and LDOE.

C. 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?

Yes. OBH is the sole monitor for close out of the Magellan contract. OBH participating in the development of the integration amendment and authorities by drafting relevant sections for submission to Medicaid. OBH hosts and facilitates cross DHH meetings and participates in Medicaid Bayou Health meetings and the behavioral health subject matter experts.

D. 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 through the integration date of December 1, 2015, and through the bayou health plan MCO contract term. As a result of all the work done to date and as DHH Medicaid and OBH have established a working relationship that compliments Medicaid's administrative functions and OBH's programmatic knowledge. Monitoring functions developed through Magellan's contract will cross over and improve the quality of behavioral health services offered by the MCOs. Progress toward Magellan's contract end will accelerate toward the termination date of November 30, 2015.

- **Where are you experiencing a significant lack of progress?**

OBH expects the OBH-Magellan contract will close out completely and on time and Medicaid and the Bayou Health plans will integrate behavioral health services timely on December 1, 2015 as planned.

Significant Progress #2: Laying Groundwork for the Development of Administrative Management of non-Medicaid Population

- **Where are you making significant progress?**

Magellan of Louisiana currently manages the authorization of behavioral treatment for both Medicaid and certain non-Medicaid populations. However, upon integration of Medicaid behavioral health services into Bayou Health effective December 1, 2015, management of the non-Medicaid population will terminate. The department determined that an alternate arrangement for the administrative management of the non-Medicaid population and services is

needed in order to ensure that this population has access to behavioral health services similar to those provided to the Medicaid population.

In January 2015, OBH began the process of developing a Request for Information (RFI) for the purpose of determining if there were any providers who would be interested in serving as an administrative services organization (ASO) for the non-Medicaid population. Subject matter experts were consulted to provide input into the components needed for coverage by the ASO. The RFI was completed and published on February 11, 2015. Potential respondents were given a designated period to submit questions and submitted responses to the RFI by March 13, 2015. The department received four responses to the RFI from companies demonstrating their interest in providing the services requested. As a result of this process, OBH began developing a Request for Proposals (RFP) to solicit proposals for an ASO contract.

A. To what do you attribute this success?

Through dedication and hard work of involved staff, the department was able to publish an RFI for the purpose of determining entities who might be interested in serving as an Administrative Services Organization (ASO) for the non-Medicaid behavioral health population.

B. Is progress directly related to specific department actions?

Yes. After many discussions, much research, and input from others, the department was able to develop the RFI and solicit vital input from outside resources into potential models for the administrative management of this population.

C. Is progress related to the efforts of multiple departments or agencies? If so, how do you gauge your department's contribution to the joint success?

The project was managed by the OBH Division of Adult, Child and Family Services with input from the OBH Divisions of Fiscal/Administration and Health Plan Management.

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

While the writing of the RFI is a one-time gain, it gave OBH the necessary information to develop the process for ensuring that the non-Medicaid population receives behavioral health services similar to those of the Medicaid population. It allowed OBH to communicate with multiple interested parties and obtain valuable information from those resources about feasibility of the model. This ultimately determined the agency's final methodology for continuing the administrative management of this population after integration.

Significant Progress #3: Peer Support Services

- **Where are you making significant progress?**

Since the inception of the PSS program in 2008, significant progress was made in the implementation of a Peer Support Specialist program. This has occurred through improvements in the training and selection criteria of those trained, implementation of requirements related to continuing educational units, and the expansion of employment options for peers working throughout the system of care. To date, 319 Peer Support Specialists (PSS) have been trained utilizing the Louisiana recognized PSS training offered through Recovery Innovations. Of the 319 trained, 185 have maintained their PSS credential.

OBH has become more selective in accepting applicants for the PSS training in efforts to ensure training participants are appropriate for future employment/volunteer work. As a result, only nine of the people trained since 2012 have exited the program. This calendar year, three Peer Support trainings have been held, graduating 52 new Peer Support Specialists.

In addition to PSS, Louisiana utilizes the Wellness Recovery Action Plan (WRAP) program to help further peer driven recovery oriented services. WRAP is an evidence-based practice through which individuals are led through a process of developing their own plan for wellness. Since January 2015, one WRAP workshop was held, helping 20 Peer Support Specialists develop WRAP plans. During this same time period, one WRAP Facilitator training was also held, graduating 12 new WRAP Facilitators who will be able to lead others through the process of developing their own WRAP plans.

Extensive research has been conducted into the Peer Support certification process in other states. Through this process, Louisiana was able to confirm that Louisiana's program is similar to many other models utilized throughout the nation. The next steps for Louisiana include plans to standardize the process by developing formal policies and procedures for credentialing Peer Support Specialists.

A. To what do you attribute this success?

Improvements to the PSS program can be attributed to improved recruitment and identification of qualified peers to participate in the trainings. In the past, everyone who applied for training was accepted. This led to excessive attrition since applicants who were unsuitable for work were trained. A system for scoring each application was developed in 2012. Since this process was adopted, those who are accepted into training are much more qualified and more likely to continue with a career in Peer Support. As a direct result of this scoring process, attrition has dropped from 66% to 9%.

With the expansion of Medicaid through the Louisiana Behavioral Health Partnership (LBHP) in 2012, peer support services have become reimbursable as a service provided by an “unlicensed professionals” through Community Psychiatric Supports and Treatment (CPST) and Psychosocial Rehabilitation Services (PSR), and substance use disorders (SUD) treatment services.

B. Is progress directly related to specific department actions?

Louisiana has made a concerted effort to dedicate funding to this initiative since 2008, with the additional objective of having a cadre of advanced level Peers trained who are capable of conducting ongoing training within Louisiana. This effort has enabled the expansion of the program to include trainings.

Additionally, growth of the PSS program has occurred in tandem to the implementation of managed care in Louisiana. This is due to the increased focus on recovery oriented services and expanded array of services in which PSS can be employed.

C. 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?

Yes, progress is related to efforts of multiple agencies. Expansion of Medicaid reimbursable specialized behavioral health services has allowed for services provided by PSS to be billed to Medicaid as “unlicensed professionals.” OBH is working in collaboration with Louisiana Rehabilitation Services (LRS) and the Veterans Administration (VA) to identify appropriate peers for training.

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

Progress of the PSS program is expected to continue at an accelerated pace. OBH is currently developing plans to have two additional peers trained as Advanced Level Peer Support Facilitators in order to increase the capacity to train and credential Peer Support Specialists. Plans are being made to develop a supervisor training in order to increase knowledge and awareness of the significant role of Peer Support Specialists in the behavioral health system of care. OBH is currently in the process of developing a Peer Support Specialists Policy and Procedure Manual to bring the program into compliance with CMS guidelines for making Peer Support Services a stand-alone reimbursable service through Medicaid. OBH is also actively engaged in discussions with the five Bayou Health MCOs, SAMHSA, and other national experts for guidance and assistance to make Peer Support Services a stand-alone billable service once behavioral health services are integrated with primary health care in December 2015.

- **Where are you experiencing a significant lack of progress?**

Louisiana has historically had difficulty establishing and maintaining peer run recovery services, which are recovery support services provided by an organization operated by Peer Support Specialists. These types of organizations have greatly improved the quality of recovery services in other states.

Lack of providers willing to hire PSS, which is attributed to lack of knowledge/training on what is a PSS, the benefits of PSS to clinical teams, and resources available to fund these positions. Increased use of peers in the behavioral health treatment programs is also an area identified for further growth. The majority of PSS currently employed have positions in the private sector, working primarily with providers of CPST, PSR, ACT, CI and/or PSH services. The training and technical assistance provided through the federally mandated First Episode Psychosis (FEP) initiative may help to increase the interest and involvement of public sector providers with supporting the value of PSS.

Significant Progress #4: Louisiana Medicaid Substance Use Disorder Collaborative: Innovation Accelerator Program for Substance Use Disorders (IAP-SUD)

Louisiana is one of seven states participating in the Innovation Accelerator Program for Substance Use Disorders (IAP-SUD) with CMS' Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare and Medicaid Innovation. With its kick-off in January 2015, the Medicaid Innovation Accelerator Program for Substance Use Disorders (IAP-SUD) represented a new collaboration from CMS' CMCS and the Center for Medicare and Medicaid Innovation. The IAP-SUD is a state technical assistance project, which intends to develop strategically targeted functions to advance delivery system and associated payment reforms, and to align with transformation efforts underway in Medicare and the commercial market.

Louisiana's Chosen Aim: Neonatal Abstinence Syndrome (NAS)

By December 31, 2016, Louisiana Medicaid intends to increase early identification, coordinated referral and treatment engagement by 5%, when compared to FY 2013, for at risk Medicaid-enrolled mothers and youth between birth and 12 months of age, who are at risk for NAS in two initial settings: a large metropolitan Women's Hospital and a rural tri-parish area/system of care.

As IAP-SUD project goals and aims are achieved, work plans will strive to generalize and extend enhancements statewide to other facilities and communities beyond the initial two settings, and will apply lessons learned to

additional substance use disorder service enhancements statewide.

- **Where are you making significant progress?**

1. Identification of pilot site settings (i.e., Women's Hospital, Project LAUNCH tri-parish area, and ACER)
2. Established Steering Committee and Sub-Committees (i.e., Data Analytics, Early Identification/Screening, Payment Reform, SUD/Women's Services and Supports)
3. Drafted work plan with the following drivers: Identify women and children at risk for and with SUD/NAS, provide access to services and supports for those at risk for and with SUD/NAS, and reform payment strategies.
4. Data Collection and Measurement Strategy Development

A. To what do you attribute this success?

The strong leadership of the steering committee and joint efforts among departments and agencies.

B. Is progress directly related to specific department actions?

Yes. OBH staff serve on the project's steering committee, chair some sub-committees, and hold membership within sub-committees. OBH plays an active role in all project activities.

C. 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?

Yes. OBH has significantly contributed to the success of the project. OBH staff serve on the project's steering committee, chair some sub-committees, and hold membership within sub-committees. OBH plays an active role in all project activities. OBH staff has and continues to influence project development, maintenance, and decision making.

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

The SUD-IAP project is newly established. Some aspects of the project are still under development. Progress is expected to continue.

- **Where are you experiencing a significant lack of progress?**

Not anticipating a significant lack of progress. Progress is expected to continue as the program becomes more established.

- **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 did not revise its strategic plan in FY 2015, but is laying the groundwork for the development of the new five-year strategic plan that is due on June 30, 2016.

- **How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?**

The formulation of the OBH strategic plan adheres to management strategies implemented by the Executive Management Team (Health Plan Management, Administration, Adult, Child and Family Operations). These strategies, at a minimum, include:

- **Training:** Ongoing training is provided to ensure staff develops the necessary skills to understand and apply the concepts of the OBH strategic plan.
- **Input:** Gathering input from all levels of the agency's functional areas. Discussions are conducted with Team Leaders and participants representing functional areas essential to support agency priorities.
- **Communication:** Receiving and sending information at the central office and the district levels.
- **Coordination:** Using technology to enhance communication and participation (e.g., teleconferences, videos, electronic media, etc.).
- **Performance measurement:** Formulation of objectives that are specific, measurable, attainable, results oriented and time-bound. Performance indicators are formulated to ensure monitoring of progress in goal/objective attainment.
- **Evaluation:** The Strategic Plan will be revised, as warranted, to reflect fiscal, managerial and programmatic changes. These revisions will be conducted using the same strategies as the original plan, as warranted. Plan revisions will utilize strategies that are pertinent to the task at hand.

III. What significant department management or operational problems or issues exist?

Operational Problems or Issues #1: Maximizing Current Resources for Hospital Based Treatment Program

OBH oversees the state's two freestanding psychiatric inpatient facilities, Central Louisiana State Hospital (CLSH) and Eastern Louisiana Mental Health System (ELMHS), which in total provide 48 acute (ELMHS), 290 intermediate (120 CLSH and 170 ELMHS), and 357 forensic (ELMHS) in-patient hospital beds. 137 beds (ELMHS) are available for community placement. ELMHS is the only one of the state's freestanding psychiatric facilities that includes a division solely designated for the provision of inpatient psychiatric treatment to forensic clients who are deemed Not Guilty By Reason of Insanity (NGBRI) or who are ordered to receive hospital-based competency restoration services, and includes the Forensic, Acute/Civil Intermediate, and Hospital-Affiliated Community Services divisions. CLSH is the single point of entry and coordinator for behavioral health intermediate bed placement in the state, and maintains the statewide register of clients who have been referred for intermediate beds at both ELMHS and CLSH, and is the primary point of entry into the system for intermediate bed placement. In FY 2015, 174 clients were served at CLSH and 1,700 clients were served at ELMHS.

ELMHS must have the ability to provide placement for those individuals who are incompetent to proceed to trial (ITP or pre-trial) and are court-ordered to receive competency restoration services, as well as those who are deemed Not Guilty By Reason of Insanity (NGBRI), which allows the system to work as it was designed: to provide placement of all clients in the most cost-effective and compliant manner and allowing clients to flow throughout the system as they move toward recovery. However, there are several factors that have impeded the program's ability to effectively move clients throughout the system: the increasing demand for bed placement to accommodate judicial admissions; the majority of civil clients admitted for inpatient psychiatric treatment at ELMHS are indigent, which has resulted in a decrease in Federal Funds and Self-generated Revenues; higher acuity levels of clients who require specialized medical care; and the lack of resources to properly manage and coordinate statewide referrals for intermediate bed placement.

Overall forensic admissions have increased by 30% from FY 2012 to FY 2015, competency restoration admissions have increased by 41%, and all others have increased by 8%. In FY 2015, forensic admissions made up 30% of the total; this trend is expected to continue. The number of admissions for hospital-based competency restoration services has increased by 54.02% from prior to the onset of the consent decree that went into effect on July 1, 2011; over the past three years, an average of 24 clients were admitted per month, which exceeded the initial projected demand of 14 clients per month. While ELMHS has thus far

maintained compliance with the PT client admission requirements, the facility is unable to admit all PT and NGBRI clients who are committed to the hospital. There is currently a waiting list of nine NGBRI and 30 PT clients for admission to ELMHS; ELMHS' current resources are insufficient to timely admit NGBRI clients, causing them to remain placed in parish jails for varying lengths of time and not in a psychiatric facility as required by law. Based on the average number of referrals for judicial admissions and utilization trends, ELMHS must admit a minimum of 3.33 additional referrals per month to keep a continuous flow through the system.

Medicaid, Medicare and Private Insurance authorize a specific number of days for which a client may receive inpatient services. Once the client has exhausted their authorized days or their life-time maximum days but still require psychiatric services, they become an indigent client with no payer source. Furthermore, many clients residing in civilly licensed beds are forensically involved and not eligible for billable inpatient psychiatric services because of their incarcerated status. ELMHS is and must remain the safety net for those clients, who will continue to receive appropriate services regardless of their ability to pay.

ELMHS currently partners with Villa Feliciano Medical Complex (Villa) in Jackson, which provides specialized medical care and rehabilitative services to medically complex clients diagnosed with chronic diseases, disabilities, and terminal illnesses, as well as higher medical acuity clients. ELMHS clients are sent to Villa for appropriate medical treatment, and typically present with more than one disease or illness. By better utilizing available bed capacity at Villa, overall care will improve for clients needing a higher level of nursing care than ELMHS is designed to provide, and can be done in a more cost-effective manner.

Management and coordination of intermediate beds is essential for the appropriate and timely placement of all clients throughout the system. Barriers to placement exist, namely, the competing number of forensic clients who are court-ordered to receive competency restoration services and NGBRI placement at ELMHS and the overall system decrease in available beds. However, once space becomes available, clients must be in position to quickly move to the most appropriate level of care, thereby creating space at acute facilities throughout the state.

Operational Problems or Issues #2: Uncertainty of “in lieu of” Programs under Integration

In November of FY 15, with the announcement to integrate specialized behavioral health services with physical healthcare under Bayou Health, sorting through the operational issues and funding mechanisms involved with the

transition became a departmental priority. During the course of the LBHP, Magellan has paid cost-effective services “in lieu of” higher cost alternatives. These “in lieu of” services have become essential to maintaining access to service, network adequacy, and continuity of care. Since March 1, 2012, “in lieu of” services have met CMS criteria of cost effectiveness by increasing lower cost community based services while reducing high cost inpatient and residential care. The State does not pay for these services explicitly, but can include payment for them in the capitation rate for the state plan services, which they would replace. As a result, adoption of these services is at the discretion of the Bayou Health Plans. In anticipation of integration Dec. 1, 2015, there has been no consistency amongst the Bayou Health Plans relative to adopting or operationalizing these additional services outside of the Medicaid state plan.

Included in the “in lieu of” service array are the following key cost-effective alternatives:

- **Residential Substance Use Treatment Facilities for Medicaid Eligible Adults (Age 21 and Above)** - Prior to March of 2012, this population was treated in residential programs not eligible for Medicaid reimbursement. As in the fee-for-service Medicaid system, some residential substance use treatment facilities are considered Institutions for Mental Diseases (IMD) because of the number of beds and the population served. However, without use of these facilities, members will be treated in more costly acute detox settings, and members will remain in hospital emergency departments while awaiting available beds. This service reduces emergency department consumption, increases substance use treatment bed capacity, and provides a less costly alternative to general bed placement. As a part of this “in lieu of” service, Magellan paid a per diem to providers to cover the costs of room and board in addition to service costs. Medicaid-eligible adults are provided residential services when they clinically meet the need for this service, but another payment source must be secured for the room and board portion of the rate. The decision by Magellan to pay for room and board allowed members to receive necessary treatment in a residential setting in lieu of higher costs associated with being admitted to the emergency room or inpatient hospitalization. To date, there has been no uniform commitment by the Bayou Health Plans to assume service costs for this “in lieu of” service for residential substance use treatment has. Similarly, a payment source for the room and board portion of this service has not been identified and the Bayou Health Plans have not yet agreed to absorb this additional cost. Without this concurrent payment alongside the service payment, this level of care cannot be utilized and access to care will be greatly reduced.
- **Utilization of Freestanding Psychiatric Hospitals instead of General Hospital Psychiatric Units for All Medicaid Eligible Adults (Age 21 and Above)** – The purpose of this alternative service is to assist adult Medicaid

members including persons with significant behavioral health challenges. In fee-for-service Medicaid, this population was treated in more expensive general hospital psych units which created access issues as beds in this setting were limited. Members often remained in emergency departments while waiting for available beds, thereby increasing costs to the healthcare system as members utilized those medical resources while awaiting beds in general hospitals. Use of freestanding psych units reduces emergency department consumption, increases psychiatric bed capacity and provides a less costly alternative to general hospital beds. Use of this “in lieu of” service expanded Magellan’s Medicaid-reimbursable adult inpatient bed capacity by 87%. Without adoption of this service by all Bayou Health Plans, access to vital, lower-cost psych beds will be lost and waiting lists will increase exponentially.

- **Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, and Crisis Intervention for 21 Year Olds Enrolled in the 1915(c) Waiver for Children/Youth with Severe Emotional Disturbances (SED)** – Members who are 21 years old are eligible for the 1915(c) SED waiver services but not for state plan services, which are restricted to children and youth **under** age 21. These services are state plan rehabilitation services. Access to these services allows continuation of the level of services being received prior to these members’ 21st birthday in their home environment, helps to increase skills, and decreases the likelihood of deterioration once the member formally transitions to state plan services at age 22. Community-based rehabilitation services work to prevent recidivism in high-cost inpatient care.
- **Crisis Intervention (CI) Services for All Medicaid Eligible Adults (Age 21 and Above)** – This service is provided to persons experiencing psychiatric crises and are designed to interrupt and/or ameliorate the crisis experience through a preliminary assessment, immediate crisis resolution and de-escalation, and referral with linkage to the appropriate community services in order to avoid more restrictive and high-cost levels of treatment. Utilization increases opportunities for diversion from emergency rooms and hospital intake departments.
- **Crisis Stabilization Units for All Medicaid Eligible Adults (Age 21 and Above)** – The use of Crisis Stabilization Units for the adult Medicaid population is to assist those members with urgent or emergent needs who are in crisis and who have need of further stabilization. Use of these units is a key component in the crisis continuum and serves those who can be diverted from an emergency department or inpatient hospitalization, or can be “stepped down” from current inpatient hospitalization. Units are staffed year round with treatment available every day of the week.

- **Peer Support Services for All Medicaid Eligible Adults (Age 21 and Above)** – Services are non-clinical, face-to-face services, designed to provide collegial support to promote recovery, resilience, and wellness. Services are grounded in the unique shared experience of living with a behavioral health condition or co-occurring disorder. This evidenced-based practice builds upon the continuum of care necessary to assist each individual realize his or her own recovery and wellness pathways through mentoring, navigating, advocacy, sharing learning and life planning. Services are adjunct and complimentary to clinical services. In addition, research is showing that while increasing consumer wellness, the use of peer specialists is decreasing costs by decreasing hospitalization and increasing adherence to treatment plans and other positive outcomes.
- **Injection Services Provided by Licensed Nurses to All Medicaid Eligible Adults (Age 21 and Above)** – Many members are unable or unwilling to take oral psychotropics, or their mental status indicates a need for injectable medication to ensure compliance and stability. Embedded in the cost of many Evaluation & Management coded visits is the cost of providing injectable medications. Allowing licensed nurses instead of physicians to perform this service delivery results in a most cost efficient and least costly service delivery, and helps to ensure compliance. The goals are reducing subsequent office visits and reducing hospitalizations due to lack of compliance.

Similar to residential substance use treatment, continuation of funding for room and board payments becomes an issue for the Therapeutic Group Home (TGH) level of care. Unlike residential substance use treatment, Therapeutic Group Homes (TGH) are covered residential treatment services in LA's Medicaid State Plan, and are available to all Medicaid-eligible members under 21 who meet medical necessity for this level of care. Medicaid funds all treatment services provided at TGH facilities; however, federal Medicaid rules prohibit Medicaid funding from reimbursing for room and board. This means that another payment source must be secured for the room and board portion of the rate.

When a youth in need of TGH is in the custody of DCFS or OJJ, those agencies provide the room and board payments for their youth (DCFS may use federal title IV-E funds for this purpose). However, DHH does not have a payor source for the room and board component of TGH for youth who are not in the custody of DCFS or OJJ. This was not previously a funding issue until the very end of FY 15 when Magellan indicated an upcoming, necessary major expansion of its TGH network and increased bed capacity (from 16 beds to approximately 140 beds). With the expansion of this service availability, an influx of non-DCFS and OJJ youth will have access to this level of care. This is a problem given that DHH (and its designated Bayou Health Plans) are required by CMS to make TGH available to all youth who meet medical necessity for the service as per the Medicaid state plan, but has no funding source for the room and board payments. DHH cannot consider custody status (and available room and board payment

source) as a factor in determining authorization for the service.

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

A. Check all that apply.

- Internal audit
- External audits
- 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)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

A. 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.

1. Synar Report: Youth Access to Tobacco in Louisiana

- a. *Data collection completed:* July 1, 2014 – June 30, 2015
- b. *Subject / purpose and reason for initiation of the analysis or evaluation:*

OBH conducts this annual Synar Report to examine the current level of accessibility of tobacco products to minors as pursuant to Federal Government guidelines. The Substance Abuse and Mental Services Administration (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.

c. *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.

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

OBH contracted with OATC to conduct the random, unannounced inspections of tobacco outlets identified by the random sample at a cost of \$73,125.00 (\$65.00 per compliance check x 1125 checks). The total cost to prepare and complete the Annual Synar Report was \$70,000.00.

e. *Major Findings and Conclusions:*

The objective of this study was to estimate the non-compliance rate for tobacco sales in Louisiana among youth under age 18. Annual targets were established to decrease the state's non-compliance rate to 20% by FY 2002. However, Louisiana achieved 20.3% non-compliance in FY 1999, only two years after the start of the Louisiana Synar Initiative, and three years ahead of the scheduled target date. The current rate of tobacco sales to minors in FY 2015 is 17.8%.

f. *Major Recommendations:*

OBH complied with all major recommendations made by the federal Center for Substance Abuse Prevention for the FY 2015 report and will adhere to any future recommendations, as warranted.

g. *Actions taken in response to the report or evaluation:*

An annual report is generated by SAMHSA including a Table listing the Synar Retailer Violations (RVRs). Louisiana was ranked among

the top states in compliance, in the FY 2013 report (most recent on file). The SAMHSA report can be viewed at <http://beta.samhsa.gov/sites/default/files/synar-annual-report-2013.pdf>. Our goal is to continue implementing current strategies since they've proven to be successful.

h. *Availability (hard copy, electronic file, website):*

The FY 2015 Annual Synar Report is available by hardcopy, and may be accessed online at

<http://new.dhh.louisiana.gov/index.cfm/subhome/10>.

i. *Contact Person:*

Dr. Leslie Brougham Freeman
Director of Prevention Services
LA Department of Health and Hospitals
Office of Behavioral Health

2. Office of Behavioral Health – Prevention Services (Quarterly and Annual)

a. *Data collection completed:* July 1, 2014 – June 30, 2015

b. *Subject / purpose and reason for initiation of the analysis or evaluation:*

OBH is committed to providing quality, cost-effective prevention and treatment services. In an effort to demonstrate accountability and transparency, OBH Prevention Services has developed a report to capture prevention services provided through the Prevention Portion of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The SAPT Block Grant 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.

c. *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 Block Grant for prevention services.

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

There is no cost associated with this report. This report is generated in-house. OBH Program Staff use data from PMIS to generate this document. Data is entered into PMIS by the LGE prevention staff, their contract providers statewide and OBH staff.

e. *Major Findings and Conclusions:*

During FY 2015, Prevention Services provided evidence-based services to 89,204 enrollees.

FY 2015 block grant funded one-time services provided to the general population reached 2,473,664 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.

f. *Major Recommendations:*

The positive outcome assessment (see above) indicates that current strategies should be continued and reinforced.

g. *Action taken in response to the report or evaluation:*

No actions other than the recommended (above) were pertinent.

h. *Availability (hard copy, electronic file, website):*

The report is distributed via e-mail and is available by hard copy upon request.

i. *Contact Person:*

Dr. Leslie Brougham Freeman
Director of Prevention Services
LA Department of Health and Hospitals
Office of Behavioral Health

3. Block Grant Reporting

a. *Title of Report of Program Evaluation*

Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG) and Mental Health Block Grant (MHBG) Annual Reports.

b. Data collection completed:

Louisiana's MHBG and SABG Behavioral Health reports must to be submitted to SAMHSA no later than December 1st of each year. If OBH misses the statutory date for submitting the reports, it will not receive any federal Block Grant funds for that federal fiscal year.

c. 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 and submit an Annual Report. The Annual Report needs to include the purposes for which the MHBG and SABG funds were expended; list of the recipients of grant funds; the authorized activities funded, and the services purchased with such funds. MHBG and SABG reports are not combined.

d. Methodology used for analysis or evaluation:

OBH HPM Quality and Analytics staff work in collaboration with the OBH program and fiscal staff and LGEs in the development of the annual reports. Reporting requires several months of preparation and typically begins in August of each year. OBH HPM Analytic staff problem solve, plan, and develop methodologies for data report analysis. OBH HPM Analytic 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 HPM Analytic staff maintain the operation of the OBH Data Warehouse, maintain the OBH Client Level Data manual, and oversee LGE's electronic health record data submissions. LGE data submissions are continuous, and are sent to the OBH data warehouse on a bi-monthly basis. Reports are submitted via SAMHSA's online portal, Web Block Grant Application System (WebBGAS).

e. 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 the reports.

f. Major Findings and Conclusions:

The primary purpose of the reports are to track and monitor fiscal, program, service and client variables/indicators across time. No Major findings/conclusions.

g. Major Recommendations:

No major recommendations.

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

Data-based decision making relative to programs and services.

i. Availability (hard copy, electronic file, website):

The report is distributed via e-mail to the Louisiana Behavioral Health Advisory Council and upon request.

j. Contact Person:

Kashunda Williams, PhD
Manager Business Intelligence and Analytics
LA Department of Health and Hospitals
Office of Behavioral Health

4. LBHP Transparency Report (Act 212)

a. Date published: December 31, 2014

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

Act 212 of the 2013 Regular Legislative Session requires DHH to provide transparency relative to Medicaid managed care programs on an annual basis. For FY 2014, this involves the OBH managed SMO contract with Magellan over the LBHP. The report outlined responses to the requests made by the legislature in Act 212 relative to Magellan's management of care within the LBHP and CSoC.

c. Methodology used for analysis or evaluation:

Act 212 details the types of information and data elements that are to be included in the report. Data was collected using Magellan's electronic health records and claims systems and compiled and checked by OBH for the report. The Department's contractor for encounter validation, Myers and Stauffer, provided third party validation of specific data elements related to claims

d. Cost (allocation of in-house resources or purchase price):

Minimal in-house resources were allocated to produce the report and the SMO contributed to data reporting as per the requirements and funding allocated through the SMO contract.

e. Major Findings and Conclusions:

The measures included in the report were used to demonstrate that the following outcomes expressed in the legislation were achieved:

- 1) Statewide implementation of CSoC;
- 2) Improved access, quality and efficiency of behavioral health services;
- 3) Seamless coordination of behavioral health services with the comprehensive healthcare system without losing attention to the special skills of behavioral health professionals;
- 4) Advancement of resiliency, recovery and a consumer-focused system of person-centered care; and
- 5) Implementation of best practices and evidence-based practices that are effective and supported by data collected from measuring outcomes, quality and accountability.

f. Major Recommendations:

Not applicable.

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

Report distributed to the Senate and House Committees on Health and Welfare and posted to the DHH OBH website. OBH determined that a more robust independent data validation protocol for the next report was needed, including setting the data parameters in-house. Additionally, changes were proposed to the reporting requirements during the 2015 Regular Legislative Session in order to provide more meaningful reportable data and increase the number of data elements that could be validated rather than self-reported. Changes in

reporting will be implemented for the FY 2015 report due June 30, 2016.

h. Availability (hard copy, electronic file, website):

Available by electronic file and on the DHH OBH website
(<http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/3198>)

i. Contact Person:

Jennifer Katzman
Director of Research and Special Projects
LA Department of Health and Hospitals
Office of Behavioral Health

5. Monitoring Risk Assessment

a. Date published:

“Risk Assessment of Louisiana’s Behavioral Health Partnership Monitoring of Magellan” - On July 2, 2015, OBH received a final report based on an evaluation conducted during State fiscal year 2014-2015 by Navigant Consulting.

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

OBH secured Navigant’s support in completing an independent risk assessment of its current monitoring efforts. As OBH initiates a transition from a single-contract for behavioral health services to an integration of these services into the existing Bayou Health program (with planned implementation by December 2015), it is important to identify and remedy any noted risks proactively.

c. Methodology used for analysis or evaluation:

Navigant’s risk assessment methodology included a Desk Review and Interview process of both OBH and Louisiana Medicaid staff. Navigant reviewed over 60 documents used in OBH’s monitoring of the LBHP. Navigant focused on such things as OBH’s monitoring process, documentation and reporting, and rapid cycle feedback.

d. Major Findings and Conclusions:

The report stated the OBH has implemented a method to monitor the Magellan contract through an Intra-Department Monitoring team and subject matter expert report review process. The report found that while OBH monitoring staff consistently articulated their approach to monitoring and have a process for collecting a large number of reports related to the contract requirements, DHH needed to evaluate the current contract requirements for changes once integration spreads these requirements across 5 health plans, utilize enhanced technology to automate collecting, evaluating and reporting findings, and create more detailed monitoring documents such as SOPs and more detailed procedures. The report also stated OBH appears to be requesting the right information to assist in its monitoring and compliance with CMS waiver reporting requirements. Navigant noted several best practices including the gatekeeping and triage process and the IMT process of report review and discussion.

e. Major Recommendations:

Major recommendations include development of a report specific standard operating protocol and a high level guide providing SME with expectations of the review process which has been accomplished. The need for report automation will also be accomplished after integration using Medicaid's FTP and SharePoint protocol for receipt of bayou health plan reports. Navigant suggested use of dashboard style reports which has been implemented. OBH also includes Magellan in the IMT meetings for rapid style feedback with formal documentation and tracking as recommended.

Specific recommendations and responsive actions are:

1. Review contract amendments for Bayou Health integration to support appropriate monitoring and improved administrative efficiency.
2. Develop reports manual with standardized templates and reporting specifications.
3. Automate the report submission, tracking, and feedback process.
4. Develop standard operating procedures and training based on process and content knowledge.
5. Improve feedback process to contractors.
6. In addition to recommendations, Navigant provided a tasks list to aid in the transition to integrated care.

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

Major recommendations include development of a report specific standard operating protocol and a high level guide providing SME with expectations of the review process which has been accomplished. The need for report automation will also be accomplished after integration using Medicaid's FTP and SharePoint protocol for receipt of bayou health plan reports. Navigant suggested use of dashboard style reports which has been implemented. OBH also includes Magellan in the IMT meetings for rapid style feedback with formal documentation and tracking as recommended.

Specific recommendations and responsive actions are:

1. Review contract amendments for Bayou Health integration to support appropriate monitoring and improved administrative efficiency. In response, OBH has worked closely with Medicaid in reviewing its entire contract with the MCO's and behavioral health related rules and CMS authorities. OBH has developed relationships with Medicaid counterparts for assistance in monitoring after integration. Behavioral health related guidance documents are being developed for the MCOs as well. OBH recommended adopting national performance measures including HEDIS measures to allow us to measure plans performance more objectively, cleaned up reporting requirements in the waiver authorities to make the reports we are monitoring more applicable and reduced volume of reports, added language in draft contract amendment to address consistency such as all plans adopting a naming convention and standard template for reporting.
2. Develop reports manual with standardized templates and reporting specifications. OBH has created a reporting document for health plan use for integration. This reporting document addresses all required behavioral health reports with reporting specifications, explanations and expectations for reporting. This document is called the Behavioral Health Companion Guide.
3. Automate the report submission, tracking, and feedback process. Currently, OBH is utilizing SharePoint for the internal review and approval process on authority required reporting. Post integration, OBH will utilize Medicaid's automated process for report receipt, review and feedback.
4. Develop standard operating procedures and training based on process and content knowledge. OBH's main monitoring team (IMT) has conducted an internal training for the monitoring

subject matter experts and developed a SOP. This internal document will be used as guidance for OBH monitoring. Navigant reviewed a draft/sample SOP from OBH during their last on site visit.

5. Improve feedback process to contractors. Currently, Magellan participates in DHH monitoring team meetings (IMT) as well as other weekly scheduled touch base and monitoring meetings. Prior to the IMT meetings the agenda and reports of concern are identified so Magellan can be prepared to discuss. There is follow up immediately following the meeting on any outstanding issues. Post integration, OBH has a detailed monitoring workflow to ensure feedback on all reports are captured and shared with Medicaid, as the contract holder and the respective health plan.
6. In addition to recommendations, Navigant provided a tasks list to aid in the transition to integrated care. DHH has completed all suggested tasks.

g. Availability (hard copy, electronic file, website):

Electronic and hard copy

h. Contact Person:

Karen Stubbs, J.D.
Deputy Assistant Secretary
LA Department of Health and Hospitals
Office of Behavioral Health

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: **Department of Health and Hospitals**
09-340 Office for Citizens with Developmental Disabilities

Department Head: **Kathy H. Kliebert, Secretary**

Undersecretary: **Jeff Reynolds**

Assistant Secretary: **Mark A. Thomas**

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

OCDD has listed a number of accomplishments for FY 2014-2015 in this section; however, it should be noted that the overall effect of these accomplishments resulted in major positive changes in the service delivery system which had positive impacts on those supported by the system. This has been validated by the two most recent reports from United Cerebral Palsy (UCP) “The Case for Inclusion 2014” and “The Case for Inclusion 2015” in that Louisiana ranked in the top seven “Most Improved” states. As system components improve, major outcome areas for people with developmental disabilities (i.e., living and participating in the community; having satisfying lives and social roles; having access and control over supports; and being safe and healthy in the environment which they live) begin to align. The UCP reports noted that Louisiana had a huge improvement in the portion of individuals and resources dedicated to community services, closed six large State institutions and had a significant drop in the portion of individuals served in large institutions.

System Transformation

A. What was achieved? Carried over from the prior fiscal year activities, in FY 2014-2015 the Office for Citizens with Developmental Disabilities (OCDD) continued research, design, and implementation activities related to System Transformation:

- **Request for Services Registry (RFSR)** - The current OCDD Request for Services Registry (RFSR) includes individuals who have requested and are waiting for the New Opportunities Waiver (NOW). The RFSR has remained lengthy despite efforts to fund additional NOW offers periodically since its inception. Stakeholder input

requesting that the Office address the lengthy RFSR and legislative requests to address the fiscal sustainability of developmental disability Home and Community-Based Services (HCBS) led to an internal analysis of the OCDD RFSR as part of OCDD's Systems Transformation Initiative which began in late 2012. Currently, over 13,000 people are on the NOW RFSR. (See Section III: Unmanageable Number of People on the Request for Services Registry.) Through this effort, the Office discovered that one-third of individuals on the RFSR were already receiving other Medicaid long-term supports and services or other comparable alternatives [e.g., other developmental disability waiver services, Office of Aging and Adult Services (OAAS) waiver services, OCDD State-Funded services, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) personal care services, and/or Long-Term Personal Care Services]. Additionally, over 80% of the individuals were Medicaid eligible and could qualify for in-home supports via the Medicaid State Plan and yet were not accessing them. A survey of a sample of individuals on the RFSR revealed that despite the fact that over 95% of the current NOW expenditures are on in-home staff supports, this was not the support most requested or identified as needed.

Based upon results of the RFSR analysis and survey, the OCDD Systems Transformation Core Stakeholder Group continued to advise the Office and Department with regard to proposed efforts to address the Request for Services Registry (RFSR). The Core Stakeholder group reviewed the current OCDD process as well as processes in other states. The information from the survey was also used to inform prioritization considerations as well as needed modifications in the available supports as OCDD moves to a consolidated waiver. In spring 2015, a proposal was completed to modify the existing RFSR process. The new process would involve completion of a more developed Urgency of Need tool, based upon an established tool and process validated in other states with specified modifications tailored to address Louisiana specific needs and supports. The tool would allow for prioritization of the entire RFSR such that individuals would be identified as having emergent (immediate), urgent (clear need within next 90 days to a year), critical (anticipated need due to upcoming life changes within next year to two years), or planning (anticipated need due to upcoming life changes within the next 2-5 years) needs. Waiver offers would proceed within this prioritized structure with individuals being ranked within categories by their RFSR request date such that those waiting longer within a prioritization category would receive an offer first. This would allow for recognition of time requesting and waiting for services but within the context of an actual determination of need and prioritization or urgency of that need. The original proposal was intended to be implemented within the comprehensive Managed Long-Term Supports and Services (MLTSS) system; completion of the tool and initial planning would have been a part of the eligibility, enrollment and managed care coordination processes. With the delay in MLTSS, OCDD has developed some phase-in options for moving toward the prioritization of the RFSR. The current efforts surround two initial actions: 1) modifying the NOW emergency waiver process (rule change) to replace the existing prioritization with use of the emergent categories within the proposed new prioritization tool and then ranking by RFSR date if emergent need is identified, and 2) piloting the full

tool with individuals who are on the RFSR but are receiving services and have an associated support coordinator.

- **Consolidated Waiver** - OCDD currently operates four Home and Community-Based Services Waivers, including the New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Children's Choice Waiver (CCW), and Supports Waiver (SW). There are approximately 11,000 individuals receiving services through these four waivers.

Through stakeholder engagement efforts, it was identified that it is difficult for individuals and providers to navigate the four separate waivers, and it was proposed that there be a consolidation of the four developmental disability waivers. Therefore, Louisiana is proposing a consolidation of the four current waivers into one comprehensive New Opportunities Waiver (NOW). (See Section III: Management of four separate Developmental Disability Waiver Services.)

The proposed consolidated NOW waiver will include services and rate structures from all four current waivers; however, services offered will be most comparable to those currently provided in the NOW. They will be comprehensive in nature. A modified Resource Allocation system will be utilized with the consolidated NOW waiver; however, this new system will most closely resemble the Resource Allocation system in place with the current NOW.

- B. Why is this success significant? The new RFSR process will offer a method for a more transparent and streamlined approach to the current process for allocating emergency waiver options. The process will address in a more immediate manner the need for an emergency waiver due to ease of application and speed of the process. The full process in pilot will support prioritization of need through routine contact and assessment with all individuals on the RFSR. This will allow for a more responsive system that will be able to provide supports closer to time of need.

The consolidated waiver will allow for ease of access to OCDD waivers and will provide an array of service options to individuals receiving Home and Community-Based Services based on individual needs.

- C. Who benefits and how? Individuals and families will benefit from all Systems Transformation initiatives. Both the interim and fully proposed RFSR process will result in an improvement in prioritization that supports a more responsive system aligned with urgency of need. The consolidated waiver will allow for a full array of services to individuals based on their specific needs. OCDD and Local Governing Entities (LGEs) will benefit via the streamlined process for RFSR prioritization that will allow better alignment of resources and quicker processing of applications and offers consistent with set criteria. The overall system will benefit by aligning needs with availability of supports and by having a consistent waiver process.
- D. How was the accomplishment achieved? The accomplishment occurred through use of a Core Stakeholder group and analysis of available data for individuals currently on the RFSR. Service utilization for all current services in all four waivers was evaluated. The data and survey results were used to identify areas for change along with improved

prioritization for a more responsive system. Other states processes, including service array options, were evaluated in the context of fit for the Louisiana system and stakeholder needs.

- E. Does this accomplishment contribute to the success of your strategic plan? Yes. System Transformation components are aligned with all six goals of OCDD's strategic plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. The approach OCDD continues to utilize in tying a comprehensive system analysis to a multi-phase strategic action plan, as well as the approach of involving stakeholders and incorporating national best-practice recommendations, is consistent with nationally recognized strategies for success in large-scale system transformation.

Enhanced Support for Individuals with High-Risk Needs via Partnerships between OCDD Resource Centers and Local Governing Entities (LGEs)

- A. What was achieved? OCDD pursued modifications to several processes for supporting individuals with high-risk needs including: 1) crisis referral and diversion process; 2) court liaison and evaluation; and 3) local oversight teams.
 - 1. OCDD established formal partnerships between the OCDD Resource Centers serving each local area and the Local Governing Entities (LGEs). The OCDD Resource Centers are now the point of crisis referral and contact for the LGEs resulting in action and support closer to the participant and family in need for every crisis situation. In the face of several emerging challenges this year, the move to local partnerships and increased Resource Center involvement allowed for continued improvement in crisis diversion such that admission rates to Pinecrest Supports and Services Center (PSSC) were lower than would have otherwise been expected. Challenges have included increases in crisis referrals (91 referrals in the first six months of 2015 compared to referral range between 69 and 78 for each year 2012-2014), more referrals (57%) from other acute/temporary institutional settings (i.e., psychiatric hospitals, jail, etc.), and increased complexity of needs and supports for participants referred in crisis (i.e., combination of behavioral and legal needs are the most common referral profile). The modified process and earlier/more consistent involvement of the Resource Centers have supported a diversion rate of 67% consistent with efforts in 2014 and an improvement from previous years. Diversion activities not only result in avoidance of institutionalization, but also in the ability to receive enhanced supports needed to remain in the current community living situation for many individuals.
 - 2. With increased referrals involving legal concerns and jail as the noted location at time of referral (i.e., 14-20% of referrals occurred from jails between 2012 and 2014) along with increased requests for DHH to assume custody, OCDD focused Resource Center efforts at partnering with LGEs for court liaison and evaluation. The OCDD Resource Center clinicians now complete all court requested custody evaluations and complete consultations for individuals referred from jails as well as

work to develop relationships with court/judicial counterparts. Involvement in these activities has doubled in 2015 compared to both of the preceding two years. Although court involvement and related activities continue to grow in general, results of these efforts have included avoidance of DHH custody for some individuals, avoidance of unnecessary institutionalization for some individuals, and to date in 2015, fewer referrals directly from jails (4% thus far for 2015).

3. Efforts toward assuring that persons with a history of and/or current challenges related to non-consensual sexual behavior (NSB) have access to needed supports were formalized statewide and Local Oversight Teams were created with membership from the OCDD Resource Centers, LGEs, providers and support coordination. Local Oversight Teams meet routinely and review each identified individual's support plan providing recommendations for any additional actions needed. The following is a summary of outcome data related to this initiative:

- Local Oversight Teams are currently following 213 individuals statewide with high-risk nonconsensual sexual behavior.
- Positive outcomes and improved supports occurred for those identified with NSB and ongoing risk needs. Since the initiation of the NSB process, only 13 persons have had a subsequent incident of NSB, and all but one person had waiver supports at the time of the incident (the other individual was residing in a community home). For these persons, not all incidents involved direct contact. Seven of the 13 incidents occurred during the second quarter (3/31/15-6/30/15). Five of these individuals remained in the waiver program; one individual was incarcerated and then returned to waiver; and the other individual maintained placement in the community home. It should be noted that on average, between 5% and 20% of known adult sex offenders will be re-arrested for a new sex crime within three to six years of follow up [Association for the Treatment of Sexual Abusers (ATSA), 2010].
- Involvement of the Local Oversight Teams has allowed for enhanced responsiveness in several situations as the individual's NSB-related support needs increased.

- B. Why is this success significant? These targeted partnerships with the OCDD Resource Centers and LGEs have resulted in positively impacted outcomes for each individual specifically supported in one of the above initiatives with fewer individuals necessitating institutional services and an enhancement in supports available to individuals in their current living arrangement. Additionally, avoidance of institutionalization has positive fiscal impacts for the system as a whole.
- C. Who benefits and how? People with developmental disabilities, their families, and providers benefit from these efforts with the ability to receive supports without institutionalization as well as minimization of rights restrictions. The Local Oversight Teams result in enhanced supports for persons with multi-complex needs, or who pose a greater risk to public safety. The activities also further strengthen collaboration between the local governmental entity and the local resource center to enhance accessibility and maximize coordination of services.

- D. How was the accomplishment achieved? The OCDD built upon the efforts achieved by the OCDD Resource Center transformation in FY 2013-2014. Each Resource Center established specific points of contact with the LGEs for specific activities, and direct partner efforts occur now at the local level. Each OCDD Resource Center works in conjunction with the OCDD Central Office Clinical Staff to further inform continued statewide efforts and needs.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a specific goal in the Strategic Plan relative to supporting people with developmental disabilities to achieve improved outcomes, quality of life, and attain personal goals through the development and provision of capacity-building activities, partnerships, and collaborative relationships.
- 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 initiative focused on using existing data to identify gaps within the current developmental disabilities services delivery system in conjunction with a review of national trends and best practices, along with input from internal and external stakeholders, to identify need for system changes.

Implementation of a new AIP Monitoring Process

- A. What was achieved? During FY 2014-2015, OCDD implemented a new Human Services Accountability and Implementation Plan (AIP) Monitoring Process. In this revised process, the OCDD Central Office Waiver Section is able to more effectively monitor and follow-up to ensure that the ten Local Governing Entities (LGEs) are complying with the requirements set forth in the Memorandum of Understanding (MOU) between each LGE and DHH/Medicaid/OCDD which includes operation of the waivers serving persons with developmental disabilities.
- B. Why is this success significant? The process results in improved quality of support plans and expedited certification and implementation of plans. With this process, the LGE waiver supervisor or designee is tasked with completing a supervisory level review on 25% of the Level of Care/Plan of Care cases per quarter. This modification allows the waiver supervisor to monitor consistency in how support coordinators, medical certification specialists, and quality enhancement specialists are reviewing waiver participants' plan of care (i.e., support plan).
- C. Who benefits and how? Waiver participants benefit by increased monitoring, improvement in the quality of their support plans, and a quicker turn around in certification and implementation of plans as errors are discovered and remediated earlier; thus, delays in processing are reduced.
- D. How was the accomplishment achieved? Collaboration among the OCDD Central Office Waiver Section staff, the Central Office AIP Monitoring team, and waiver management staff at the Local Governing Entities was the key to this accomplishment.

- E. Does this accomplishment contribute to the success of your strategic plan? Yes. OCDD has a specific goal in the Strategic Plan relative to supporting people with developmental disabilities to achieve improved outcomes, quality of life, and attain personal goals through the development and provision of capacity-building activities, partnerships, and collaborative relationships.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Although this is a best practice and preventative approach, this new AIP Monitoring process is unique to OCDD and the Local Governing Entities who oversee implementation of the four waivers which serve individuals with developmental disabilities. Therefore, it would not be useful to other departments or agencies.

Continuation of Employment First Foundation Building

- A. What was achieved? In FY 2014-2015, OCDD continued foundation building for Louisiana's Employment First Initiative. The following successes were achieved:
- Increased the expectation that at least 10% of individuals supported by Support Coordination will become employed in the community.
 - Began training on the expectations for the new Center for Medicare and Medicaid Services (CMS) Home and Community-Based Services (HCBS) Settings rule in regards to vocational providers. (Settings now have to be integrated and individualized and offer employment opportunities for everyone they serve. All settings must be in compliance by 3/17/19. Training has been provided to Local Governing Entity (LGE) offices, vocational providers, and various stakeholders.)
 - Conducted Public Forums around the state to educate stakeholders on the HCBS rule as well as gain public input into the changes regarding employment.
 - Conducted trainings with all providers, LGE offices, Support Coordinators (SCs) and stakeholders regarding changes that will be taking place over the next several years regarding employment.
 - Began Employment Roundtables, which have been scheduled in every region, giving providers the ability to discuss their current programs and talk about changes that will need to be made.
 - Developed vocational provider self-assessments which will allow the providers to accurately assess where they stand in regard to compliance with the rule and begin the process of compliance planning.
 - Developed the "Path to Employment" Form to be completed by all SCs with each individual that is supported in the waiver. (This sets the stage to begin the discussion of employment with everyone.)
 - Participated in regional job fairs.
 - Participated in Employer Summits in Shreveport and Baton Rouge.
 - Reserved opportunities (slots) in the Supports Waiver for individuals transitioning from "School to Work" that want to work in competitive employment in the community but will require follow along.

- Added a voluntary Provider Report Card that is part of the Freedom of Choice list which will allow individuals to make an informed choice when choosing vocational providers.
 - Began working with Louisiana Rehabilitation Services (LRS) on a Memorandum of Understanding (MOU) to affirm a working partnership to improve competitive and integrated employment outcomes for individuals with disabilities.
- B. Why is this success significant? Individual employment in the community has become a major focus within OCDD over the last few years. OCDD released a position statement in 2011 that stated “*Employment will be the primary outcome for all persons receiving OCDD services who are of working age.*” OCDD continues to make strides toward increasing individual employment that is integrated in the community. OCDD’s work toward increasing employment outcomes for persons with intellectual and developmental disabilities aligns with the last HCBS Settings Rule that was effective 3/17/14. As OCDD continues to focus on employment and as concerns about employment are alleviated through improvement of service delivery, more individuals with developmental disabilities can achieve and maintain employment thereby increasing their independence.
- C. Who benefits and how? Individuals with developmental disabilities who want to work and achieve employment will benefit from the improvement of employment services as they will be able to obtain and maintain employment thereby increasing their independence and enriching their lives. Families benefit by the increased independence of their family members and through a decreased level of financial responsibility. The state will benefit as these individuals will pay taxes and spend money, thereby improving the economy.
- D. How was the accomplishment achieved? This was achieved by making individual integrated community employment a major Office focus and by making changes to employment services that are offered in the waivers, as well as placing an emphasis on the need for employment for individuals with developmental disabilities. Additionally, to maintain the successes and to continue to make strides in the area of employment, OCDD continues to host meetings and trainings with partner agencies partner, such as Louisiana Rehabilitation Services and Louisiana Workforce Commission, as well as individuals who are served through OCDD and their families. This allows opportunities to get feedback on the changes and to be responsive to what is being asked of OCDD in the way of employment.
- E. Does this accomplishment contribute to the success of your strategic plan? Yes. Development of policies and procedures to provide pathways to community employment is a strategy in OCDD’s current Strategic Plan.
- F. Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies? Yes. This process will continue to be implemented in order to continue the outreach and education specific to employment. Changes will continue to be made within the OCDD

to increase the number of individuals in community employment. Employment should be a focus for all agencies that serve individuals with any type of disability, not just developmental disabilities. Employment for people with the most significant disabilities has been in the national spotlight for the last eight years and individual, integrated employment is highlighted in the new CMS HCBS Settings rule and the new Workforce Innovation Opportunity Act (WIOA).

EarlySteps Expenditure Reduction and Improved System Performance

A. What was achieved? The EarlySteps program achieved several significant accomplishments during FY 2014-2015:

1. Achieved one of the primary program purposes in that forty- five percent of the children exiting EarlySteps improved in their development such that they were functioning at the level of their typical peers at exit of the program. (Note: This is a seven percent gain in outcomes compared to the previous two years).
2. Following the implementation of new Eligibility Criteria in May 2012, continued reduction in State General Fund dollars by an additional \$1.14M in expenditures for services compared to the previous year.
3. Achieved successful implementation of family cost participation in EarlySteps services. (Families with income above 300% of the Federal Poverty Level contribute to a portion of the cost for some services received. Estimated revenue projected for FY 2014-2015 was \$350,000 and the program actually collected \$351,911 in revenue.)

B. Why is this success significant?

1. One of the stated purposes of the early intervention program is to minimize the potential for developmental delay in young children. This result indicates the benefit of early intervention through its impact on a child's development.
2. Since moving into OCDD in 2007, EarlySteps expenditures increased primarily due to a 30% increase in the number of enrolled children. A change in eligibility criteria decreased the number of eligible children in the program resulting in continued reduction in expenditures and contributed to the sustainability of the program.
3. Implementation of cost participation will assist in the sustainability of the program.

C. Who benefits and how?

1. Effective service utilization benefits all children in the system by efficiently and effectively designing services, making services more available to everyone who is eligible, and eliminating delivery of unnecessary services.
2. The early intervention system benefits overall in that stable revenue can continue to support the program without further cost containment measures.
3. Families and children benefit through the successful development of their children. In addition, another stated purpose of early intervention is to minimize the need for future special education services for children. By attaining developmental

milestones, this risk is minimized for a child.

D. How was the accomplishment achieved?

1. EarlySteps uses a regional system of technical assistance and training provided through its nine regional coordinators. Data is reviewed frequently and follow-up is conducted when targets are not met. In addition, several statewide training activities have occurred over the past 2-3 years which have focused on strategies to improve in targeted areas. In FY 2011-2012, training was conducted with regional provider teams on correctly identifying family needs regarding their child's development and focusing on developing program plans designed to meet those needs. Service delivery, focused on these specifically identified needs, assists both providers and families in targeting activities with children. These activities are continuing, and they have contributed to the ongoing successful implementation.
2. Staff compared eligibility criteria of other states to those used by EarlySteps prior to modifying program eligibility criteria. A more restrictive criterion of 1.5 standard deviations below the mean in two areas of development was selected and cost savings were projected based on the change. Staff monitors implementation of the criteria on an ongoing basis to ensure sustainability.
3. EarlySteps staff utilized the resources of its Central Finance Office (CFO) contractor to develop the cost participation system. The CFO has assisted other states in utilizing the process. Stakeholders were involved regularly in the implementation of the changes through regional meetings and regular updates. Materials were developed to assist in implementation, and reviews of implementation are ongoing.

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

1. Yes, reaching/exceeding the targets set for this accomplishment demonstrates the benefit of the program.
2. Yes, a major focus for EarlySteps is providing quality services and reducing costs. The eligibility change allowed EarlySteps to reduce costs for services.
3. Yes, additional revenue generated from cost participation will support program operations moving forward.

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

1. Yes, EarlySteps used data on children enrolled in the system to project the cost savings (child outcome data at entry and the costs per child). Results of the calculations indicate that the cost savings continue to be correctly predicted.
2. The training model used for regional training was based on nationally available content, which was individualized for EarlySteps. The training included features of Implementation Science, which incorporates follow-up activities to sustain changes in performance.
3. Yes, EarlySteps used the model from other states and worked with the Office of

Special Education Programs to accomplish the development and implementation of cost participation.

II. Is your department 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.

OCDD is making progress in its five-year Strategic Plan/Business Plan particularly with those initiatives that support the following strategic plan goals: 1) To provide a Developmental Disabilities Services System which affords people with information about what services and supports are available and how to access the services system; 2) To provide a person-centered planning process consistent with a needs-based assessment 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 Business Plan Priorities: 1) System Transformation, 2) Resource Center Transformation, and 3) Privatization. The success of the following initiatives in FY 2014-2015 has moved the Office toward goals/objectives outlined in both OCDD's Strategic Plan and Business Plan: System Transformation, Enhanced Support for Individuals with High-Risk Needs via Partnerships between OCDD Resource Centers and Local Governing Entities (LGEs), EarlySteps Expenditure Reduction and Improved System Performance, Continuation of Employment First Foundation Building, and Implementation of a new AIP Monitoring Process.

◆ Where are you making significant progress?

Supporting Individuals with Complex Behavioral Health Needs to Live in their Community

OCDD Resource Center Community Support Teams (CSTs) and Community Psychologists have continued to shift services to supporting individuals with the most complex behavioral needs and currently act as a service of last resort. Presentation of behavioral health needs and/or legal involvement represent the primary reason for high cost institutionalization within the OCDD system. A performance indicator (PI Code #24259) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative. This year the efforts of the OCDD CSTs and Community

Psychologists to support individuals referred with complex behavioral health needs resulted in maintenance of community living for 98% of the individuals supported. These results represent significant positive outcomes for these individuals and speak to the success and importance of this OCDD effort.

1. To what do you attribute this success? OCDD resource centers employ clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral and medical support needs. The resource centers utilize 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 at an accelerated pace for a greater number of individuals. With implementation of triage initiatives, the resource center staff members are able to provide services to a greater number of individuals and provider agencies. With implementation of crisis/diversion initiatives, the resource centers in collaboration with the Local Governing Entities are able to initiate a consultation prior to escalation of a crisis situation such that one's community connection is maintained, or within a timeframe that increases the likelihood of diversion to the most integrated setting.

Enhanced Training for Community Professionals and Providers to improve capacity to support individuals with complex needs

OCDD Resource Centers utilize the professional expertise of their staff to develop and conduct training and technical assistance activities with community providers and professionals in an effort to enhance the ability of these providers and professionals to support individuals with complex medical and behavioral support needs. These activities are offered at the initiation of both the Office and actual provider/professional request. A performance indicator (PI Code #24696) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative. Efforts have resulted in a 97% satisfaction rate from providers and professionals.

1. To what do you attribute this success? OCDD resource centers employ clinicians with expertise in supporting and treating individuals with developmental disabilities and complex behavioral and medical support needs. As part of the Resource Center Transformation initiative, OCDD established a workgroup that included internal and external stakeholders across multi-disciplines. Workgroup members included OCDD clinical and administrative staff; resource center nursing, behavioral health, and allied health staff; human services district and authority designees; a provider designee; and support coordination designee. The workgroup provided feedback and structure to training designed to meet customer needs. The training is provided utilizing a multi-disciplinary approach working to improve the ability of caregivers and providers to achieve positive outcomes for persons with developmental disabilities and 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 at this accelerated

pace. Feedback is obtained from customers at the time of each training event. This feedback and suggestions for additional training will allow OCDD to be responsive to customers' training needs.

Successfully Supporting Transition from Institutional Services to Home and Community-Based Living

OCDD Resource Centers designate transition and technical support staff to assist Pinecrest Supports and Services Center and Cooperative Endeavor Agreement agencies to transition individuals from these facility-based settings to home and community-based living situations. The transition and technical support staff act as a bridge between the facility teams and the community teams and follow the individual for at least one year post move to ensure needed supports are in place. A performance indicator (PI Code #24699) is included in OCDD's Strategic Plan and Operational Plan to monitor success with this initiative. This FY, 91% of individuals transitioning indicated satisfaction with their new living arrangements.

1. To what do you attribute this success? OCDD has utilized a person-centered approach and tools as individuals transition from a large Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) setting into less restrictive community settings to ensure individuals' support needs are met and to assist with improving quality of life in the less restrictive environment. The PIQ process allows ongoing oversight for a minimum of one year after transition from a large ICF/DD to ensure that supports are being met and that the inter-disciplinary team is actively responding if issues are identified.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress is expected to continue at an accelerated pace. OCDD will continue to refine activities in FY 2015-2016 to further improve the oversight process following transition from a large ICF/DD to ensure quality of life and support needs being met.

EarlySteps' Success in Exceeding Performance Standards related to Development and Implementation of Individual Family Services Plans

One of the primary program purposes of EarlySteps is to enhance the capacity of families to meet the needs of their infants and toddlers with disabilities. A key measure of success for meeting this need is timely service delivery to eligible infants and toddlers. Performance is measured through two indicators:

Development of Individual Family Service Plans within 45 days of referral:

A focus on improving the State's compliance related to this requirement has been in place since 2008. A performance indicator (PI Code #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 2014-2015, this standard was exceeded with an achievement of 99%.

1. To what do you attribute this success? EarlySteps is able to generate reports from its data system and closely track timelines for completion of IFSPs by its entry offices. When performance is less than 100%, monitoring is triggered to determine the reason for the delay. The system now tracks delays which are due to family reasons as compared to system or internal office reasons; if the delay is due to a system reason, a finding is issued and the entry office receives technical assistance in managing its timelines.
2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Progress has been steady and is expected to be maintained.

Implementation of Individual Family Services Plans within 30 days of parent consent:

A focus on improving the State's compliance related to this requirement has been in place since 2008. A performance indicator (PI Code #24665) is included in OCDD's Strategic Plan and Operational Plan to monitor compliance with this requirement. The current performance standard for this indicator is 94%. In FY 2014-2015, this standard was exceeded with an achievement of 95%.

1. To what do you attribute this success? Since 2007, EarlySteps has conducted provider recruitment and enrollment activities to increase the availability of providers around the state. Lack of provider availability is the main reason for a delay in meeting the 30-day timeline. Availability impacts regions in central and north Louisiana specifically. In addition, support coordinators are required to have team meetings and contact the regional coordinator if there are problems with provider availability. With an increased number of providers in place and the addition of the follow up by the support coordinator, the performance standard has been met. Early in FY 2014-2015, EarlySteps formed a workgroup to specifically address this need. Provider recruitment and policy changes to support alternate means of meeting child/family outcomes (such as a telehealth model) are being explored.
 2. Is this significant progress the result of a one-time gain? Or is progress expected to continue at an accelerated pace? Since 2004 when EarlySteps began collecting data for this indicator, steady progress has been shown; it is expected to continue due to increased availability of providers.
- ◆ **Where are you experiencing a significant lack of progress?**

Reducing the Waiting Time on the Request for Services Register (RFSR)

The current OCDD Request for Services Registry (RFSR) includes individuals who have requested and are waiting for the New Opportunities Waiver (NOW). The RFSR has remained lengthy despite efforts to fund additional opportunities and repeated reform initiatives over the past several years. Performance Indicators (PI Code #24648, 24649, and 24650) are included in OCDD's Strategic Plan and Operational Plan to monitor progress related to established standards. The Office has been unable to reach Performance Standards related to these indicators for many years, and unless a

substantial number of opportunities (slots) are added the waiting time will continue to escalate.

1. To what do you attribute the lack of progress? No additional state appropriations for waiver opportunities have been funded by the Louisiana legislature for several years. Thus, as more individuals request waiver services and are added to the RFSR without any new opportunities being offered, the natural trend is for more persons to wait longer and the overall average wait time for the RFSR to increase over time. This is the trend which has been demonstrated in the data for the three performance indicators listed above. In FY 2014-2015, the trend continued with no additional developmental disabilities waiver opportunities being funded/allocated and, consequently, the wait time increasing for persons on the registry who were waiting for developmental disabilities waiver services.
 2. Is this lack of progress due to a one-time event or set of circumstances? A set of circumstances which are described in question number 1, above.
- ♦ **Has your department revised its strategic plan/business plan to build on your successes and address shortfalls?** Yes. OCDD's Strategic Plan has been updated for FY 2015 through 2019. Updates to both the Strategic Plan and Business Plan include revisions to program objectives, strategies and indicators to reflect Office direction, to build on successes, to provide strategies in areas where success has not be 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?** Objectives are assigned to staffs within the Office 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 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?

Community settings lack adequately trained professionals and direct support staff to deliver needed (1) behavioral services, including qualified persons to deliver applied behavior analysis to people with autism, and (2) services and supports, including skilled nursing services, to individuals who are medically fragile

A. Problem/Issue Description

1. What is the nature of the problem or issue? There continues to be a lack of adequately trained professionals and direct support staff to deliver needed behavioral and medical/nursing services to individuals with complex needs in community settings, including a lack of qualified professionals to deliver applied behavior analytic therapies to persons with autism. There is a shortage of trained staff to provide services and supports for individuals with significant medical needs, including skilled nursing services for individuals who are medically fragile and reside in community settings.

Adequate behavioral supports can be very effective in improving quality of life and reducing behavioral symptoms/challenges for individuals with intellectual and 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 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 and improvements have occurred in some areas, a general problem continues to exist. It is believed that a multi-faceted and multi-year approach is required to resolve the problem.

2. Is the problem or issue affecting the progress of your strategic plan? Yes. Lack of professional supports in community settings has continued to be the primary contributor to admissions to the supports and service center and other more restrictive settings, with requests for admissions resulting when community providers are unable to meet behavioral and psychiatric needs of people whom they are serving in community settings and in smaller numbers those with complex medical needs. Lack of trained autism professionals negatively impacts the ability to develop new autism services, which can prevent more severe negative developmental outcomes. The inability to teach functional behavioral skills adequately detracts from community participation objectives (i.e., that individuals with disabilities are participating fully in communities). Continued movement from ICF/DD settings to community-based living arrangements is also hampered due to the challenges in securing needed behavioral and medical/ nursing supports for individuals with complex needs.
3. What organizational unit in the department is experiencing the problem or issue? OCDD and the Local Governing Entities have been impacted by this problem for a number of years. The Office of Behavioral Health (OBH) and Medicaid are also likely experiencing some impact due to this problem.
4. Who else is affected by the problem? Individuals supported and their families, support coordinators, and private providers who serve persons with developmental

disabilities in community homes, family homes, and supported independent living settings are impacted by this problem. Hospitals are impacted when individuals with co-occurring needs present at the emergency room due to difficulty accessing other needed services.

5. How long has the problem or issue existed? The problem is longstanding.
6. What are the causes of the problem or issue? How do you know? Many factors contribute to the problem beginning with a historic lack of training of persons equipped to deliver these services. Many professional training programs offer no training in developmental disabilities. Recent national reports indicate that there is a general shortage of behavioral health professionals in many areas of the country with access for those with co-occurring intellectual/developmental disabilities and behavioral health needs even more challenging. The cost of providing nursing services in individual settings and challenges in terms of isolation in these arrangements negatively impact the access to needed medical/nursing supports. Both the increasing number of persons with developmental disabilities now being served in the community and the downsizing of institutional services, generally considered to be positive and progressive developments in developmental disabilities services, have contributed to an increased need for medical/nursing and behavioral/psychiatric supports in the community. In addition, private Supported Independent Living (SIL) providers serving persons in waiver settings and private community home providers generally conduct and are required to conduct very little training with direct support staff on positive behavior supports and medical/nursing needs.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Consequences include a significant number of people with developmental disabilities having unmet needs, a continued need for costly institutional admissions to the higher treatment cost supports and service center, continued high utilization of high cost acute services, and an inadequate number of practitioners to positively impact the developmental trajectories of children with autism, other behavioral challenges and/or complex medical needs leading to increasing service costs over the course of their lifespan.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue? The following are recommended actions to alleviate the problem:
 - Continue implementation of opportunities for partnering with university programs that provide training as well as individual clinicians resulting in additional needed professionals, growing the service provider pool.

- Continue implementation of statewide access to training for direct support workers through the Money Follows the Person (MFP) Rebalancing Demonstration (My Place Louisiana) program with additional development of specialized/customized approaches for providers and evaluate opportunities for expansion of access to needed training.
 - Include behavioral and medical therapeutic respite options via the OCDD Consolidated waiver and research to develop specialized shared living waiver models for individuals with complex medical and behavioral needs.
 - Participate in partnership with OBH and Medicaid to support implementation of the behavioral health integration into Bayou Health beginning 12/1/2015.
 - Continue OCDD developed and sponsored professional continuing education opportunities.
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? Yes. A recommendation has been included in this annual report for the last few years. Some recommendations have been implemented, while others remain and new recommendations are included.
4. Are corrective actions underway? Yes. A number of actions are underway:
- OCDD's statewide Positive Behavioral Supports (PBS) curriculum for direct service workers has been expanded to include statewide certified trainers and has been incorporated into the resource center transformation as an ongoing option with local accessibility.
 - OCDD continues its statewide offering of Medical/Nursing Direct Service Worker (DSW) training via Money-Follows-the-Person (MFP) Rebalancing Demonstration.
 - OCDD continues to offer Board Certified Behavior Analysts (BCBA) continuing education opportunities as well as other behavioral and psychological continuing education options.
 - OCDD continues to provide consultation and technical assistance via the Resource Centers.
 - OCDD continues to work with Medicaid to support Applied Behavior Analysis (ABA) services via the State Plan. Licensure of Behavior Analysts began in January 2014 which allowed offering ABA services to children with a diagnosis of Autism or other appropriate diagnosis through the Other Licensed Professional option in the State Plan. OCDD collaborated with Medicaid in the development of assessment and prior authorization processes, and continued collaboration is ongoing to address needed continued expansion of service access.
5. Do corrective actions carry a cost? 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 2020. While other corrective actions

could carry a cost in so far 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. However, costs are in all probability offset by costs associated with failure to implement corrective actions as: 1) failure to intervene at the community level can result in extensive additional institutional treatment costs and 2) failure to intervene with persons with autism at an early age does result in extensive lifelong service costs that are estimated at over one million dollars per person and incurred by families and the taxpayer.

Management of Four Separate Developmental Disability Waiver Services

A. Problem/Issue Description

1. What is the nature of the problem or issue? Current Developmental Disability Waiver Services are distributed across four 1915 (c) waivers with different services in each waiver. This design is confusing for participants and unwieldy for staff.
2. Is the problem or issue affecting the progress of your strategic plan? Yes. One of the goals of the OCDD Strategic Plan is to afford people with information about available services and supports and how to access the services system. The four different waiver options make it difficult to provide clear information and often cause confusion for those seeking services and supports in that applicants are uncertain of which option will best meet their specific needs.
3. What organizational unit in the department is experiencing the problem or issue? OCDD and Local Governing Entities are affected by this problem.
4. Who else is affected by the problem? Individuals who are applying for services or already participants and their families, support coordinators, private providers and stakeholder groups are impacted by this problem.
5. How long has the problem or issue existed? The first waiver was titled the Mentally Retarded and Developmentally Disabled Waiver (MRDD Waiver). The Children's Choice Waiver was added in February 2001. The New Opportunities Waiver (NOW) replaced the MRDD Waiver in April 2003. The Supports Waiver followed in July 2006, and the Residential Options Waiver (ROW) in October 2009. As new waivers were added and existing waivers amended to add new services, the problems began and have continued to escalate.
6. What are the causes of the problem or issue? How do you know? Four different Home and Community-Based Services (HCBS) waivers serving one population (individuals with developmental disabilities) without the consistency needed to maximize services, simplify service coordination, and avoid confusion has caused the problem. It is evident through observation of day-to-day coordination/delivery of waiver services in Central Office and Local Governing Entities, as well as

feedback from applicants/families and other stakeholders.

7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Consequences include continued confusion about services offered by the four waivers, improper utilization of available services, along with continued difficulty in management of waiver services.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes
2. What corrective actions do you recommend to alleviate or resolve the problem or issue? Consolidation of the four Developmental Disability Waivers into a single waiver.
3. Has this recommendation been made in previous management and program analysis reports? Not specifically
4. Are corrective actions underway? Yes. OCDD is working to develop a single 1915(c) waiver (Consolidated NOW) which will combine many services and add new service coverage. The target for FY 2015-2016 is to have a consolidated waiver amendment prepared for CMS review. This waiver amendment will include a new Resource Allocation method, the service array options available, and a phase-in plan. Draft service array options and a concept paper have been developed. While a rate structure for services and a resource Allocation method will need to be developed. (See Section I: System Transformation - Consolidated Waiver.)
5. Do corrective actions carry a cost? No, the goal of the consolidated waiver is to implement with budget neutrality.

A Growing Number of People on the Request for Services Registry (RFSR)

A. Problem/Issue Description

1. What is the nature of the problem or issue? The Developmental Disability Request for Services Registry (RFSR) has a growing number of people waiting for services and has no prioritization system to allow individuals with the most immediate needs to be served most quickly.
2. Is the problem or issue affecting the progress of your strategic plan? Yes.
3. What organizational unit in the department is experiencing the problem or issue? OCDD and Local Governing Entities are experiencing the problem.
4. Who else is affected by the problem? Individuals who are applying for services and their families, support coordinators, private providers and stakeholder groups are

impacted by this problem.

5. How long has the problem or issue existed? This has been a problem for many years. The RFSR, also known as the waiver “waiting list” has been the subject of repeated reform initiatives over the past several years, in an effort to reduce time spent waiting for waiver services.
6. What are the causes of the problem or issue? No additional funds to increase the number of waiver opportunities (slots) needed to provide additional services and reduce the waiting list. Additionally, not having a process for evaluation and prioritization of those currently on the waiting list. Once put into place, such a system will likely result in lower numbers and a better system to serve those with the greatest need first.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? Individuals and their families continue to wait for needed services while the “waiting list” continues to grow. This is a particularly significant problem for those individuals/families who are experiencing urgent situations and who are at risk of institutionalization or hospitalization due to lack of services availability.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes
2. What corrective actions do you recommend to alleviate or resolve the problem or issue? Improving processes/tools for managing the RFSP to include re-evaluation/prioritization of individuals currently on the waiting list and periodic updates to maintain accuracy are recommended. These actions will result in a more accurate list which will likely result in lower numbers and, more importantly, result in those with greatest need receiving services first.
3. Has this recommendation been made in previous management and program analysis reports? The growing number of individuals on the RFSR waiting for developmental disability services has been a long standing problem. While strides have been made over the years with the addition of new waivers and validation of waiting list information, the problem continues to the dismay of both OCDD and the people waiting for services. The problem has been addressed in different ways in annual reports in the past several years.
4. Are corrective actions underway? Yes. During a RFSR re-evaluation, OCDD discovered that one-third of individuals on RFSR were already receiving other Medicaid Long Term Supports and Services (LTSS) or comparable alternatives and over eighty percent were Medicaid eligible and could qualify for in-home supports through the Medicaid State Plan but were not accessing them. This re-evaluation,

along with input from the Core Stakeholder group, formed the basis for the creation of a RFSR prioritization tool, which will allow individuals with the most immediate needs to be served most quickly in the NOW program. No target has been set for full implementation of new RFSR process, as the target date is dependent on many other factors. The new process has been outlined, and a pilot of the tool is currently in process with individuals who currently have a Support Coordinator and therefore have a mechanism to pay for screening with the tool. (See Section I: System Transformation - Request for Services Registry.)

5. Do corrective actions carry a cost? Yes. The cost of conducting a prioritization screening for all individuals on the Request for Services Registry is approximately \$3 million. All individuals on the RFSR must be screened in order for full implementation of the process to occur. No funds have been allocated for this so far. Implementation will require reallocation or additional funds to the department.

Maintenance associated with facilities in which the campuses have been vacated

A. Problem/Issue Description

1. What is the nature of the problem or issue? Over the past ten years, eight former supports and services centers have been privatized or closed, and OCDD continues to be responsible for costs associated with six of these eight facilities. These costs may include acquisitions and major repairs, risk management fees, building and grounds maintenance, utilities, and/or loss prevention/security. In addition, OCDD remains responsible for risk management fees at three privatized facilities and for major repairs and identified maintenance costs per the Cooperative Endeavor Agreement for operation of the former Northlake Supports and Services Center facility. OCDD will continue to be responsible for all of these costs as long as the properties belong to DHH/OCDD and will continue to be responsible for the risk management fees for two (2) years after the properties no longer belong to OCDD. Total cost associated with maintaining the closed and privatized OCDD properties was approximately \$7,407,667 in FY 2014-2015.
2. Is the problem or issue affecting the progress of your strategic plan? Yes. Although indirectly, this problem is affecting OCDD's progress in implementing its strategic plan in that the fiscal resources required to maintain the vacated properties could be better utilized to further OCDD's progress toward any one or all of its strategic plan goals. In addition, the opportunity to utilize state-owned property as revenue-generating property as campuses are vacated has been explored; however, there are current legislative rules in direct opposition to this course of action.
3. What organizational unit in the department is experiencing the problem or issue? OCDD is managing the problem by continuing to allocate necessary resources to manage the costs associated with maintaining the properties and fulfilling Office of Risk Management (ORM) and other state requirements.
4. Who else is affected by the problem? The OCDD budget authority and the

employees fulfilling the duties are affected by this problem.

5. How long has the problem or issue existed? It was identified in FY 2009-2010.
6. What are the causes of the problem or issue? The problem is caused by mandatory duties related to state-owned property insured by ORM. Also, though vacated, the properties remain the property of the State and efforts must be made to keep the physical plant in good condition and to prevent theft or destruction of property.
7. What are the consequences, including impacts on performance, of failure to resolve the problem or issue? The consequence of this issue is a continued expenditure of funds to maintain properties that are no longer used by OCDD. These expenditures may cause shortfalls in future fiscal years.

B. Corrective Actions

1. Does the problem or issue identified above require a corrective action by your department? Yes.
2. What corrective actions do you recommend to alleviate or resolve the problem or issue? DHH/OCDD should secure permission and/or an exception to the Legislative rules and regulations to utilize state-owned property as revenue generating property or amend existing legislation.
3. Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)? Yes. This recommendation was made in this annual report since 2009-2010.
4. Are corrective actions underway? Yes. As current legislation prohibits the sale or lease of state property to a non-government entity, the Office is exploring the possibility of introducing legislation to change this restriction. Additionally, the Office is also working to identify potential buyers for the vacated properties.
5. Do corrective actions carry a cost? No. There would be no direct costs related to researching and developing amendments to existing legislation as these actions would be completed by existing staff. However, as mentioned above, failure to correct the restriction will result in long-term costs to the state for maintaining unoccupied buildings/facilities.

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

A. Check all that apply.

Internal audit

- External audits (Example: audits by the Office of the Legislative Auditor)
- 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)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

National Core Indicators Project - Since FY 2008-2009, the Louisiana Office for Citizens with Developmental Disabilities (OCDD) has participated in the National Core Indicators (NCI) Project. Currently, forty-one states and the District of Columbia participate in the NCI Project. The purpose of NCI Project is to identify and measure core indicators of performance of state developmental disabilities services systems. The NCI Project is co-sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI). Annually, three family surveys are sent to the families of people with developmental disabilities participating in various developmental disability programs and adults with developmental disabilities are interviewed. A number of reports are prepared to summarize the results of this project. Response rate for completed family surveys has decreased over the past five years (especially for the Family Guardian Survey), probably due to some people being selected in the random sample in multiple years. To increase the response rate, during FY 2014-2015, OCDD sent a follow-up reminder postcard approximately two weeks after mailing the family surveys, with a phone number to call if the family has any questions or needs another copy of the survey, which enabled OCDD to receive enough completed surveys for inclusion in all of the national reports when the FY 2014-2015 reports are issued in June of 2016. During FY 2013-2014, OCDD did not receive enough Family Guardian completed surveys to be included in the national report.

1. Title of Report or Program Evaluation:

Reports prepared by Human Services Research Institute and the National

Association of State Directors of Developmental Disabilities Services:

- National Core Indicators Adult Consumer Survey 2013-14 Final Report: This report provides a summary of the results of interviews with adults receiving developmental disability services and provides comparisons between Louisiana and the national average of other participating states.
 - National Core Indicators Adult Family Survey 2013-14 Final Report: This report provides a summary of the survey which was mailed to families of adults receiving developmental disability services who reside with their families and provides comparisons between Louisiana and the national average of other participating states.
 - National Core Indicators Child Family Survey 2013-14 Final Report: This report provides a summary of the survey which was mailed to families of children living and receiving services in the family home and provides comparisons between Louisiana and the national average of other participating states.
2. Date completed: Final reports prepared by Human Services Research Institute and the National Association of State Directors of Developmental Disabilities Services were published in June 2014. (Surveys and interviews were completed between January and June 2014.)
 3. Subject or purpose and reason for initiation of the analysis or evaluation: Surveys and interviews were conducted to evaluate the effectiveness of the Louisiana Developmental Disabilities Services System. Interview questions concerned satisfaction, quality of care, and quality of life. Analyses compared Louisiana statewide results with results of other states participating in the National Core Indicators Project.
 4. Methodology used for analysis or evaluation: The primary tools used for this evaluation were family surveys and consumer interview questions. Analyses reported both the number and percentage of responses to each question. Comparisons were reported among the participating states.
 5. Cost (allocation of in-house resources or purchase price): The family mail-out surveys were printed and mailed through a purchase order for \$8476. All other activities were performed in-house. Obtaining and verifying information for families for the mail-out samples and consumers for the interview sample took approximately 272 hours of staff time. Scheduling interviews, completing background information, and interviewing consumers took approximately 1,400 hours of staff time. Entering family survey data and consumer interview data into the NCI database took approximately 184 hours of staff time. Postage costs for a Business Reply Permit and return postage costs were approximately \$3,000. Finally, travel costs to conduct 400 interviews were approximately \$6,000.

6. Major Findings and Conclusions: Overall, Louisiana was ranked within the average range for the *Child Family Survey*, *Adult Family Survey*, and *Consumer Outcomes Interviews*. The majority of responses were “Within Average Range” with a substantial number falling five or more percent above average. However, there were a few areas that were five or more percent below average.
7. Major Recommendations: Acquire information/explanations/causes related to areas that fell below average and develop/implement strategies to improve issues identified.
8. Action taken in response to the report or evaluation: OCDD’s quality improvement process includes review of NCI data as well as data from other sources such as: data on regional performance indicators as part of the Human Services Accountability and Implementation Plan and data from EarlySteps and Home and Community-Based Services (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 Assistant Secretary.
9. Availability (hard copy, electronic file, and website): Available in electronic file on the National Core Indicators website:
www.nationalcoreindicators.org
10. Contact person for more information, including:
Name: Dolores Sarna
Title: Program Manager 2
Agency & Program: Office for Citizens with Developmental Disabilities,
Quality Management Section
Telephone: 225-342-5714
E-mail: Dolores.Sarna@LA.GOV

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
09-375 Imperial Calcasieu Human Services Authority

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Executive Director: Tanya M. McGee

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

Increase in Staff Productivity & Self-Generated Revenue within Behavioral Health (BH)

A. What was achieved?

Since ImCal was created, we have strived to increase behavioral health clinical staff productivity in an effort to increase self-generated revenue. In FY14-15, individual staff productivity levels, which are measured by calculating direct clinical service hours, increased an average of 41% across the four (4) ImCal BH Clinics, which resulted in an increase of 23% in self-generated revenue as compared to the previous fiscal year.

B. Why is this success significant?

This move is significant for a number of reasons. National research demonstrates that the increase in revenue among behavioral health providers averages 4% a year. ImCal increased revenue by more than five times the national average. This increase is even more significant when you factor in that approximately 40% of the individuals served within ImCal are indigent. This demonstrates substantial increase in Medicaid and 3rd party billing.

C. Who benefits and how?

This benefits all individuals served by ImCal HSA as well as the Southwest LA community. ImCal must continue to increase revenue to prevent reductions in programs and services.

D. How was the accomplishment achieved?

This achievement was accomplished through multiple performance improvement strategies within the BH clinics. One of which was to include specific productivity expectations within the clinical staff PESs (Performance Evaluation System) and holding staff accountable for meeting those expected standards. Restructuring all prescriber appointments to a 30 minute block as opposed to 60 minute assessment and 20 minute follow-ups. By doing this, no-shows were better controlled and appointment availability for prescribers increased. The billing unit also made enhancements to the billing process such as implementation of policy & procedures for claims management, revenue tracking, client scheduling according to payer source, client eligibility & authorizations, working denials, provider credentialing with 3rd party payers, 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

Consolidation of Allen and Beauregard Behavioral Health Clinics

A. What was achieved?

ImCal HSA consolidated its Allen and Beauregard Behavioral Health Clinics in an effort to maintain current mental health and addiction services, while increasing efficiency and use of state funds that support services in those parishes.

B. Why is this success significant?

After close monitoring over the previous fiscal year of the number of persons served in both clinics, executive management discovered that direct clinical services were occurring less than twenty hours a week in each clinic. So with this move, we were able to maintain the same level of service currently being provided by the facilities at a significant cost saving to the state. With the consolidation, ImCal realized a \$280,838 cost savings and an increase of 25% in clinical staff productivity.

C. Who benefits and how?

This benefits the individuals served by the Allen and Beauregard Behavioral Health Clinics. With the increased monitoring of the clinics and productivity, establishment of measurable performance measures, and regular staff turnover, the Allen and Beauregard Behavioral Health clinics did not have enough licensed staff to operate nor did they have the client demand that warranted a full-time 5 day a week clinic in both locations. Without the successful consolidation of the clinics, one or both would have faced possible closure forcing clients to travel over an hour to Lake Charles to receive services.

D. How was the accomplishment achieved?

Beauregard BHC open for services on Monday, Wednesdays and Fridays and Allen BHC open for services on Tuesdays and Thursdays. Existing staff are shared among the two facilities. All staff work in both Allen & Beauregard on scheduled open clinic days. Phone coverage remains open for both clinics 5 days per week for scheduling, phone screening, crisis calls, etc. Each clinic retained admin support staff with split duties at both clinics, ex. receptionist/operator/screener vs. purchasing/medical records/scheduler. Utilize the days closed at Allen BHC for expansion program serving kids and adults with Autism.

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****Implementation of an Applied Behavioral Analysis Program in Allen BHC****A. What was achieved?**

Through a partnership with the McNeese State University Autism Program, ImCal developed and implemented a program in the Allen Behavioral Health Clinic to treat individuals with autism or other developmental disorders and their families through intensive individualized interventions using the evidence-based practices of Applied Behavior Analysis (ABA). Services include, but are not limited to, behavioral assessment; development, monitoring, and revision of individual behavior plans; monitoring effectiveness; and providing consultation services.

B. Why is this success significant?

With the inclusion of ABA services under the Medicaid State Plan amendment, many ABA providers opened their doors to provide services to individuals on Medicaid, however all of these providers (with the exception of one) were only providing services to individuals in Calcasieu Parish. Through the implementation of this program, ImCal was able to fill in the gap and ensure that others in SWLA had access to ABA services.

C. Who benefits and how?

This benefits individuals with autism or other developmental disorders and their families within Allen and Beauregard Parish as well as neighboring parishes. By offering this program within the rural communities surrounding Oberlin and DeRidder, we are able to prevent families from having to drive over 2 hours roundtrip to receive ABA services in Lake Charles. For the most intensive cases, services are provided up to 8 hours a day, 5 days a week.

D. How was the accomplishment achieved?

ImCal HSA entered into a professional services contract with McNeese State University to provide the licensed and certified ABA providers for the program. ImCal renovated space

at the Allen Behavioral Health Clinic to accommodate the program and purchased all of the needed equipment and supplies to implement the services. With the Medicaid revenue generated from the ABA services provided, the program pays for itself.

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

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

II. Is your department Five-Year Strategic Plan/Business Plan on time and on target for accomplishment? To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.

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

ImCal HSA is on time and on target to meet the goals and objectives set within our 5 year strategic plan. The mission of Imperial Calcasieu Human Services Authority (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. Since ImCal HSA completed the DHH Readiness Assessment Process and gained Authority over behavioral health and developmental disability services in SWLA, we have made strides in developing policies and procedures throughout all of our 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.

- ◆ **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:

ImCal HSA continues to make steady progress in all three Program Activity areas. As one of the newest districts within the state, we continue to learn how to function as an agency under the state umbrella. In assuming control over all administrative, fiscal, and programmatic responsibilities for the administration of Behavioral Health and Developmental Disability services in SWLA, ImCal continues to develop and revise policies and procedures related to

Budget, Contracts, Purchasing & Procurements, Information Technology, Property, Safety, Emergency Preparedness, Human Resources, Payroll, Workforce Development, and Community Services.

Outside of the three accomplishments described in Section I. above, while ImCal has not significantly exceeded any stated objectives and strategies, we have made steady and efficient progress in all objectives and strategies as indicated in our 5 year plan.

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

ImCal has made steady and efficient progress in all objectives and strategies as indicated in our 5 year plan.

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

ImCal Executive Management Team utilizes the 5-year Strategic plan to develop ImCal HSA's annual operational goals and objectives as well as develop its annual budget. Performance measure data outlined within the 5-year Strategic Plan is collected quarterly and shared with the Executive Management Team. Performance measures are adjusted as needed.

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

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

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

A. Problem/Issue Description

Unattainable Self-generated Revenue (SGR) targets for Behavioral Health Services

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

ImCal HSA's budget was received through Interagency Transfers (IAT) with the Office of Behavioral Health and the Office for Citizens with Developmental Disabilities. The State General Funds from OBH were reduced and a self-generated revenue target of \$2.1 million was placed within ImCal budget. The expectation was that with the changes in moving BH services to a managed care system and the additional addiction treatment services that were included under the LBHP, ImCal HSA would self-generate funding to sustain its budget. In FY

12/13, our BH clinics under the authority of OBH Region 5 generated less than \$400,000 in self-generated revenue. The expectation to increase that by over 300%, within those same clinics with the same number of staff and resources, was completely unreasonable and unattainable. In FY 14/15, ImCal through successful reduction of expenditures decreased the SGR means of financing target down to \$1.6 million. Even with this significant reduction of SGR, as well as the 23% increase in funds generated in FY 14/15 compared to the previous year, the \$1.6 million target is still grossly unattainable.

2. **Is the problem or issue affecting the progress of your strategic plan? (See Section II above.)** N/A
3. **What organizational unit in the department is experiencing the problem or issue?** All areas of ImCal HSA due to the reduction of expenditures required to balance the unmet SGR target.
4. **Who else is affected by the problem? (For example: internal or external customers and other stakeholders.)** N/A
5. **How long has the problem or issue existed?** When the Self-generated revenue targets were added to the budget for FY 13/14.
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?** Reduction of self-generated revenue target.
3. **Has this recommendation been made in previous management and program analysis reports? If so, for how long (how many annual reports)?** N/A
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? FY 16/17
 - 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

A. Problem/Issue Description

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

ImCal HSA struggles with recruitment and retention of licensed professional staff due to the requirements and rules issued by La Department of Civil Service. Under a BH Managed Care environment, ImCal HSA is expected to operate similar to the private sector in order to generate revenue to support the budget. This is not feasible when forced to operate as a governmental entity in regards to Human Resources. The requirements and rules regarding the posting and filling of positions, disciplinary actions, and any re-organization of staffing patterns or job duties cripples ImCal HSA in hiring and sustaining high quality staff.

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

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

issue? All areas of ImCal HAS

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 rules of the LA Department of Civil Service.
7. **What are the consequences, including impacts on performance, of failure to resolve the problem or issue?** ImCal will have difficulty filling vacancies.

B. Corrective Actions

8. **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.

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)
- 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)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review
- Customer/stakeholder feedback
- Other (please specify):

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

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

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

Louisiana State Civil Service Drop In Review

1. Title of Report or Program Evaluation

Louisiana State Civil Service Drop In Review

2. Date completed

September 16, 2014

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

Preparation for Full Civil Service Audit to occur FY 15/16

4. Methodology used for analysis or evaluation

Review of personnel records, human resource policies and HR staff interviews.

5. Cost (allocation of in-house resources or purchase price) no cost to ImCal

6. Major Findings and Conclusions

Documentation of certification for compliance was not provided for two appointments and two reallocations as required by Civil Service rule 15.3(b). For two appointments documentation of a department preferred reemployment list check was not provided. For one appointment, documentation of a department preferred reemployment list check was untimely. Documentation of the identity of the person who verified that the employee met the minimum qualification requirements for the position was not provided for two appointments. For one appointment, the LA Careers posting showed that some applicants were not moved through the evaluation steps resulting in an incomplete eligible list.

7. Major Recommendations

Agencies must ensure that certification for compliance with Civil Service rules is documented for all personnel actions taken by the agency as required by Civil Service Rule 15.3(b) and directives contained in Chapter 15, Job Aids and Resources, Documentation and Reporting Requirements located in the HR Handbook on the Civil Service website. Agencies must adhere to Civil Service Rule 22.3 and procedures contained in Chapter 22 in the HR Handbook located on the Civil Service website.

8. Action taken in response to the report or evaluation

Human Resource staff reviewed policy and procedures related to the appropriate documentation of certification of compliance, regular monitoring and review of the DPRL list, and documentation of which HR

staff verify minimum qualifications.

9. **Availability (hard copy, electronic file, website) electronic file:**
Available upon request.

10. Contact person for more information:

Name: Sheryl Meek
Title: DHH Monitor, Corporate Compliance Officer
Agency & Program: ImCal HSA
Telephone: 337.475.3100
E-mail: sheryl.meek@la.gov

Louisiana Legislative Audit

1. Title of Report or Program Evaluation

Louisiana State Legislative Audit

2. Date completed

April 28, 2015

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

Legislative Auditors conducted procedures at the Imperial Calcasieu Human Services Authority (ImCal) to evaluate certain internal controls ImCal uses to ensure accurate financial reporting and transparency, compliance with applicable laws and regulations, and to provide overall accountability for public funds.

4. Methodology used for analysis or evaluation

The Auditors evaluated ImCal's operations and system of internal controls through inquiry, observation, and review of its policies and procedures, including a review of the laws and regulations applicable to ImCal. Based on the documentation of ImCal's controls and our understanding of related laws and regulations, we performed procedures on selected controls and transactions focusing on ImCal's participation in LBHP.

5. Cost (allocation of in-house resources or purchase price) \$22,068

6. Major Findings and Conclusions

- Eligibility certifications for clinical assessments are not performed timely by the contracted third-party assessor. The approval process, as required under the LBHP, takes from 60-90 days from initial assessment to approval.
- ImCal did not award the 1915(i)-Only waiver program for individuals who may have qualified. Patients who may not qualify for behavioral health services under Medicaid only due to financial qualifications, may qualify

under the 1915(i)-Only waiver program.

- ImCal is currently not billing Medicaid for Qualified Medicare Beneficiary Plus claims, in which Medicaid pays for the co-insurance amounts for Medicare patients.
- ImCal has not performed an adequate reconciliation of claims collections to accounting records and client files due to needed improvements in the Magellan information provided to ImCal and an inadequate effort on reconciling by ImCal.
- ImCal has been unable to perform an adequate reconciliation of the checks sent to DHH for deposit into the ImCal State Treasury account to what is recorded by DHH in the accounting system due to lack of assistance by DHH.
- ImCal is not adequately tracking or collecting accounts receivable. ImCal has no report that provides a complete listing of accounts receivable, when billings/claims were sent, or the ages of the balances. Private-pay patient claims are not timely or consistently billed.
- Errors with coding of expenditures by DHH exist which causes inefficiencies in ImCal's work flow.
- It appears ImCal will not successfully meet the self-generated budget. ImCal had only collected approximately 14% of its annual fiscal year 2015 budget through December 31, 2014. ImCal does not set its own budget for self-generated revenue.
- ImCal has adequate controls over safeguarding and deposit of cash; processing expenditures; human resource records; safeguarding, inventorying, and updating records on new and deleted assets; maintaining support for financial reporting over these areas; and complying with state regulations over these areas.

7. Major Recommendations

ImCal should work closely with DHH and Magellan to ensure that the 1915(i) eligibility determinations can be completed timely. For the delay caused by lack of capacity by Pathways, ImCal should request that both DHH and Magellan instruct Pathways to consider increasing capacity. Even though Medicaid co-insurance payments may be small, ImCal should continue working with their system vendor to find an effective and efficient solution. ImCal should also work with DHH and any other districts/authorities that use the same system to develop a solution. With tight funding and routine budget cuts, ImCal should work to maximize any billings and collections. ImCal should work diligently with DHH and Magellan to gain the understanding of Magellan remittance information to reconcile Magellan payments to accounting records and client records. ImCal should work diligently with the system vendor and any management of other district/authorities who use the same system, to design and implement effective

internal controls over accounts receivable. Considering the tight budgets and routine budget cuts, ImCal should make every effort to maximize collections. Good internal control over accounts receivable will help maximize collections. ImCal management should work closely with DHH to ensure the authority is adequately funded to meet its statutory obligation for providing safety net behavioral health services in the region.

8. Action taken in response to the report or evaluation

Regarding the reconciliation of Medicaid and other revenues, ImCal has been working with DHH and the auditor team to revise internal processes related to the reconciliation of remittance information to bank statements and ImCal's Electronic Health Record (EHR). We are now able to reconcile 100% of all Magellan payments and recoupments through our bank statement and client record. In addition, ImCal has sought assistance from Acadiana Area HSD and DHH to ensure we have access to the appropriate revenue reports to be able to reconcile other revenues by coding back to ImCal's budget. The ImCal accountant now routinely runs these reports and reconciles the coding applied by DHH to the monthly closings generated by ImCal.

We strongly agree with the auditors' recommendation to strengthen our accounts receivable program. ImCal had initially utilized the DHH/OBH-supported Online Accounts Receivable System (OARS). DHH recently shut down the OARS program, and ImCal learned in the course of this audit that DHH would not be replacing OARS with any accounts receivable program. ImCal is now working closely with our EHR vendor to find an accounts receivable program to purchase in order to perform the billing, tracking, and collections of all patient accounts.

ImCal will continue to work closely with DHH regarding reduction of the over-inflated self-generated revenue target and the continued provision of adequate funding to maintain services. In addition, ImCal will continue to work with DHH, OBH, Magellan and the Bayou Health plans in determining client eligibility for 1915i waiver services and Medicaid billing in order to ensure clients have timely access to care and revenue streams are maximized.

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

<http://www.la.la.gov/> OR electronic file available upon request

10. Contact person for more information:

Name: Sheryl Meek
Title: DHH Monitor, Corporate Compliance Officer
Agency & Program: ImCal HSA
Telephone: 337.475.3100
E-mail: sheryl.meek@la.gov

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
09-376 Central Louisiana Human Services District

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Executive Director: John Egan Jones, LCSW

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

Administration

A. What was achieved?

A new Electronic Health Record (EHR) was selected and all necessary preparations were made to implement the new EHR by July 1, 2015.

B. Why was this success significant? The current system provided by Magellan was not a true EHR and was unable to provide adequate reporting or billing capacity. The system was not user friendly and did not allow for movement to a paperless health record system. Our new EHR, ICANotes, is a widely used web-based EHR that assists clinicians to create clinical reports with ease and assists with determining the highest billing code for services. The new EHR will allow Central Louisiana Human Services District to bill and track third party payers and provides an easier mechanism for obtaining monies owed for services provided by the District. The new EHR has the capacity to eliminate the need for any paper record.

C. Who benefits and how? The new EHR will allow for more proficient movement of persons through our system. Information about persons served will be in a secure, centralized location making it easier to access information, track information, and share appropriate information with others. It will also improve

billing practices which will increase the District's self-generated revenue. Increased revenue can then be used to enhance and increase services throughout the District.

D. How was this accomplishment achieved? Appropriate steps were taken to enhance our IT capacity and train employees and persons served on the new technology.

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

Yes. It will improve record keeping and billing practices and enhance revenue generation thus; increasing our capacity to provide behavioral health services to the persons 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?

Not Applicable.

Information Technology (IT) Department

A. What was achieved?

During FY 2014 -2015 the CLHSD IT Department successfully completed its Migration off the DHH Network. This allowed the District to establish its own Wide Area Network (WAN) connections and Internet Access capabilities. All systems were maintained throughout the year. CLHSD had two IT expansion projects: (1) Video Conferencing services for telemedicine capabilities with Tulane University's Department of Psychiatry was implemented throughout all clinics in the District and (2) WAN connections for the Leesville Mental Health Clinic were established.

B. Why was this success significant?

Completion of the migration off the DHH Network resulted in the District becoming independent of DHH IT Network Support and developing its own network at the Local Governing Entity (LGE) level. Expansion projects brought increased service capacity to the District Clinics and Network Connections brought greater local level decision making into the process of meeting District IT needs. WAN allows for all District services to have Virus Protection, File Storage and Software programming.

C. Who benefits and how?

District Staff and Clients both benefit with greater access to resources and increased Psychiatric service options.

D. How was this accomplishment achieved?

Both expansion projects were accomplished by working with AT&T Video services and other contractors.

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

Yes. Improving access to services/resources and using state of the art technology increases the scope, speed and quality of services provided and contributes to treatment success.

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

Yes. Sharing strategies that use available technologies is a best practice that benefits both providers and consumers of services.

Developmental Disabilities**A. What was achieved?**

Increased the number of individuals served through the Individual and Family Support (IFS) program which resulted in our fulfillment of a Corrective Actions Plans to utilized and expend IFS Budget dollars. Additionally, we implemented in-house changes that were effective in meeting the required timeline for completing applicants' eligibility process, thus alleviating the need for a Corrective Action Plan. Due to the release of N.O.W. Waiver Slots served an increased number of individuals in through our Waiver Unit.

B. Why was this success significant?

The above accomplishments were significant in that CLHSD DD section served more people without an increased budget but rather through successful monitoring and prioritization of needs.

C. Who benefits and how?

Individuals/Families of Individuals with DD who reside in the CLHSD eight parishes (Avoyelles, Concordia, Catahoula, Grant, LaSalle, Rapides, Winn and Vernon) benefit because their needs are being met through available financial and/or community resources.

D. How was this accomplishment achieved?

Community outreach was achieved through the Office of Behavioral Health (OBH), Collation Meetings, Schools and other Public meetings/forums.

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

Yes. Increasing the number of people served (at no additional cost) is a primary goal/objective of the Strategic Plan.

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

Yes. Collaborative impact resulting in increased number of people served/services is a best practice on its own. Given the financial constraints of our current budget, expansion without cost becomes a critical strategy.

Business and Funding Development (BFD)**A. What was achieved?**

Through technical assistance and professional consultation, the BFD leadership was instrumental in the development of the first Mental Health Court (MHC) for Adults in the Central Louisiana Human Services District (CLHSD), and the first MHC in Rapides Parish. Initially, there were four (4) individuals identified for this program. During FY 2014-15 the program has expanded and there are currently eleven (11) Mental Health Court participants.

B. Why was this success significant?

The role of CLHSD is to guide and support local courts in the exploration of reasonable alternatives to incarceration, that includes the diversion of people with mental illness to community based services, where these mentally ill persons can find appropriate treatment and support. These programs have both an economic and a treatment impact, as the cost of incarceration is significantly greater than the cost of treatment and experts consider MHC to be one of the best approaches for avoidance of criminalization of people with mental illnesses. The aim of MHC is to ensure timely access to the services and supports that are crucial to people with serious mental illness that otherwise would be trapped in the Criminal Justice System.

C. Who benefits and how?

This program targets individuals in the local area of Adult Probation and Parole System that meet the Court's criteria. An outcome of the program is its impact on the mentally ill population by providing access to treatment opportunities in order to decrease further criminal involvement. As such, the Individual, the Criminal Justice System and the community at large will be positively impacted.

D. How was this accomplishment achieved?

The collective impact of this project started in 2013, when CLHSD staff visited the St. Tammany Mental Health Court to ascertain how that particular project was implemented without any formal source of funding. After studying the St. Tammany Parish model, a consortium formed by a presiding Rapides Court Judge, Assertive Community Team (ACT), a Community Psychiatric Support Team (CPST), Caring Choices Behavioral Health Clinic Staff and the Business and Funding Development Officer began interviewing candidates for the program. To this date the program continues to successfully operate, with candidates referred for individual assessment and based on the results of the assessment they are assigned to diversionary programs that best match their needs.

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

Yes. The Mental Health Court program provides services to a special population and enhances the effectiveness of treatment for the mentally ill clients.

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

Yes. This strategy benefits both the Agency and the community and is a cost effective manner, potentially improving treatment quality. As the program matures, the acquired learning should be shared across Parishes and ultimately, the State.

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

CLHSD's Strategic Plan/Business plans are on target to accomplish the set Administrative, Behavioral Health and Developmental Disabilities programmatic goals and objectives.

♣ Where are we making significant progress?

CLHSD continues to make strides the Agency goals 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. The District's Compliance Division conducts regular on site monitoring of programs 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 District, Departmental, State and Federal guidelines. One of the primary focuses has been educating the community on the importance of prevention, early detection and intervention, and facilitating coalition building to address localized community problems. A noteworthy effort is the implementation of public forums in each of the Parishes we serve and the

collection of regional data to include a survey of needs and priorities for each parish. The Developmental Disability (DD) Department has succeeded in serving a greater number of people without incurring additional cost. The IT Department is working toward linking the entire District using information technology and electronic communication. The Administration has led the charge to transfer/implement an Electronic Health Record System to be used by District and Contracted providers.

1. To what do we attribute this success?

This success is attributed to the joint effort among the Administration, Fiscal, IT, Behavioral Health, Corporate Compliance, Business & Funding Development and the Human Resource Divisions. It is the result of top level leadership and participation at all levels of functioning. The entire Agency is geared toward maximizing existing resources and complying with Federal, State and District guidelines. Individual departments have collaborated to reallocate resources and utilize technology to increase productivity and ultimately to meet the needs of the people we serve.

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

Our goal is for progress to continue. There may be some challenges due to external pressures, but the District will use all of its available resources to move forward.

♣ Where are we experiencing a significant lack of progress?

None.

1. To what do you attribute this lack of progress?

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

♦ Has your department revised its strategic plan/business 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?

This is Not Applicable.

♦ How does your department ensure that your strategic plan is coordinated throughout the organizational and management levels of the department, regularly reviewed and updated, and utilized for management decision-making and resource allocation?

The formulation of the CLHSD strategic plan will adhere to management strategies approved by the Executive Director. These strategies, at a minimum, will include:

- **Input:**

At the *District level*, the initial steps consist of gathering input from all levels of the agency's functional areas. Meetings are conducted with CLHSD Executive Team and District and Contract program managers to share the leadership mission and vision and to obtain feedback for implementation of Agency goals and objectives.

At the *community level*, Community Awareness and Partnership Forums are conducted to gather information regarding the priority needs of the people we served in each Parish and this feedback will be incorporated in the development of the Strategic Plan Objectives. Stakeholders' surveys are conducted during these forums.

At the *Executive level*, the Executive Director exchanges ideas with the CLHSD Board and invites their input and feedback on monthly meetings. The Board will give review the plan and give an final approval

- **Communication:**

The Strategic Plan will be available for review at all provider sites and on the DHH website as part of a compilation of Strategic Plans for DHH.

- **Coordination:**

Using technology to enhance communication and participation, e.g., teleconferences, videos, electronic media, etc.

- **Training:**

Ongoing training is provided to ensure all stakeholders become familiar and buy into the District's goals and objectives.

- **Performance measurement:** Formulation of objectives that are Specific, Measurable, Attainable, Results oriented and Time-bound. Performance indicators are formulated to ensure monitoring of progress in goal/objective attainment.

- **Evaluation:** The Strategic Plan will be revised, as warranted, to reflect fiscal, managerial and programmatic changes.

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

A. Problem/Issue Description

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

Closure of the Central Louisiana State Hospital, Pineville and other collateral issues: Central Louisiana State Hospital is the free-standing inpatient facility that provides acute, intermediate and long-term mental health care, treatment and rehabilitative services to adults in Central Louisiana. In 2012, DHH announced a two-phase plan to vacate the current Central State Hospital property and build a new facility on land adjacent to Pinecrest Supports and Services Center. In the second phase, DHH will build a new building on property it already owns and maintains adjacent to Pinecrest along with using already vacant buildings that will be refurbished for ancillary services. The new Central Louisiana State Hospital will remain separate and apart from Pinecrest. Construction on the new building is expected to last between a year and a year and a half, at which time the current Central property will be completely vacated.

This issue was reported in CLHSD AMPAR 2014-2015 report and it still unresolved. Although there are no current plans determining the future of Central Hospital's grounds, the fact remains that it would happen, perhaps in the near future. Several issues must be addressed for a smooth transition:

- a. The hospital building infrastructure would have to be disposed of (pipes, plumbing, kitchen equipment, etc.). Issues related to asbestos contamination must be also addressed. Predictable salvage value is mostly negligible and is generally exceeded by the cost of disposition.
- b. There are several agencies/programs –including CLHSD and CLHSD contractor programs- that reside in the Central Hospital campus that will need to relocate. At the time the grounds need to be vacated, those programs (including CLHSD's) will have to relocate. The process of relocation will require a significant investment of time and money.
- c. Services located on the grounds of Central State Hospital serving more than 13,000 consumers annually include:
 - Behavioral Health Clinic of Central La providing both mental health and addictive disorders services to the Alexandria/Pineville area
 - Halfway House for men with Addictive Disorders
 - Halfway House for women with Addictive Disorders
 - Residential Treatment for Women with Dependent Children (TANF)
 - Halfway House services for Homeless Veterans
 - The Extra Mile, Region 6 including food pantry and clothes closet for those in need
 - Residential Treatment for Adults with Addictive Disorders (Red River)
 - Residential Treatment for Adolescents with Addictive Disorders (Gateway)
 - Co-Occurring Disorders Unit for those with both Addictive Disorders and Mental Illness
 - Adolescent Intensive Outpatient Services

- 9th JDC Adolescent Drug Court
 - Compulsive Gambling Outpatient Services
 - CLHSD Prevention Programming
 - VOA Transitional Living Program
 - CLHSD Administrative Offices
- d. Non-positive outcomes of changing locations. The cost of relocation extends beyond the actual move to a new location.
- Currently, there is a minimal cost incurred to reside in the grounds (rent free, low utilities etc.).
- e. Patients' accessibility to treatment will be negatively impacted.
- Distance is a factor in facilitating services. By virtue of being on campus, programs are able to easily communicate and provide wrap-around services, depending on the clients' need.
- 2. Is the problem or issue affecting the progress of your strategic plan?**
As delineated above, this issue is potentially detrimental to the Agency's future goals. There will be a period of adjustment for both the District and the people we served.
- 3. What organizational unit in the department is experiencing the problem or issue?**
The entire District and the providers currently on the grounds of Central will be impacted by this issue.
- 4. Who else is affected by the problem?**
The people we serve and their families are members of the community, thus the entire community and stakeholders are ultimately impacted.
- 5. How long has the problem or issue existed?**
The issue resulted from the proposed closure of the Central Louisiana State Hospital, in 2012.
- 6. What are the causes of the problem or issue? What are the consequences, including impacts on performance, of failure to resolve the problem or issue?**
See A-1 above.

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 proactive plan of action needs to be implemented including possible alternatives, such as allowing programs to remain on campus, as part of the final disposition of the grounds and/ or DHH providing supplementary funding for reallocation cost.

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

This is not applicable.

4. Are corrective actions underway?

Time frame and plans unknown.

5. Do corrective actions carry a cost?

No. If not, please explain.

Yes. If so, what investment is required to resolve the problem or

There are too many unknown variables to predict cost.

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: CLHSD Corporate Compliance Department conducts regular monitoring and identifies /reviews any areas of concern.

External audits (Audits by the Office of the Legislative Auditor, DHH Annual monitoring/MOU is conducted to ensure compliance with the Human Services Accountability and Implementation Plan (AIP). It includes on-site monitoring and corrective action plan, if warranted.

Licensing reviews are conducted annual by the DHH Health Standards staff to certify providers abide by established guidelines.

CLHSD Board's reviews: The Board in conjunction with the Executive Director reviews the District operations and endorses Business and Strategic Plans.

OBH oversees Block Grant and TANF programs.

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: CLHSD Division of Corporate Compliance conducts quarterly assessments of District and Contract Programs.
- Program evaluation by contract
- Performance Progress Reports: Louisiana Performance Accountability System (LAPAS)
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
- Peer review
- Accreditation review: CARF Quality standards form the cornerstone of CARF accreditation. Conformance to quality standards is a way to identify areas for improvement and growth and help the service provider focus on improved service outcomes, satisfaction of the persons served, and quality service delivery. Accreditation was granted in July 2013, for a period of three (3) years.
- Customer/stakeholder feedback (Stakeholders Surveys):
Community Awareness and Partnership Forums are conducted at the community level to gather information regarding the priority needs of the people we serve in each Parish and this feedback is incorporated in the development of the Strategic Plan Objectives. Stakeholders' surveys are conducted during these forums.
- Other (please specify): N/A

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.

Annual Management and Program Analysis Report

Fiscal Year 2014-2015

Department: Department of Health and Hospitals
09-377 Northwest Louisiana Human Services District

Department Head: Kathy Kliebert, Secretary

Undersecretary: Jeff Reynolds

Executive Director: Doug Efferson

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

For each accomplishment, please discuss and explain:

- A. **What was achieved?** Increased self-generated revenue collections by 34% over the previous fiscal year.
 - B. **Why is this success significant?** The dollars being realized are significant and the increase can be expected to continue going forward.
 - C. **Who benefits and how?** The State of Louisiana benefits by having self-generated revenue collections that better match budgeted expectations. NLHSD benefits by better meeting budget expectations.
 - D. **How was the accomplishment achieved?** This dramatic increase documents the success of improving clinic billing processes, centralizing the billing staff, and using ICANotes for claims processing instead of Magellan's Clinical Advisor software.
 - E. **Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) Yes
 - F. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes
-
- A. **What was achieved?** Psychosocial Rehabilitation Services (PSR) was implemented.
 - B. **Why is this success significant?** PSR is designed to restore the integration of the individual as an active and productive member of his or her family, community and/or culture with the least amount of ongoing professional intervention through the use of Peer Support Specialists.
 - C. **Who benefits and how?** The primary beneficiaries are clients and families as the

organization increases the use of ‘best practices’ with regard to services provided.

- D. **How was the accomplishment achieved?** Throughout the fiscal year, the peer support specialists received training on the Boston Model of Recovery. Soon after completing their training, PSR groups were implemented.
- 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**
- A. **What was achieved?** Created an independent IT Domain structure for NLHSD and migrated NLHSD from the Department of Health and Hospitals (DHH) IT Domain to the NLHSD IT Domain.
- B. **Why is this success significant?** NLHSD completed the process well ahead of schedule and before becoming an LGE. Also, the faster connectivity greatly improved clinical services by speeding up the online electronic medical record (EMR) interface.
- C. **How was the accomplishment achieved?** Use of NLHSD IT staff and a contracted IT Network Specialist allowed the District to move forward with the project quickly and resolve technical issues without service interruptions.
- D. **Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) Yes
- E. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes
- A. **What was achieved?** An 11% increase in the number of Developmental Disability clients who received waiver and community support services.
- B. **Why is this success significant?** This increase helps reduce the number of individuals waiting for services and improves the lives of those who receives services due to the increase.
- C. **How was the accomplishment achieved?** The NLHSD Developmental Disability Staff worked very hard to qualify individuals for waivers when they were available and support services when dollars were freed up due to attrition.
- D. **Does this accomplishment contribute to the success of your strategic plan?** (See Section II below.) Yes
- E. **Does this accomplishment or its methodology represent a Best Management Practice that should be shared with other executive branch departments or agencies?** Yes

- II. Is your department Five-year Strategic Plan/Business Plan on time and on target for accomplishment?** To answer this question, you must determine whether your anticipated outcomes—goals and objectives—are being attained as expected and whether your strategies are working as expected and proceeding on schedule.
- 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?

Key elements of the five-year Strategic Plan focus on the successful transition of governance, leadership, and services from the DHH to the LGE. Fiscal Year 2015 is the first year NLHSD operated as an LGE and completion of the first year represents significant progress in the five-year 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:

We are making significant progress by seeing an increase in the number of Developmental Disability clients who received waiver and community support services through NLHSD.

1.To what do you attribute this success?

With regard to waiver services, the increase is due to the additional funding allocated for waiver services and the aggressive work done by DD staff at NLHSD to qualify individuals for waiver services. With regard to community support services, the increase is due to the hard work done by DD staff at NLHSD to quickly qualify individuals for services and assure allocated funds are fully spent.

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

This progress is expected to continue as long as funding is available to expand developmental disability 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:

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/business 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?

Due to the short time since implementation of the NLHSD Five-year Strategic Plan, there has not been a need to revise the plan.

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

The areas of focus for the strategic plan were developed based on stakeholder input and the creation of an End Statement by the NLHSD Board of Directors. The NLHSD Senior Leadership Team then developed the goals and objectives of the plan based on input from management staff. The final draft has been disseminated to staff via e-mail and posted on the NLHSD shared folder for all staff to reference when needed. Review of the plan is set to occur twice a year with a summary report to the Board of Directors for their review and input.

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

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

None

Complete Sections A and B (below) for each problem or issue. Use as much space as needed to fully address each question. If the problem or issue was identified and

discussed in a management report or program evaluation, be sure to cross-reference the listing of such reports and evaluations at the end of this form.

A. Problem/Issue Description

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

None

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)
Semi-Annual Legislative Audits and Annual Civil Service Audits
- Policy, research, planning, and/or quality assurance functions in-house
Performance Improvement Committee reviews
- Policy, research, planning, and/or quality assurance functions by contract
- Program evaluation by in-house staff
Behavioral Health Services Annual Performance Analysis Report
- Program evaluation by contract
- Performance Progress Reports (Louisiana Performance Accountability System)
LaPAS and C'est Bon Reports
- In-house performance accountability system or process
- Benchmarking for Best Management Practices
- Performance-based contracting (including contract monitoring)
Contract Monitoring
- Peer review
Medical Staff Review and OCDD Peer Review process
- Accreditation review
3-Year CARF Accreditation with annual conformance review
- Customer/stakeholder feedback
Input solicited from surveys, during public forums, and requested during the NLHSD Board's annual strategic planning process.
- Other (please specify):

Annual Human Services Accountability and Implementation Plan (AIP) On-Site Monitoring 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:

Northwest Louisiana Human Services District – Behavioral Health 2014-2015 Annual Performance Analysis Report

2. Date completed

August 21, 2015

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

This report is generated to fulfill CARF accreditation standards. The report establishes specific, measurable goals and tracks the District's performance in an effort to determine the degree to which the District is achieving the desired service and business outcomes.

4. Methodology used for analysis or evaluation

A systematic annual review of Financial/Resource Allocation, Accessibility, Corporate Compliance, Cultural Competency and Diversity, Risk Management, Human Resources, Technology, Health and Safety, Strategic Planning, and Service Delivery Improvement.

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

No direct cost. Used in-house resources.

6. Major Findings and Conclusions

- 34% increase in self-generated revenue collections
- Received a 5-year "La Partnerships for Success" prevention grant
- Expanded "scan to email" capabilities for record and business functions
- Implemented a new IT Domain for NLHSD
- Implemented a shared folder system for electronic file sharing among behavioral health staff

7. Major Recommendations

- Implement an automated call reminder system to reduce no shows
- Transition to a new clearinghouse for better claims management
- Promote services through the development of a District website and the use of social media

8. Action taken in response to the report or evaluation
 - New clearinghouse chosen and contracted with
 - Automated call reminder system implemented
 - NLHSD website created and now online

9. Availability (hard copy, electronic file, website)
 - Electronic file is available on the District's shared folder

10. Contact person for more information, including
 - Name: Doug Efferson
 - Title: Executive Director
 - Agency & Program: Northwest Louisiana Human Services District
 - Telephone: (318) 862-3085
 - E-mail: Douglas.Efferson@la.gov